MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

THURSDAY 9TH MAY 2013

AT 6.30 PM

PLEASE NOTE START TIME

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

Dear Councillors,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
1.	Minutes (12 February 2013)	1 - 10
10.	NHS Quality Accounts 2012/13:- • North London Hospice Quality Account 2012/13 • Barnet and Chase Farm Hospitals NHS Trust Quality Account 2012/13 • Barnet, Enfield and Haringey Mental Health NHS Trust Quality Account	11 - 114
12.	Any Other Items that the Chairman Decides are Urgent:– • Members' Item (Cllr Geof Cooke) – Hospital Transport Services	115 - 122

Andrew Charlwood 020 8359 2014 andrew.charlwood@barnet.gov.uk

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Decisions of the Health Overview and Scrutiny Committee

12 February 2013

AGENDA ITEM 1

Members Present:-

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

Councillor Geof Cooke	Councillor Barry Rawlings
Councillor Julie Johnson	Councillor Reuben Thompstone
Councillor Arjun Mittra	Councillor Sury Khatri (In place of Kate Salinger)

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

Apologies for Absence

Councillor Maureen Braun	Councillor Kate Salinger
Councillor Bridget Perry	

1. MINUTES

RESOLVED that the minutes of the meeting held on the 11 December 2012 be agreed as a correct record.

The Chairman updated the Committee in relation to the following minute item:

Item 6 (Barnet and Chase Farm Hospitals NHS Trust – Maternity and Accident & Emergency Services Update) –

i) the corrected data relating to the attendances by PCT had not been supplied by the Trust;

ii) the issues raised by Dr Rounce had not been formally responded to by the Trust;

iii) details of still births and how the Trusts figures compared with the rest of London had not been provided; and

iv) the number of staff who had undertaken Alzheimer's training was 1207

RESOLVED that Scrutiny Office be instructed to request the information detailed at i) to iii) above from Barnet and Chase Farm Hospitals NHS Trust.

2. ABSENCE OF MEMBERS

Apologies for absence had been received from Councillors Maureen Braun, Bridget Perry and Kate Salinger. Councillor Kate Salinger had been substituted for by Councillor Sury Khatri.

3. DECLARATION OF MEMBERS' PECUNIARY AND NON-PECUNIARY INTERESTS

Member	Subject	Interest declared
Councillor Barry Rawlings	Agenda Item 7 (Central London Community Healthcare (CLCH) NHS Trust Foundation Trust Application – Stakeholder Engagement)	Non-pecuniary interest as Councillor Rawlings participated in the CLCH Reference Group
Councillor Alison Cornelius	Agenda Item 6 (Barnet, Enfield and Haringey Clinical Strategy – Ambulance Services)	Non-pecuniary interest by nature of being on the chaplaincy team at Barnet Hospital

4. PUBLIC QUESTION TIME

None.

5. MINUTES OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 22 OCTOBER 2012

The Committee considered the minutes of the North Central London Sector Joint Health Overview and Scrutiny Committee (JHOSC) which had taken place on 22 October 2012.

Members noted that the main item of business related to the closure of the Northgate Clinic and the subsequent impact on the Northgate Pupil Referral Unit due to the New Beginnings Clinic reaching capacity.

The Committee noted a JHOSC Transition Workshop had been held on 28 November 2012 where it had been agreed continue with the current joint scrutiny arrangements for a further year. Members were advised that the next JHOSC would be taking place on 14 March 2013 in Camden.

RESOLVED that the Committee note the minutes of the meeting North Central London Sector Joint Health Overview and Scrutiny Committee held on 22 October 2013.

6. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - AMBULANCE SERVICES

The Committee welcomed Dr Nick Losseff (Medical Director at NHS North Central London), Siobhan Harrington (BEH Clinical Strategy Programme Director) and Steve Colhoun (Ambulance Operations Manager at the London Ambulance Service).

In presenting the item Siobhan Harrington advised the Committee that BEH were on track to deliver the Clinical Strategy in November 2013. The Committee were informed

that building was taking place on the Barnet Hospital site and the clinical team were undertaking 'deep-dives' into each area and obtaining workforce detail.

In relation to performance of the London Ambulance Service, Steve Colhoun informed the Committee that Barnet generated approximately 112 calls per day from a London-wide total of 3,000. Referring to the implementation of the Clinical Strategy, Mr Colhoun considered that ambulance services would not be adversely affected by the service reconfiguration. He added that the Ambulance Service would work with commissioners to analyse the impact of the Chase Farm accident and emergency department converting to an urgent care centre and any subsequent impact on performance. The Committee noted that ambulance paramedics would determine the most appropriate care pathway for patients which, in some instances, required transfers to different specialist centres across London. It was noted that performance targets related to ambulance response times, rather than patient transfer times to hospitals.

Referring to destinations for ambulance patients, the Committee questioned how decisions were made by the Ambulance Service. Steve Colhoun reported that patients would be transferred to the nearest accident and emergency department, unless that department was under pressure. Dr Nick Losseff added that it was the responsibility of the NHS Trust to keep the accident and emergency department moving and address any system blockages. He advised the Committee that NHS Trusts worked closely with Clinical Commissioning Groups regarding moving patients on at the appropriate stage. Siobhan Harrington reported that capacity management at the front-end would be important in demand management; it was anticipated that up to 40% of accident and emergency patients would be treated in urgent care centres.

The Committee questioned what the outcome of the BEH Clinical Strategy Transport Committee meeting (which had taken place in January 2013) had been. Siobhan Harrington reported that the Transport Committee meeting had been chaired by Tim Peachey (Interim Chief Executive of Barnet and Chase Farm Hospital NHS Trust). The Committee had received the draft Transport Impact Assessment and further work had been commissioned to strengthen this. It was noted that representatives from Barnet, Enfield, Haringey and Transport for London had been in attendance at the meeting. Members questioned whether longer journeys for patients and residents would have an impact on patient care. Dr Nick Losseff advised the Committee that clinical evidence supported service reconfigurations which would lead to reduced mortality and morbidity.

Members questioned how the London Ambulance Service had been addressing the issues of ambulances not having the correct equipment and whether the current number of ambulances were sufficient to meet demand. Steve Colhoun informed the Committee that the Service had introduced improved procedures regarding equipment management and that he was confident that London Ambulance Service would continue to provide the same level of service following implementation of the BEH Clinical Strategy.

Referring to the Care Quality Commission inspection of the London Ambulance Service in December 2012 and their finding that the Service was facing higher demand than they could meet, Members questioned how this issue was being addressed. Steve Colhoun acknowledged that the Service had struggled with the demand profile and resourcing was an issue. He added that in meeting their targets relating to life threatening patients, other areas had suffered. The Committee noted that the BEH Clinical Strategy had considered resourcing and there was a commitment from commissioners to invest in the Service.

3

Responding to a question regarding commissioning of ambulance services during 2012/13 following closures of accident and emergency departments, the Committee were informed that the National Commissioning Board held this information. Steve Colhoun reported that for the BEH Clinical Strategy, ambulance service requirements had been defined through joint modelling.

The Chairman referred to a case where an ambulance had been called to two incidents, but had failed to attend in a reasonable time. In the event, the families had been required to take the patients to hospital. Steve Colhoun advised the Committee that he couldn't comment of specific cases and suggested that the patient be referred to the Patient Experience Team. He added that at times, there were more incidents than resources available. Emergency call handlers were required to triage calls and place patients into one of four categories which would require either a 10, 20, 30 or 40 minute response time.

RESOVLED that:–

1. **The Committee be provided with details of the final version of the BEH Clinical Strategy Transport Impact Assessment.**

2. **The Committee note the information provided by health partners in relation to the Barnet, Enfield and Haringey Clinical Strategy and ambulance services as set out in the committee report, presentation and the oral submissions as set out above.**

During consideration of the item above, Councillor Thompstone left the meeting at 7.30pm

7. ROYAL FREE HOSPITAL - POTENTIAL ACQUISITION OF BARNET AND CHASE FARM HOSPITALS

The Committee welcomed Dr Tim Peachey (Interim Chief Executive of Barnet and Chase Farm Hospital NHS Trust) and Dr Sue Sumners (Chairman of NHS Barnet Clinical Commissioning Group) who provided an update on the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free Hospital NHS Foundation Trust.

Dr Sue Sumners reported that a clinical working group had been established with representatives from the five Clinical Commissioning Groups (CCGs) in the North Central London cluster. The Outline Business Case for the acquisition had been focussing on the 10 principals for establishing the new organisation. The Committee expressed concern that the terms of the acquisition would be detrimental to Barnet and Chase Farm Hospitals.

Dr Tim Peachey advised the Committee that the Royal Free Hospital NHS Foundation Trust Board would be considering the Outline Business Case on 28 February 2013. If this was approved, it would be presented to the Barnet and Chase Farm Hospital NHS Trust Board in March 2013. The Committee noted that the acquisition would enable the new Trust to provide a wider range of services than were currently available across the combined hospital sites.

4

In relation to land ownership, Dr Peachey clarified that the Barnet and Chase Farm hospital sites were wholly owned by the Trust and would not be transferred to PropCo. The Committee were informed that Finchley Memorial and Edgware hospital sites were owned by PropCo. Members sought assurance that following the acquisition, the new Foundation Trust would be able to retain capital receipts from land sales to repay debts.

RESOLVED that the Committee note the update on the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free Hospital NHS Foundation Trust as set out in the presentation and the oral update detailed above.

8. CLCH FOUNDATION TRUST APPLICATION - STAKEHOLDER ENGAGEMENT

The Committee welcomed Murray Keith (Director of Strategy and Business Development and Central London Community Healthcare NHS Trust). Mr Keith advised Members that Central London Community Healthcare (CLCH) NHS Trust were undertaking a refresh of their consultation regarding their Foundation Trust application between 18 February and 3 April 2013. A refresh of the public consultation was required because there was a proposal to revise the proposed make-up of the Council of Governors. In addition, best practice states that if trusts have not achieved Foundation Trust status within a year of conducting their initial public consultation, then they needed to refresh the consultation to ensure it provides a more up to date picture of the views of stakeholders.

Responding to a query regarding the make-up of the Council of Governors, Mr Keith reported that there would be representation from the three core boroughs, with additional representation from other fringe boroughs. Members noted that the Trust had been experiencing difficulty in recruiting to the Council of Governors because of the community based nature of the services provided.

RESOLVED that:

1. **The Committee note the update on Central London Community Healthcare (CLCH) NHS Trust Foundation Trust application as set out in the report and above.**

2. **The Committee review their previous submission to CLCH NHS Foundation Trust on the Foundation Trust application and make any amendments necessary before resubmission.**

9. BARNET CLINICAL COMMISSIONING GROUP - FINANCE UPDATE

The Committee received an update from Dr Sue Sumners (Barnet Clinical Commissioning Group Chairman), Bev Evans (Interim Cluster Finance Director for North Central London) and Maria O'Dwyer (Assistant Director, Service Development and QIPP, Barnet Clinical Commissioning Group) on the Barnet Clinical Commissioning Group (CCG) Financial Plan for 2013/14. Members were informed that from a total expenditure of £500 million, the CCG were anticipating a £30 million deficit in 2013/14. Maria O'Dwyer reported that the CCG were developing plans to recover the position over a one to four year period. Dr Sumners advised the Committee that there was a track record of delivering transformational changes as both a Primary Care Trust and a CCG.

Members expressed concern regarding the projected deficit and sought assurance that the QIPP (Quality, Innovation, Productivity and Prevention) Plan would not result in reductions in the number of frontline staff. Ms Evans advised the Committee that staffing reductions were not an option, with the focus being on the best and efficient use of resources. Members commented that QIPP savings targets needed to be identified and actions taken to achieve savings early in the financial year otherwise there was a significant risk of them not being achieved. Maria O'Dwyer reported that early work was being undertaken to identify efficiencies (e.g. cardiology and respiratory services reconfiguration, admissions avoidance, rehabilitation and local authority reviews of care homes).

RESOLVED that:

1. **The Interim Cluster Finance Director for North Central London be requested to provide the Barnet CCG savings plan to the Committee.**

2. **The Committee receive updates at future meetings on the financial status of Barnet CCG.**

10. PUBLIC HEALTH TRANSITION

The Committee welcomed the Cabinet Member for Public Health, Councillor Helena Hart, and the Director for People, Kate Kennally, to the meeting to present a report on the development of a shared Public Health function between the London Boroughs of Barnet and Harrow. The Committee were requested to give consideration to the draft report to Cabinet on 25 February 2013 and make comments and/or recommendations on the proposals contained therein.

The Cabinet Member for Public Health reported that the Council had successfully lobbied to have the resource allocation from the Department of Health increased from £13.799 million per annum to £14.355 million per annum. It was emphasised that Barnet had received the third lowest settlement in London. The Committee noted the concern that health checks undertaken after service transfer might result in an increased need for services. With reference to the London Borough of Barnet Commissioning Intentions for 2013/14, the Committee were advised that the Council would be developing an additional priority of 'Supporting First Time Mothers'.

In relation to the performance of services that the Council were taking over responsibility for providing, the Committee were informed that there were a number of areas where Barnet currently had significantly lower performance than regional and/or national averages. There was a requirement to work closely with the Barnet CCG to deliver improvements in these areas.

The Committee noted that, due to the funding uncertainties, not all public health programmes had been identified in advance of the transfer of the public health function to the Council.

In considering the public health contracts transferring to the Council (Appendix 2), Committee Members emphasised the importance of effective procurement via the shared service to ensure value for money. The Committee noted that the London Borough of Harrow would be the lead authority for commissioning and an associate commissioner would be working with the NHS to understand the year 1 baseline position. Re-

6

procurement decisions for services delivered in Barnet would be taken via the Shared Service Governance Board.

A Member of the Committee expressed concern regarding the split of executive responsibilities and how the audit function would be conducted in the shared service. Officers advised that they were working with the Director of Assurance regarding executive decision making and auditing of the shared function.

Members noted the overlap of some of the public health functions with some service areas that fell within the DRS service cluster (e.g. Environmental Health and Trading Standards). The Committee were assured that close working would continue with these services in the new organisational model.

RESOLVED that the Committee support and endorse the proposals set out in the Public Health Transition report to Cabinet.

During consideration of the item above, Councillor Julie Johnson left the meeting at 9.34pm.

11. MEMBERS' ITEMS - MATERNITY SERVICES (CAESAREAN BIRTHS)

The Committee considered a Member's Item in the name of Councillor Kate Salinger which related to maternity services in the borough. Councillor Salinger requested that NHS partners be requested to provide details of caesarean births in the borough, specifically the Royal Free London NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust who were requested to provide responses to the following questions:

1. In 2012 how many Caesarean operations were performed in:
   a) Barnet Hospital
   b) Chase Farm Hospital
   c) Royal Free Hospital

2. In 2012 how many of these Caesarean operations were elected by the patient in:
   a) Barnet Hospital
   b) Chase Farm Hospital
   c) Royal Free Hospital

3. In 2012 how many of these Caesarean operations were recommended by medical staff PRIOR to the patients admittance to give birth at:
   a) Barnet Hospital
   b) Chase Farm Hospital
   c) Royal free Hospital

4. How many inductions were performed at:
   a) Barnet Hospital

7

b) Chase Farm Hospital

c) Royal Free Hospital

5. How many of these inductions led to a caesarean operation at:

a) Barnet Hospital

b) Chase Farm Hospital

c) Royal Free Hospital

RESOLVED that the Director of Public Health be requested to investigate the issues outlined above and prepare a report for the next meeting of the Committee on 9 May 2013 detailing: comparative London statistics; any abnormal trends; and reasons for inductions (local and national).

12. HEALTH OVERVIEW AND SCRUTINY FORWARD PLANNING

Members considered the current Health and Well Being Board Forward Work Programme, current published Advanced Notice of Proposed Decisions under Executive Functions and the Committees Forward Work Programme.

The Cabinet Member for Public Health highlighted that a major item at the Health and Well Being Board on 25 April 2013 would relate to the Francis Report which had been published following the public inquiry into patient care provided by the Mid-Staffordshire NHS Trust. Councillor Hart advised the Committee that she had written to the Chairman of the four health trusts requesting details of actions that the trusts will be taking in response to the findings.

The Committee noted that the Francis Report had also made specific comments about the role of the Local Involvement Network and local health scrutiny committee. Officers undertook to review these findings and recommendations and report them to the next meeting of the Committee.

RESOLVED that:

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

2. **The Committee receive a briefing on the findings and recommendations of the Francis Report at the next meeting on 9 May 2013.**

3. **Following the receipt of a representation from a member of the public, the Committee receive a report on the Brunswick Park Health Centre at the next meeting on 9 May 2013.**

4. **The Committee receives updates on Health and Social Care Integration projects be added to the Forward Work Programme for reporting to a future meeting of the Committee.**

8

13. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

The Scrutiny Office was requested to collate Members availability (including the Cabinet Members for Education, Children & Families and Adults) for a visit to Finchley Memorial Hospital.

The meeting finished at 9.58 pm

9

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Quality Account 2012/201

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North London Hospice in Finchley 47 Woodside Avenue, London N12 8TT
North London Hospice in Enfield 110 Barrowell Green, London N21 3AY
Registered charity No: 285300

Contents

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 2013-14 are proposed:

1. Improvement of users' experience through the ongoing development and review of new volunteer roles.
2. Introduction of an ultrasound service on the IPU.
3. The introduction of version 12 Liverpool Care Pathway tool into the community

The 2012-13 priorities for improvement projects are reported and have contributed already to increased user feedback through the rich narratives of patient stories, improved IPU nurse knowledge and documentation of wound care, new planned review of community patient risk assessments where PCSS staff find these uncompleted at point of care and improved training, communication with users and documentation of advanced care planning decisions.

NLH received two unannounced inspections by the Care Quality Commission, one on our site in Enfield and the other on our site in Finchley. We were found to be compliant against the required standards.

Key service developments are described concerning new Enfield Day Service provision, volunteer development, use of Situation Background Assessment Recommendation (SBAR) tool in community multidisciplinary meetings, the introduction of an associate role in the

community and end of life training including the awarding of NLH as national regional centre for end of life training for care homes.

Service data is highlighted and discussed. IPU cared for 306 new patients and their average length of stay was 12.6 days. 26% patients were discharged from IPU. The community teams cared for a total of 1271 patients in their own homes (of which 898 were new patients)and supported 55% of these patients to die at home where this was their preferred place of care. PCSS cared for 242 patients and provided a total of 9,497 hours of one-to-one nursing care to people in their own homes.

NLH's user surveys revealed that 100% patients were satisfied with our service and 98% would recommend service to families and friends. Our case study reported on page 47 provides one current users feedback.

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

I am pleased to present North London Hospice's second Quality Account which covers the period 2012-13.

The Quality Account is produced to inform our scrutineers and the public of our commitment to providing high quality services.

North London Hospice is a registered charity (No.285300) and has been caring for people in the London Boroughs of Barnet, Enfield and Haringey since 1984, thanks to the generous support of our local community.

The charity makes no charge to its patients or their families or carers. It cost £5.8 million to provide these care services during 2012/13. NHS grants contributed 36% towards this.

Our 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.

Our mission states
"We care about people with a potentially life-limiting illness and aim to add quality and meaning to their life journey.
We do this by:

- 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

We provide this care and support to people in their own homes, care homes or in the hospice itself."

As a charity, we are challenged to deliver our vision and mission during the current economic climate. Following two previous years of declining charitable income we have stabilised our voluntary income

through the implementation of a robust fundraising strategy. However the running costs of the Hospice continue to increase. Due to careful management in the past, North London Hospice has reserves that we have continued to use to prevent any reduction in our care services but obviously this is not sustainable indefinitely and we are currently exploring options that would return us to financial balance by April 2015. Our Hospice charity shops have done well and our expansion to 18 shops has helped. Central to our corporate objectives for 2012-13, therefore, was balancing the sometimes conflicting priorities of developing quality services whilst making cost savings.

We have worked together with our staff to review our workforce skill mix and numbers and to identify cost savings.

This year has shown significant developments in our volunteering workforce and we have increased the training and supervision of our volunteers so that they can work more closely with our users.
We were successful in receiving Department of Health capital funding which we successfully matched with a Fundraising Capital Appeal to build a second NLH site at Enfield. This site was opened in late summer of 2012 and re-housed our Enfield Community Team as well as providing a purpose-built site for our new style day service providing services closer to our Enfield and Haringey users.

NLH Board of Trustees reviewed and approved this Quality Account at a meeting
On….

I am confident that the information set out in this Quality Account is a true reflection of the quality of our current health care provision.

Quality is important to us. We hope you find our Quality Account useful. We welcome your suggestions for our future accounts.

Douglas Bennett
Chief Executive of North London Hospice
April 2013

Introduction
NLH started to produce and share with the public its Quality Accounts from 2011-12. This 2012-2013 Quality Account is however the first mandatory Quality Account.

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

The 2011-12 Quality Account has been made available to the public on the internet (NHS Choices and NLH website) and a copy is readily available to read in the reception areas at the Finchley and Enfield sites. Paper copies are made 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, chaplains and volunteers. NLH offers the following clinical services:

1. Community Specialist Palliative Care Teams (CSPCT)

2. An Out-of-Hours Telephone Advice Service

3. Day Services (DS)

4. Inpatient unit (IPU)

5. Palliative Care Support Service (PCSS,NLH'sHospice 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 2013-2014

The following priorities for improvement for 2013-2014 were identified by the clinical teams and are endorsed by the Clinical Governance Sub Committee and Board of Trustees.

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

1. Priority One: Patient experience

Improvement of service users' experience through the ongoing development and review of new volunteer roles.

It 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 clinical services providing emotional and practical support to patients and their families. New volunteer roles are planned for Finchley Site Hospitality and the Inpatient Unit.

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

- April 2013 Project Group formed
- May 2013 six-month Volunteer Transition Lead post appointed. Recruit survey volunteers
- By June 2013 agree user survey questions
- June-September 13 user survey period
- By July 2013 complete staff/volunteer survey re reception volunteering and identify actions for developing new hospitality volunteer role. Identify questions for staff/volunteer surveys re existing volunteer roles.
- September 2013 start staff/volunteer survey re existing volunteer roles
- January 2014 Project Group to consider findings from all surveys
- February 2014 publicise survey findings internally with volunteers and staff
- March 2014 review arrangements based on feedback and produce action plan

- This will lead to a more evidenced, user-informed action plan for these developments.

2. Priority Two: Patient safety

Introduction of an ultrasound service on the Inpatient Unit

The inpatient unit (IPU) team plan to develop an ultrasound service for assessing if patients have an accumulation of fluid within their abdomen (ascites). Currently the team rely on clinical assessment alone to assess for the presence of ascites and perform paracentesis (drainage of the fluid) or have to transfer the patient to the local hospital for an ultrasound.

The use of ultrasound assessment prior to paracentesis is now considered best practice where ultrasound is available. This will improve the diagnostic certainty regarding the presence of ascites and exclude differential diagnoses. It will enable the team to identify if proceeding to paracentesis is safe and appropriate. On completion of training for all the IPU consultants it should be standard practice for all IPU patients to be assessed by ultrasound prior to paracentesis.

This ultrasound service will be available for IPU patients but can also be accessed by community patients who are able to attend the Hospice for assessment. The primary aim of introducing the ultrasound service is to improve patient safety and improve the efficacy of our resources. However, it will also limit the need for patients to attend hospital for an ultrasound, which will improve the patient experience.

Project Action Plan:

- Baseline review of current paracentesis activity on the unit.
- Protocol development for the use of ultrasound and paracentesis activity procedures at the Hospice.
- Establishing the service
- Audit to assess the level of access to the service and see if the Hospice is adhering to the protocol.
- Case review (results of assessment, whether proceeded to paracentesis, outcome of the paracentesis procedure, reflection on any learning)
- Learning applied to practice

3. *Priority Three: Clinical Effectiveness*

The introduction of version 12 of the Liverpool Care Pathway tool into the community

The Liverpool Care Pathway (LCP) is an integrated care pathway published by the Marie Curie Palliative Care Institute Liverpool that is used by healthcare professionals in order to optimise and standardise care during the last hours and days of life. Use of the LCP is widely considered to be best practice when caring for dying patients. Following a national review of the previous document (version 11) an updated (version12) was published in 2009. The LCP is published in a generic form, which can be used in any care setting, however it is possible for healthcare institutions to amend the generic document to best suit their working environment.

An adapted version of LCP version 12 is currently in use on the inpatient unit at NLH, however the community teams are still using version 11.

The aim of this project is to work with Community Palliative Care Clinical Nurse Specialists from NLH, District Nurses and General Practitioners in order to update the version of the LCP in use in the local community to version 12 in line with nationally accepted standards.

Project Action Plan:

- Approval of version 12 LCP tool Enfield End of Life Steering Boards- **To complete by May 228936802201**3228936802User
- Submit to Liverpool (Marie Curie Palliative Care Institute) for matching if required- **To complete by June 2013**
- Plan implementation programme with Clinical Nurse Specialist (CNS)/District Nurse's (DN's) teams- **To Complete by August 2013**
- Implement version 12 LCP to community- to include adapting current LCP training delivered by NLH CNSs to DNs- **To complete by July 2013**
- Audit after 6/12 of use (of complete document using audit tool provided by Liverpool)- **To complete by April 2014**

Project plans will be monitored through management structures and quarterly progress reports to the Clinical Quality Group. The Clinical Governance subcommittee will receive reports on progress every six months.

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 2012-2013, 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 2012-2013 represents 27 per cent of the total operational income generated by the North London Hospice for the reporting period 2012-2013.

Participation in clinical audits
During 2012-2013, 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 was eligible to participate in during 2012-2013 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 2012-2013, 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 2012-2013 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 reports of 15 local clinical audits were reviewed by the provider in 2012-13 and NLH has taken or intends to take the following actions to improve the quality of healthcare provided.

Summary of Audits 2012-13:

Audit Topics	Key Findings	Actions
Mouth care audit	Requirement for more detailed documentation and need to involve relatives more	Mouth care guidelines introduced. Assessment tool being developed to include relative's involvement. Standard for 1st documentation being created.
Room cleaning and maintenance handover between these teams and clinical team on IPU	Standards of cleanliness good. Gaps in room handover sheet documentation.	Housekeeping lead being recruited (May 13) to oversee this and work closer with newly appointed Head of IPU (plan completion August 2013).
Hand-washing Audit 1	High level of hand decontamination compliance though lower between tasks with same patient.	Highlight results to staff (several formats). Looked at reviewing tool for next audit but could not because it is an international used tool (WHO). Agreed to review if reoccurring theme at next audit in 6/12. Planned to extend audit sample to bank and non clinical staff.
Hand-washing Audit 2	As above	Plan observational audit next time.
Infection Control Audit	High level of compliance.	Action plan has shown significant improvements.
Audit of new Incident Policy	Variation in incident form completion & risk score	Incident form reviewed and currently being piloted (June 13)with consideration of developing electronic form. Staff training adapted to share learning.
NICE End of Life Audit	11 green, 7 amber, 2 red standards. Red- verification of death and need for after death policy and 24 hour 7/7	Draft after death policy being reviewed by IPU (expected implementation date August 13), environment outside viewing room improved, 24 7/7 restricted by resources of hospice as charity funded organisation.

	admissions.	
Opioid Documentation in the Community Teams Notes on iCare	Inconsistencies in documentation persist despite increased staff training (may have been affected by IT issues at time).	New process in place for recording medication changes and medication charts now reviewed as part of weekly MDT.
Care Quality Commission (CQC) Standards Compliance Audit for All Clinical Services		Action plans incorporated in to services corporate plans and monitored by Clinical Quality Group (CQG)
Wound Care Audit	High level of pressure sore status documented on admission. Appropriate mattresses in place for all.	Pressure sore/wound care status added to First Assessment Checklist. Electronic patient record code for wound care introduced to identify all such entries. Wound care plan in use. Wound care teaching topic for April 13.
Blood Transfusion Checklist Audit	Poor documentation of procedure	Risk identified. Results fed back to staff. Observational audit actioned confirmed practice good so risk was isolated to documentation. Questionnaire given to staff to assess knowledge of practice & procedures.
Completion of risk assessments for the Palliative Care Support Services (PCSS) Audit	Good (75%) completion rate. Not all held in correct location or updated.	Risk identified. Results fed back to staff including District Nursing Services who considered completion rate high. Moved to carbon copy so can be held at required sites. Review of NLH lone worker policy.
Recording of allergies at first visit	community teams re audit- 100% compliance.	IPU implemented community improvement of checking status at weekly MDT. This will be added to MDT review performa

	IPU- new audit lower compliance.	being developed.
Drug Errors Reporting Audit	Increase in drug error reporting. Identified incident form did not monitor all aspects of procedure so documentation required improvement.	Reporting increase suspected to be part of increased incident reporting organisational culture change. Risk identified to poor documentation of procedure. Staff informed and debated changes required at Clinical Forum. Prospective review of drug error incident identified good practice. Pilot of new drug error incident form. Re audit planned.
Complaints Audit	High completion of new form and procedure compliance.	Fed back to staff. Improvements required highlighted in staff annual training programme.

Research

The number of patients receiving NHS services, provided or sub-contracted by North London Hospice in 2012/2013, 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 2012/2013 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 2012-2013.

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

In June 2012 the Care Quality Commission (CQC) approved the registration of the Hospice's new building in Enfield and day services commenced there in August 2012.

In September 2012 (Finchley site) and February 2013 (Enfield site) the CQC carried out unannounced inspections as part of a routine schedule of planned reviews. 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 2012-2013 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.

NLH has reviewed the processes and where necessary put in place procedure to capture and maintain the accuracy of the patient data.

A more detailed review has been done of the clinical data to enable NLH to provide the information split between the different Boroughs to which it provides a service.

NLH is committed to developing electronic documentation system to reduce clinical time spent in form filling and support the need to provide greater evidence of care actioned. NLH is in the process of introducing SMART forms (user defined patient and professional information tools) onto the iCare clinical record computer system.

NLH is also working on ways to improve the capture and timely reporting of Human Resource statistics and where possible relate it to performance.

All of this work compliments the work this year on Information Governance.

Statistics relating to activity for the various services
North London Hospice Information Governance assessment report score overall score for 2012-2013 was 60 % and was graded not satisfactory.

In 2012, NLH applied for level two of the toolkit for which the target score was 66%. For the toolkit North London Hospice has to assess itself against requirements for:

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

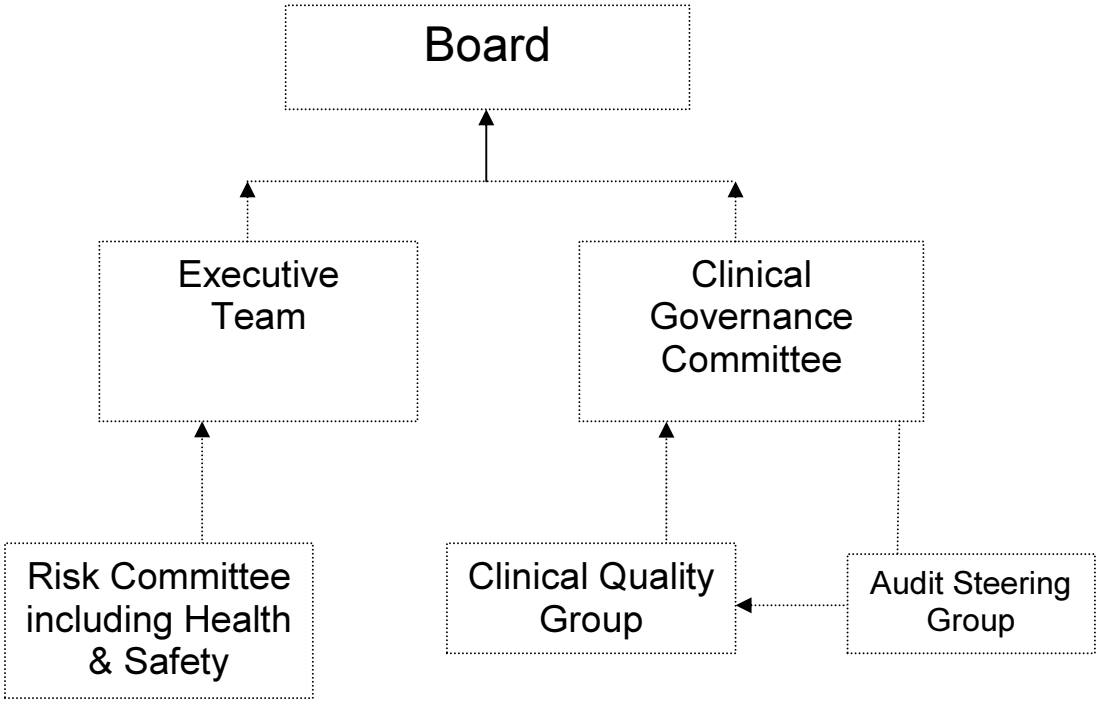
An action plan has since been approved by NHS Connection for Health which aims to see NLH achieve required score of 66% at the next annual submission in March 14. Progress for this is monitored by the Hospice's Information Governance Steering Group which reports to the Executive Team quarterly

North London Hospice was not subject to the payments by results clinical coding audit during 2012-2013 by the Audit Commission. This is not applicable to independent hospices.

Performance statistics prepared monthly are reviewed by the clinical directors and shared with the various NHS commissioners. Further work to report the performance that best reflects the activity in the Day Services is in progress.

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 Two for role description of above groups

Key Service Developments of 2012-13:

Enfield new Day Service development
Day Services opened on August 16 2012, initially for one day a week with patients who transferred from the previous Day Centre in Finchley. In September the Hospice expanded the service to include new referrals and to offer more Complementary Therapies. In October it began opening two days a week and in February of this year, three days a week. The Hospice also started a weekly physiotherapy clinic in February. It has now broadened the referral criteria to include referrals from GP's, hospital based Palliative Care Teams and Site Specific CNS.

NLH Day Services is currently offering Reiki, Reflexology, Massage, Hypnotherapy, Group Relaxation, Art Therapy, Beauty Therapy, Hairdressing and a Carers Group. NLH plans to further develop services to include Psychological Therapies and Music Therapy. More informal activities also take place in the 'Open Space' to promote socialisation and a lively cafe at lunchtimes. The Day Services CNS is available to carry out holistic nursing assessments when needed and to offer advice and support for symptom management.

Since September Day Services has been working collaboratively with CAB and Macmillan offering fortnightly appointments for benefits and financial advice to cancer patients and their families
Links have been formed with a local secondary school to offer insight into the work the Hospice does.

Volunteer Development
North London Hospice has more than 930 volunteers working in a variety of roles from fundraising, shops, drivers to counsellors, art therapists and chaplains. NLH Volunteer Strategy 2012 communicated desired changes around the role, delivery and management of volunteer services. 2012-13 has seen much work implemented in increasing the depth of training and supervision to volunteers as well as the development of existing and new volunteer roles across the organisation. This work will continue as well as the move of volunteer management to services. See Appendix Three for further details.

The Use of the SBAR tool within the Community Specialist Palliative Care Multi-disciplinary Team (MDT) Meeting
There is good evidence to suggest that communication improves where the clinical information presented is carried out using a structured reporting format. This led to the recommendation by the World Health Organization for the use of the SBAR tool to standardised handover communications.
The SBAR process is a straightforward framework used to communicate succinct relevant information and focuses the communication on **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation. The Community Service Management Team have introduced the tool for its MDT patient presentations. Over the next few months an electronic SMART FORM in the SBAR framework will be developed for staff to use in iCare. This will continue to build on the efficiency and quality of record keeping.

The Introduction of Associate Community Specialists Palliative Care Nurse role

The introduction of two Band six Posts was a result of a restructuring review of the Community CNS service last year. The posts were recruited in December 2012. Their main role is to work clinically as autonomous practitioners, assisting and supporting the Clinical Nurse Specialist (CNS) in managing a caseload. They work within clear boundaries, always have a CNS overseeing and managing the caseload and therefore do not have the responsibility of all the other components of the CNS role. These posts allow the recruitment of experienced nurses who do not have the essential person specification required for a Band 7 CNS role whilst giving staff career development opportunities.

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.

Education and training

NLH delivers a bi-annual "Foundations in Palliative Care" course for trained nurses and allied health professionals over four days and bi-annual Foundations for Palliative Care" course for Health Care Assistants and Support Workers, which runs over four half days. The Hospice also delivers basic and advanced syringe driver training and Liverpool Care of the Dying Tool training to community nurses on a rolling programme, at both the Finchley and Enfield sites.

NLH provides a variety of training placements for:

- 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

- placements for Specialist Registrars from London Postgraduate Deanery and registrars from Barnet General Practitioner Vocational Training Scheme
- chaplaincy placements
- work experience for those wishing to apply for nurse, medical, allied health professional training

.

The Hospice is currently providing a commissioned End-of-Life training programme in care homes and this was extended to also include an agreed group of domiciliary agencies in Enfield this year.

In early 2013 NLH became one of seven national regional centres for end-of-life training for care homes through the Gold Standard Framework for Care Homes Programme.

NLH provides a rolling induction programme for new staff and volunteers as well as annual mandatory training. Additional internal training is also provided for staff.

From April 2013, NLH plans to build upon the courses we offer.

Care Environment

At NLH we are committed to providing a warm, friendly and welcoming, non institutional environment for our patients and their visitors. We realise we will not get a second chance to make a good first impression.

The physical design of our new Enfield site provides an open, light and friendly space, including a cafe area looking on to gardens. We purposely chose not to have a reception area; each visitor, patient, family member/significant other is individually welcomed. We are working towards this model on our original Finchley site - this will form part of improvement to the hospitality area.

On the IPU, prior to a new patient being admitted, their room undergoes a series of maintenance and housekeeping checks to guarantee the room and bathroom meets the required standard of cleanliness and functionality. An annual infection control audit is carried out by an external auditor. In 2012 NLH scored 87% with Clinical Environment scoring 84%.

The facilities team take pride in their work and gain satisfaction from providing patients with a facility everybody can be proud of.

Service Activity Data

INPATIENT UNIT

Data Highlights

In 2012-2013, the IPU cared for a total of 326 patients, of which 306 were new patients. A total of 346 patient admissions occurred. Comparing this with 2011-12 data the IPU cared for a similar number of total patients (316 in 2011-12 vs 326 in 2012-13), new patients (300 in 11-12 vs 306 in 12-13) and admissions (325 11-12 vs 346 12-13).

Analysis of IPU admissions and outcomes:

1. 49 patients (14%) admitted had been cared for on the unit before(vs 15% 2011-2).
2. A patient's average length of stay was 12.6 days (vs 14 days 2011-12).
3. 7 patients (2%) were admitted as day cases for treatment infusions (vs 1% 2011-12).
4. 264 patients (74%) admitted to the unit died on the unit (vs71% 2011-12).
5. 80 patients (22%) were discharged home (vs 22% 2011-12).
6. 9 patients (3%) were discharged to a care home (vs 3% 2011-12).
7. 4 patients (1%) were transferred to hospital for acute care management (vs 4% 2011-12).

Bed Usage

The IPU had a 73% bed occupancy rate. This was the same in 2011-12. The definition of bed occupancy is 'a bed that is occupied at midnight' so if for example a patient died at 2345 hours the bed will be counted as not occupied for that day. This definition impacts on this rate.

Over the last year, IPU have had a total of 85 closed bed days. This was mainly due to plumbing repairs and deep cleaning of rooms following patients with MRSA. This accounts for 1% of the total bed availability. This is improved on 2011-12 when there were 156 closed bed days.

There are peaks and troughs of demand for beds on the IPU but to try and increase bed usage and address peaks in demand, a number of strategies are in place:

- Trying to make beds available sooner after patient's death, whilst balancing sensitively the needs of deceased patients' relatives.
- The refurbishment of the room to view patients who have died to improve the experience of relatives and friends as well as increase its use. Working with the hygiene technician team to complete cleaning of rooms as soon as is possible and reviewing the shift patterns of the hygiene technicians.
- The introduction of a standard for room turnover.
- An increase in junior doctor staffing, has enabled us to increase the number of admissions during the day
- A review by the clinical team to look at the feasibility of staggering doctors' working times to accommodate later medical admission clerking.

Also to prevent admission to an acute hospital while a patient is awaiting an IPU bed, the NLH PCSS has supported patients to remain at home.

DAY CARE SERVICES

As discussed previously, this year the model and site of day service provision changed so the day service data is split accordingly.

In anticipation of these changes and to minimise the impact on patients using the day service, the Finchley day service site ceased to accept new referrals from July 2011 but continued to care for existing patients until they died or were discharged with a small number transferring over to the Enfield site. For the period of 13 weeks (April-June 2012) Finchley Day service cared for 13 patients. There were 173 attendances (70% attendance) and 73 (30%) where patients were booked but did not attend.

As described on page seventeen, the new model Day Service has been developing at the Enfield site this year with increasing patient numbers and a range of services provided. From middle of August 2012 to March 2013 there have been a total of 415 attendances with only 15 patients (3%) who were booked that did not attend.

The table below shows the increasing use of new components of the service since August.

Sessions provided by Day Services at Enfield

	Aug/Sept	Oct/Dec	Jan/Mar
Acupuncture (Started November)	n/a	9	13
Art Class	7	20	25
Art Therapy (Started October	n/a	13	22
Beauty Therapy (Manicure/Pedicure)	5	46	54
Carer Group	12	18	20
CNS Assessment	9	40	31
Hair Dressing (Started October)	n/a	9	15
Hypnotherapy	5	9	7
Massage	1	15	16
Reflexology (Started October)	n/a	3	6
Reiki	11	37	39
Relaxation Group	21	52	84
Total	**71**	**271**	**332**
Patients attending during Quarter	**45**	**155**	**215**
Days provided during Quarter	**7**	**23**	**27***

* During March six Day Services days were cancelled because of adverse weather

COMMUNITY TEAMS

Highlight information

In 2012-2013, a total of 1271 patients were seen by the two specialist community teams (607 Enfield, 664 Finchley). This was a similar figure to 2011-12 where they cared for 1255 patients.

In 2012-13 898 of these patients (Finchley 483, Enfield 415) were new patients. Of which:

- 76% had a cancer diagnosis.
- 21% had a non-cancer diagnosis.

From the specialist community teams, each patient had an average of:

- 5 visits (vs 5 in 2011-12).
- 12 phone calls to/from patient and family (vs 16 in 2011-12).
- 9 phone calls to/from other professionals (vs 12% in 2011-12)

In addition, outside the normal working hours of the Community Teams, the IPU team supported, through its advice line, each community team patient with an average of

- 3 phone calls to/from patient and family.
- 1 phone calls to/from other professionals

In 2012-13, 61% of the total patients seen by the two specialist community teams died during their care period. Of these:

- 55% (n=427) died in their own home (including 12% who died in a care home i.e. their home)
- 22% died in a hospice.
- 20% died in hospital.
- 3% died in other places.

Figures regarding place of death were similar for 2011-12.

PALLIATIVE CARE SUPPORT SERVICE (PCSS)

PCSS was launched as a new service in Barnet on 1st April 2011. In June 2012, the service incorporated care to Enfield patients too.

It has cared for 242 patients in 2012-13 and provided a total of 9,497 hours of direct care to patients in their own homes. This is an average of 39.25 hours of care per patient.

This reveals a marked increase (29%) in service care provision compared to 2011-12 where the service cared for a total of 188 patients and provided 8339 hours of direct care.

PCSS Work provided for each Borough 2012/13			
	Barnet	**Enfield**	**Total**
Total number of patients	149	93	242
Health Care Assistants	4,419.50 hours	3,718.25hours	8,137.75 hours
Registered Nurses	732.50 hours	626.75 hours	1,356.25 hours
Total hours of care	5152.00 hours	4345 hours	9,497.00 hours
Average hours per patient	34.6 hours	46.72 hours	39.25 hours

Service Quality Data

Indicator	Threshold	Outcome
Percentage of audits completed on schedule	80%	42 % actual (65% anticipated*)

There were 29 audits on the original 12-13 audit cycle. During the year 2 additional audits have been added so a total of 31 audits were due for completion through the year. The ability to complete more audits has been impacted by workforce reorganisation and staff vacancies some at senior level.It has become apparent that the audit plan for 12-13 was aspirational in terms of numbers of audits.

NLH anticipates a total of 19/31 (65%) audits will be completed for the audit year 12-13 in 13-14 cycle. Of the remaining audits scheduled for the 12-13 audit 6 have been deferred. 6 audits will not be completed but will be assessed via the internal CQC audit in September.

Patient Experience

User Involvement 2012-13:

Quality and Performance Indicators	Quality and Performance Indicator(s)	Threshold	Outcome 2011-12	Outcome 2012-13
Service User Experience	% of patient/carers satisfied with the service	80%	99% (n=68) rated care as satisfactory and above	100% (n=87) rated care as satisfactory and above
Service User Experience	% who would recommend service to friends & family	80%	84% (n=68) would recommend service to friends & family	98% (n=85) would recommend service to friends & family
Relatives Experience	% of patient/carers satisfied with the service	80%	95% (n=46) rated care as satisfactory and above	100% (n=138) rated care as satisfactory and above
Relatives Experience	% who would recommend service to friends & family	80%	93% (n=45) would recommend service to friends & family	99% (n=216) would recommend service to friends & family

NLH is committed to listening to the views of patients, relatives, carers and friends across all services and in 2011 the NLH User Involvement Strategy was developed. User feedback has been gathered in a number of ways this year:

- Annual survey
- Comments cards
- Patient stories

Surveys:
3 key areas were measured in the 2011-12 and 2012-13 surveys

- Percentage of overall care marked 'satisfactory' and above
- Percentage who marked 'Yes' or 'Mostly' to being treated with respect and dignity
- Percentage who would recommend the service to family and friends 'to some extent' and above

232 survey responses were received from the total of 890 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)

Overall care rated 'satisfactory' and above

	CT	CT Rel	IPU	IPU Rel	PCSS	Average
2012 %	**100**	**100**	**100**	**100**	**100**	**100**
n=	**74**	**88**	**13**	**43**	**7**	
2011 %	92	87	100	100	-	95
n=	61	27	7	19	-	

Were you/the patient treated with respect and dignity?

	CT	CT Rel	IPU	IPU Rel	PCSS	Average
2012 %	**97**	**n/a**	**100**	**100**	**100**	**99**
n=	**73**	**n/a**	**11**	**42**	**7**	**-**
2011 %	99	n/a	100	100	-	99
n=	62	n/a	6	18	-	-

Would you recommend the service to friends or family?

	CT	CT Rel	IPU	IPU Rel	PCSS	Average
2012 %	**96**	**98**	**100**	**100**	**n/a**	**99**
n=	**72**	**89**	**13**	**42**	**-**	**-**
2011 %	96	86	71	100	-	88
n=	63	26	5	19	-	-

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

Total no. of comments included:	**371**	
Positive comments:	**310**	**86%**
Negative comments:	**61**	**14%**

Service:	**Positive**	**Negative**
Community Team patients	**76%** (n=39)	**24%** (n=12)
Community Team relatives	**88%** (n=148)	**12%** (n=21)
Inpatient Unit patients	**91%** (n=10)	**9%** (n=1)
Inpatient Unit relatives	**75%** (n=66)	**25%** (n=22)
Palliative Care Support Service	**90%** (n=47)	**10%** (n=5)

Day Services were not included in the 2012-13 surveys as the centre had only just opened and was not fully operational. User views were collected through case studies and during visits by the User Involvement Lead and a volunteer, which were fed back to the Day Services team.

Some comments from new Day Service visitors:

Q: **What do you like about coming here?**

a) Meeting other people; chatting; change of environment. Have been twice before on Tuesday – that's quieter but they are building it up. I came today because of an appointment to work out my benefits. They have a lot going on here. (patient)

Q: Do you feel welcome?

a) Very. People are always being kind and seeing if there is anything I need. (patient)
b) Really open and welcoming (carer)

Day Services will be included in the 2013-14 User Surveys.

COMPLAINTS

Quality Performance Indicator	**Threshold**	**Outcome 2011-12**	**Outcome 2012-13**
Number of Complaints	25	31	19

Quality Performance Indicator			**Outcome 2011-12**	**Outcome 2012-13**
Investigations completed at 31 March 2012			25	14
Investigations incomplete at 31 March 2012			6	5
Investigations Completed, complaint founded			21	13
Investigations Completed, complaint unfounded			4	1
The number of complaints action plans completed	90%	100%	19(90.4%) completed 2(9.6%) Action Plans being completed	14 (100%) completed

The number of complaints in 2012-13 decreased from those in 2011-12.NLH aims to give the best possible care to patients and support to their families, friends and carers. However, sometimes expectations are not met. To help improve services, we encourage feedback about any problems or concerns are encouraged. Any feedback received about clinical or non-clinical services, however minor, follows the complaints process internally to ensure that it is fully investigated and that learning is identified and acted upon. If the complainee states that they do not wish to receive formal feedback, this is acknowledged.

Patient Safety

INCIDENTS

As reported last year NLH introduced a revised incident reporting procedure which, during 2012-13, has continued to show an increase in the number reported.

During the period 2012- 2013, 279 incidents were reported, 168 relating to clinical incidents and 111 to non-clinical incidents, an overall increase of 35% (n=72).
The breakdown of the incidents reported is as follows:

	All Incidents 2011-2012		**All Incidents 2012-2013**	
Independent Contractor	1	0%	1	0%
Other (Inc. Security, Facilities, IT)	2	1%	56	20%
Patient	147	68%	175	63%
Staff (inc Bank)	47	22%	23	8%
Visitors/Relatives	12	5%	9	3%
Volunteers	8	4%	15	6%
Total	217		279	

The noticeable percentage increase has been under the sub section "Other" which can be attributed to how incidents have been categorized.

This year NLH has embarked on a benchmarking exercise with five other hospices to compare clinical data which initially is including falls, pressure ulcers and medicine incidents. It is hoped this will help understand optimum incident numbers.

ACCIDENTS, INCIDENTS & NEAR MISSES

The impact of every incident reported is risk scored. The incidents reported were classified as detailed below:

Impact of Incidents	**2012-13**			
Category	**Clinical**		**Non Clinical**	
No Effect	51	30%	26	24%
Minor	70	42%	47	42%
Moderate	41	24%	31	28%
Major	6	4%	7	6%
Critical	0	0%	0	0%
	168		111	

There were no significant differences between impact of incident between years.

Category of Incidents	**2012-13**			
Category	**Clinical**		**Non Clinical**	
Admission, discharge, transfer	9	5%	1	1%
Drug Error*	15	9%	0	0%
Medical device/equipment	10	6%	0	0%
Moving and handling	5	3%	6	5%
Patient Information	1	1%	7	6%
Pressure sores	5	3%	0	0%
Slips, trips and falls	60	36%	14	13%
Treatment	26	16%	0	0%
Violence and aggression	4	2%	7	6%
Premises and Security	4	2%	25	23%
Other	29	17%	51	46%
	168		111	

In 2011-12 the category with the largest number of incidents reported was Slips, Trips and Falls. This remains the case in 2012-13 during which time 74 incidents were reported (27%) against 63 (29%) in 2011-12.

No patients suffered a major injury as a result of their falls. However, most falls in patients at the Hospice can be seen as the result of a number of interacting factors such as:

- Walking unsteadily
- Being confused
- Being incontinent or needing to use the toilet frequently
- Taking medication
- Deteriorating condition

- Individual personal struggle to accept limitations of their decreasing mobility

During the year 2012-13 the following measures have continued to be followed by Hospice staff to maintain the safety of the patients:

- Risk Assessment for falls are completed for all patients
- Falls assessment on admission to the Inpatient Unit
- Further assessment when a need is identified e.g. after a fall, as the patient's condition deteriorates
- Environmental audits of the Inpatient rooms
- Use of other falls prevention measures
- Regular maintenance of Hospice equipment
- Guidance and advice given to patients by the physiotherapists'
- All patient related falls incidents are reviewed by the Clinical Quality Group

Pressure sore monitoring and reporting

	2011/12	2012/13
Number of patients admitted to the IPU with pressure sores graded 3 or 4	9	7
Number of patients who developed pressure sores grade 3 or 4 within 72 hours of admission whilst on the IPU	1	0
Number of patients who developed pressure sores grade 3 or 4 after 72 hours of admission on IPU	1	4

During 2012-13 seven patients were admitted to the Hospice's Inpatient Unit with pressure sores graded 3 or 4., i.e. a high score in which a patient is deemed at risk and where the incident has to be reported externally. In all these cases the appropriate declarations were made by the previous carers. In addition, four patients developed grade 3 pressure sores more than 72 hours after admission to the Unit. They had been cared for on the unit for between 31 and 53 days and all patients skin condition deteriorated despite optimum pressure area care because of their generalised deteriorating condition and expected dying period. All cases were reported to adult safeguarding department, the local NHS Trust and the Care Quality Commission in accordance with both local procedures and legislation. In addition Tissue Viability specialist referrals were made regarding the later

group of patients. In all cases hospice staff were advised that they had used the appropriate skin care interventions and that in view of the patient's condition this was unavoidable. The patient and family were kept informed throughout.

Infection control

Quality and Performance Indicator(s)	Number 2011-12	Number 2012-13
The number of patients known to be infected with MRSA on admission to the IPU	2	4
The number of patients known to be infected with Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission to the IPU	0	0
Patients who contracted these infections whilst on the IPU	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 2012-13 there were no cases noted where patients contracted reportable infections whilst on the IPU.

Priorities for Improvement 2012-13
Following consultation with hospice staff and local palliative care commissioners and scrutineers, the following three priorities for improvement were agreed for 2012-13:

Priority 1-Patient Experience- **Case Studies**
By giving people the opportunity to tell their own story, NLH can hear about their experience as a whole and it is often the smaller details that give greater insight into what makes a difference to patients and families in the Hospice's care.

Case studies have been obtained from across all services - some involve more than one service.

Service	**Total**	**Positive**	**Negative**
Inpatient Unit	**8**	8	0
Community Teams	**3**	2	1
Day Services	**2**	2	0
PCSS	**1**	1	0
Mixed	**4**	4	0

See Appendix Four for sample Case Study

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

Priority 2 -Patient safety

2. **a) Care planning and how it ensures patient risk is minimised.**

Patients cared for on the IPU have a variety of wounds from pressure sores, fungating tumour lesions to post operative wounds. Due to many patients being near the end of their lives, the focus of wound care is often on maximising comfort and preventing further deterioration rather when treating the wound. The plan of care needs to be individualised to meet patient's specific requirements.

ACTION PLAN:

- August 2012: Questionnaire of nurses learning needs in wound care completed. This identified gaps in nurses' knowledge in grading of wounds and types of dressings to use.

- September 2012: Audit of pressure sore documentation to identify areas for improvement which will translate to all wound care on IPU was completed. This highlighted lack of documentation in wound care plans and the need to be more effective in adding pressure sore grades to ICare. All patients who had a pressure sore were on the appropriate pressure relieving mattress.

- February 2013: Met with practice educator, IPU Consultant about IPU education needs (incorporating wound care) Revamped IPU education programme to be rolled out in April 2013

- April 2013: Draft Wound care competencies for all staff being agreed by Service Management Team and Clinical Quality Group.

- Wound care is the teaching focus on IPU for April 2013. First of two teaching sessions on wound care has taken place. The

second session is planned for 18/4/13 and wound care representative talk planned 23/4/13. Articles are on display on the IPU teaching board. Improvements to wound care assessment to be discussed in Nurses Meeting of 22/4/13. Reflective practice session planned for June 2013 on the prevention, review of care and reporting of grade 3 pressure sores.

- New iCare code in use for all wounds

Sustaining Change Plan 2013-14:

June 2013:

- Wound care competencies to be cascaded to all IPU clinicians

December 2013

- Re-audit of pressure sores and wound care documentation and practice

2.b) PCSS risk assessments in the community

The Community teams planned to review the process of risk assessment for community patients. The project group worked with the local Community Nursing Services.

- The project team gained support for the audit from Barnet Community Services Manager who requested that they adopt NLH risk assessment forms.
- The audit identified that 75% patients had risk assessments available, although 20% of that number were held at NLH rather than in the patient's home. NLH felt an action plan was required to bring this closer to 100% and the recommendations were to consider the use of self duplicating risk assessment forms to enable a copy to be held in the patient's home and the Hospice, and for the completion of risk assessments to be extended to Health Care Assistants (HCAs) if commissioners support.
- Self-duplicating RA's are currently being trialled with the CSPCT in Barnet. Agreement is to be sought from commissioners relating to HCA risk assessment completion. Barnet DNS perceived the results as good which was different to our view. Therefore NLH lone worker policy is to be updated to cover where a risk assessment is not in place.

Priority 3 - Clinical effectiveness**: Advanced Care Planning (ACP)**

Advance Care Planning is recommended by national strategy to enhance end-of-life care, allowing clearer understanding of patient goals, and aiding patient centred decision making.

Some work on ACP had already taken place in 2011, including the development of a policy and relevant documentation.

During 2012-13 the following was achieved:

1. All patients are offered information on ACP

   Information leaflet has been approved, is being printed and will then be offered to all patients on first assessment.

2. Training has continued to increase the confidence of staff

   The first of regular six-monthly sessions with the community team has been held, and was well evaluated.

   Training for IPU staff has been re-assessed. 2 training sessions for IPU staff have been delivered, with more planned, and a process has been agreed to ensure that all staff attend training.

   ACP will be discussed regularly at the doctors meetings to ensure junior doctors are up to date.

   ACP will also form part of the ongoing training offered at the Hospice, incorporated in the training for the Mental Capacity Act.

3. Statement of wishes and preferences and Advanced Directive to Refuse Treatment documents are available on iCare as SMARTt forms.

   This has been delayed because of delays to the development of iCare 2. However, this is now being taken forward with the iCare user group.

4. All patients are asked about their preferred place of care where possible and this is documented using the code on iCare

   This conversation is a standard part of practice in the community and on IPU, however has not been routinely documented under a separate code. Part of the training session is used to raise awareness of documentation.

   Both community teams now routinely highlight ACP as part of the MDT discussion of patients to ensure code is completed. If patient was unwilling to discuss ACP, or it was inappropriate to raise the issue, this is also being documented.

   The use of the code is currently being audited. Results of the audit will be available by end of April 2013.

What NLH staff say about the organisation

NLH employs 136 staff, has 930 volunteers, and bank staff 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
Staff joined	17	38
Staff left	21	16

NLH joined 30 other hospices in a Help the Hospices staff survey during summer 2012. The following are NLHís key results:

- 85% were proud to work for NLH and 73% felt job satisfaction
- broad messages were well communicated, but staff felt NLH was less effective in ensuring clear internal communication
- staff thought diversity was valued, and clarity of roles, empowerment and performance feedback scored highly, though some felt procedures could be unhelpful and others said they did not feel appreciated
- 71% would recommend their line manager as a boss, but a number expressed concerns about workload, stress and job security
- Although only a minority of staff felt comfortable to challenge the status quo and that morale was high, 75% planned to be working for NLH in a year's time

The following significant staff improvement initiatives are underway:

- Workforce Development Programme (WDP):As part of the WDP, a revised Performance Development Review (PDR) process and documentation are being implemented within the nursing workforce prior to roll-out across the whole Hospice. Designed to ensure clear communication between managers and staff, recognise and ensure effective feedback on clearly defined SMART objectives and competencies, and to establish SMART goals and learning and development needs for the future.

- In 2013 we will embark on the third 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
- Since survey NLH has appointed Communications Manager and a Communications Strategy has been developed.

    - Regular staff presentations are now are in place to assist cross-department/cross-discipline understanding and plans for regular information/consultation sessions involving all staff and management.

    - A fortnightly 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.

- Proposed staff Information and Communication Forum.

- Introduction of HR data base called Staff.Care to assist management and coordination of staff and volunteers

- Re-survey once improvement activities given chance to bed in.

NLH Board of Trustees Quality Account Comment

The first Quality Account presented in 2012 set a benchmark. This is the second Quality Account received by the Board of Trustees and the first mandatory Quality Account for NLH. The Board welcomes the assurance provided in the Quality Account of the continuing high standards of care, the commitment of skilled dedicated staff and the ongoing developments that are aimed at increasing the numbers of patients and families who can have access to care through NLH

It is heartening to see the achievements against the priorities for improvement set last year around case studies, care planning and minimising of risk and advanced care planning processes. These are important points along our journey towards providing the best quality of care possible. The User Involvement Strategy with its introduction of User Forums provides the Hospice with continuous feedback streams that inform the way we care for patients and manage our services.

Likewise, there have been some exceptional achievements in the involvement of one of the Hospice's most valuable resource, our volunteers. A comprehensive review of the way in which we use the experience and expertise of our volunteer workforce has generated a way of working that ensures that volunteers are trained and fully supported in the roles that they undertake. Systems have been set up, as with service users, to provide regular opportunities for volunteers to be kept up to date on Hospice developments, and to share their views and perspectives on the quality of all aspects of the work in which they are involved.

In addition, the opening of the Enfield Day Services unit is a major achievement in the journey towards making our services accessible to more people in Barnet, Enfield and Haringey. It also represents a shift in the model of care, with greater emphasis on individual programmes that attend to specialist medical, emotional and social needs generated by living with life limiting illnesses, as well as providing a much wider range of group activities.

As a Board of Trustees, we welcome the increased transparency and scrutiny demonstrated by this report and the recent developments described in the Quality Account. We know that complacency is not an option for us, and that quality has to be at the core of all that we do.

We welcome the priorities identified for the year ahead and will continue to support the Hospice Executive, staff and volunteers in sustaining the achievements to date and achieving the priorities for improvement in the coming year.

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 1

Our Clinical Services

1. Community Specialist Palliative Care Teams (CSPCT)

Two teams of nurses, doctors, physiotherapists and social workers working in the community, provide expert support and advice. One team is based in Finchley and provides care to Barnet and Haringey patients; the other is based in Enfield and provides care to Enfield patients. Their work complements that of General Practitioners (GPs), district nurses, social services and hospital teams. This specialist service includes:

• Advice to patients on symptoms, both physical and emotional

• Help with any anxieties or concerns that patients, carers, families and children may have. This includes care at home, housing and financial matters (also supported by CAB Macmillan)

2. 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.

3. Day Services

Day Services is now based in the new building in Enfield and provides additional specialist palliative care support to patients and carers using a new more bespoke day service model than that previously provided at the Finchley site. The service offers 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 who provide a range of complementary therapies including, reiki, reflexology, massage and hypnotherapy, Art Therapy, a relaxation group, Citizen's Advice Bureau, beauty therapy and hair dressing as well as hands-on care. Carers/families can attend carer's Groups and can join "Open Space" activities and relaxation groups.

Day Services is currently open 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, music therapy and creative writing and psychological therapies. Bereavement support will also be developed.

4. 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.

5. 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.

6. Loss and Transition Service (including Bereavement Service)

The aim of this service is to support individual NLH patients or their carers in coping with the emotional effects of loss of health or the loss of a person close to them and eventually to adjust and make the transition to a new way of living.

The support is provided by volunteers who have trained in support skills or by volunteer qualified counsellors. This service is in addition to that provided by the specialist palliative care staff (nurses, social workers and doctors) and is provided following a referral and assessment process to NLH patients and their families/friends while the patient is under the Hospice's care and offered to all families/friends of NLH patients who have died, for up to 14 months after their loss.

Appendix Two: 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 Clinical Governance Sub Committee (CGC) for clinical risks and the Executive Team for non clinical risks.

Executive Team

The Executive Team will monitor non clinical risks on behalf of the Board. They will receive assurance from the Risk Committee and provide assurance to the Board that non clinical risks are being managed within the Hospice. The Clinical Directors are responsible for ensuring high standards of care are maintained.

Clinical Governance Sub Committee (CGC)

The CGC is a sub committee of the Board and provides assurance that an effective system of control for all clinical risks and monitoring of quality is maintained. The committee also reviews the results of audit work completed on the Hospice's Audit Steering Group.

Clinical Quality Group (CQG)

The CQG reports to the CGC with overarching responsibility for ensuring that clinical risk is identified and properly managed. It will advise on controls for high level clinical risks and to develop the concept of residual risk and together with the Risk Committee to ensure that all Directorates take an active role in risk management and that this includes the active development of Risk Registers[1]. If the Group has any concerns relating to any issues raised with it, it will specifically report on these to the CGC.

[1] Risk Registers are populated with the identified risks of the Hospice that could have an impact upon their business objectives, compliance with standards.

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

CQG also authorise and validate the Hospices Audit Programme, receive completed audit reports, endorse recommendations and action plans and prioritises all audits

Risk Committee including Health and Safety Committee
The Risk Committee reports to the Executive Team with responsibility for ensuring that non clinical risks are identified and properly managed. It will also advise on controls for high level non clinical risks and to develop the concept of residual risk and to ensure that all Directorates take an active role in risk management and that this includes the active development of Risk Registers. If the Group has any concerns relating to any clinical issues raised with it, it will specifically report on these to the CGC.

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

Appendix Three: **Volunteering Developments**

BANDS OF SUPPORT VOLUNTEERS: NORTH LONDON HOSPICE

Banded according to the emotional depth of the support they provide to vulnerable patients & families

LOSS & TRANSITION SUPPORTER TRAINING

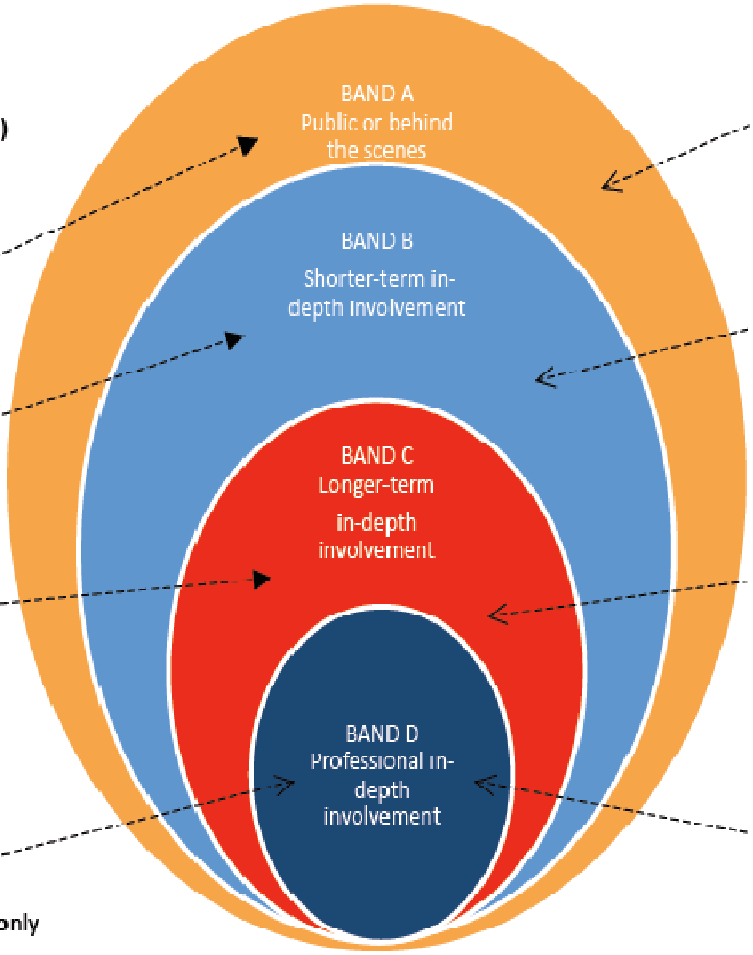
(NB in addition to induction & mandatory training plus updates)

AMBER: half day
"Introduction to Emotional First Aid'

BLUE: 15 hours
'Skills of Emotional First Aid'

CRIMSON: 21 hours
'In-Depth Loss & Transition Support Skills'
(having done Blue training first)
TOTAL: 36 hrs plus updates

DAMSON:
induction & mandatory training only



EXAMPLES OF VOLUNTEER ROLES

Fund-raiser, laundry, admin, gardener, librarian, shop, driving equipment

Driver/companion, ward clerk, phone admin, home companion, welcomer/ reception

Pre-&/or post bereavement supporter, assistant to nurses, social workers or spiritual care coordinator

Counsellor, chaplain, art therapist, complementary therapist

TO BE DEVELOPE

LEAD VOLUNTEER ROL FOR EACH BAND

ORGANISING eg rosters

SUPPORTING & DEVELOPING VOLUNTEERS eg buddying; mentoring; support/ reflecti supervision grou training

LEADING NEW PROJECTS eg Fund-raising; practical suppo teams; ongoing support groups f patients, carers, bereaved; 'Men Shed'; allotmen hospice Uni of th Third Age etc

Appendix Four: Case Study

Patrick has been visited by Community Nurse Specialist Eileen for the past eight months and has just started attending Day Services on Thursdays.

He lives with his wife, Ursula, who is his main carer. Patrick is dependent on oxygen to help him breathe and cannot be left on his own. His condition is not particularly stable and can deteriorate very quickly.

"I don't know what we'd do without Eileen from the Hospice. Within 10 minutes of being in the house she had correctly assessed my situation. She seemed to instinctively know what I needed and calmly dealt with the situation.

"She is much better than my GP at sorting out my medication. Before Eileen was involved, he didn't seem very interested in me but now Eileen contacts him and tells him what I need and it gets done. Eileen will ring the surgery and if the GP is there my prescription is usually ready within half an hour. That would never happen before. She just sorts everything out for us. Eileen even tried to help my painful shoulder which I've had for years – everyone else always pushed that to one side. She is very concerned that I have a good quality of life and is the only person who treats me like that.

"I also have a respiratory nurse, Helen, who isn't a Hospice nurse. It was Helen who first suggested that the Hospice should be involved in my care. She and Eileen are a fantastic combination and they work together to look after me, each keeping the other informed about my state of health."

Ursula had heard of North London Hospice and although Patrick knew about hospices, he hadn't heard of NLH. Neither were scared of being referred to the Hospice as they knew that it would be a great help to them both. It has taken pressure off Ursula.

"Patrick has complicated health issues and hospital is no longer the right place for him. He needs special care and he can't seem to get that in hospital. We are no longer using carers. It was very awkward as Patrick's condition changes frequently and at certain times of the day he is just not able to do anything, so they would come as arranged but there was nothing they could do. Now his symptoms are

better controlled he can do things when he feels able to and that works very well.

"On Tuesdays and Fridays, we go to our daughter's house and she looks after Patrick while I do a bit of shopping, or anything else that needs to be done. The routine suits us both but we have to keep to it."

Patrick is now attending the Hospice Day Services at Barrowell Green.

"Eileen told me about Day Services and I really enjoy going there every week. I'm having art therapy although I've never painted before - I find it very relaxing. I have also had a manicure, reiki and join in the relaxation session. What I most enjoy though is being able to meet and talk to other people. It's really brought me out of myself. It's no good being stuck at home the whole time – you end up thinking about your illness and problems. Spending time at the Hospice in Enfield takes me away from all that. I don't want to be indoors all the time – I've never done that in my life.

"I chat away to the staff, volunteers and other patients. The canteen is brilliant – I usually have an omelette and mash. The chef puts everything he can think of in the omelette. I can't fault the food at all and the place is immaculately clean. Everyone is so friendly – the chefs all know my name, even if I haven't met them before. How do they do that? It will be lovely there in the summer with the doors opening onto the garden.

"It's so friendly there and you're never left on sitting your own – there's always a volunteer who will come over and chat to you. Ursula was left at the dining table once when I went off to an appointment and within seconds someone else had come over to sit with her.

"Before I had been into the building I thought it would be like being in hospital but it's totally different. In hospital you're being taken off for tests and x-rays all the time and it's hard to relax. The Hospice is very calm and that's what I need."

Ursula takes Patrick to Day Services and picks him up. She stayed with him at first but not now.

"I don't need to – I won't usually leave Patrick anywhere but I know he's well looked after and they understand his condition. When I first walked in, it felt so calm and relaxing. Luisa there knows how to set up his nebuliser and can make sure his medication is correctly given. I

don’t even trust the hospitals to do that. They don’t know enough about Patrick’s condition. I’m sorry to have to say that but I’ve witnessed it in various places for myself. Luisa will look round at all the patients who are there and knows if they are all ok.

“I am really benefitting from it too. I can do things like go to the dentist, have a physiotherapy appointment and get my medical needs sorted out.

“Patrick has been recommended for some respite care at the Inpatient Unit in Finchley and we’re waiting to hear if that will happen. I have complete confidence in all the Hospice staff and would have no qualms about him being there without me, although of course I will visit him.”

Patrick would like to stay at the Hospice as it would give Ursula a break from looking after him.

“Everyone I have met at the Hospice is so caring and nothing is too much trouble. I would like to put a halo over all their heads, the care is so fantastic.”

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-20110-2012.aspx

How to provide feedback on the account

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

If you have comments contact:

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Barnet and Chase Farm Hospitals NHS
NHS Trust

Draft Quality Accounts 2012/13

INTRODUCTION AND STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am proud to present the Trust's fourth set of quality accounts in what is my first year in charge of this organisation. Though I have only been here a few months, I am already hugely impressed with the efforts made by staff at all levels to improve their part of the service we provide.

We have made progress in many key areas over the last 12 months, both in terms of our acute services and also in integration with community-based healthcare in keeping with the changes outlined in the Social Care and Well Being Bill. A new medical model has been introduced that improves patient flows into, within and outside our care. As part of the BEH process we are moving rapidly towards the implementation of the SAFE standards across the organisation. Our partnerships with NHS Enfield have seen us working on setting up community-based pain and outreach cardiology clinics, both of which will be introduced early in 2013/14.

Reports released by health authorities and the CQC over the course of the year have highlighted areas where we can improve but also demonstrate the generally high quality of our services. The Health and Social Care Information Centre calculated figures using the new summary hospital-level mortality indicator (SHMI) from July 2010-June 2012 and found the Trust to have lower than expected mortality rates. We also scored very highly in the annual Patient Environment Action Team (PEAT) Assessments; Barnet Hospital scored a 5 (for 'Excellent') on both Environment and Food, whilst Chase Farm Hospital scored a 4 (for 'Good') and a 5 for these two areas respectively. Both hospitals scored a 4 on Privacy and Dignity.

The BEH Clinical Strategy has now moved into its proposed implementation phase and we are ensuring that patient experience continues to improve during as well as after the changes in November 2013. Extra car parking spaces are being provided at Barnet Hospital to improve accessibility, and as the A&E department becomes busier the clinical benefits of having services specialised in fewer locations will start to become evident.

The Trust would like to thank the local community for their patience during the reconfiguration process; it has been a challenging journey over a number of years but as we near 'going live' we are confident of our ability to deliver substantial improvements in our levels of care to our patients and relatives.

OUR QUALITY PRIORITIES FOR 2013/14

Our mission statement reads that: "Barnet and Chase Farm Hospitals NHS Trust will deliver excellent patient outcomes and care, of which patients, the public and staff can be proud."

Each year we set quality improvement priorities that are monitored by the Trust Board. In deciding on our quality priorities for 2013/14, suggestions were invited from clinicians across the Trust and opinions were sought from our patients via account workshops attended by our medical representatives, local LINKs and commissioning groups and councils representatives. The Trust's Quality and Safety Committee considered all suggestions and agreed the following six priorities set out below which following evaluation through the Local Scrutiny Committees, Clinical Commission Groups and LINKs will be put forward to the Trust Board.

Priority one: Dementia services

The Trust Dementia Strategy was launched in April 2011. Since then, the Trust has piloted and implemented a range of practical steps to support patients with dementia. The launch of the strategy included the commencement of the dementia care pathway.

Training in dementia care remains a high priority and the Trust has implemented a range of training programmes. These include bespoke training provided by Middlesex University as well as an eLearning training package. The Trust is also actively involved in the UCLP dementia training initiative.

The Trust has purchased and implemented distraction boxes for elderly patients and we have recently implemented Tiptree tables on some wards at Barnet Hospital which are being supported by the current Mayor of Barnet, Cllr Brian Schama, fundraising activity this year.

As part of the commitment to supporting carers the Trust has also implemented the Carers Badge Scheme. The purpose of this scheme is to ensure appropriate support and acknowledgement for carers whilst they support vulnerable people in hospital. Carers will be identified by the badge that they wear.

The use of the Carers Badge Scheme and also the Butterfly Scheme (the latter was detailed in last year's Quality Account) will form part of our audit programme for the forthcoming year to further emphasis our commitment to this programme and in recognition of the vital role the community play in the care of these patients.

The Trust has also chosen to be part of the new Quality and Innovation (CQUIN) scheme to support carers in the community which will be launched shortly.

Priority two: National Safety Thermometer

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of avoidable harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for venous thromboembolisum. These four high volume patient safety issues represent the direction of the NHS Outcomes Framework to measure improvements against key outcomes.

The Safety Thermometer CQUIN is a mandatory requirement for NHS organisations and seeks to enable Trusts to understand where the key avoidable harms are occurring in their patient population and how to address them by focussed improvement. The Trust was among the original 10 trusts in London who participated in the national safety pilot and so gained a head start in the understanding of improvements needed for harm free care delivery.

In 2012-2013 our CQUIN goal was to achieve 100% measurement of all eligible patients each month on the collection date so that a baseline could be established. In 2013-14, we will use the established baseline to endeavour to demonstrate a significant reduction in Hospital Acquired Pressure Ulcers (HAPUs).

It should be noted however, that the NHS Safety Thermometer was designed to measure local improvement over time and should not be used to compare organisations, as there are differences in patient mix and data collection methods that can invalidate comparison across organisations. For example, this Trust has a high percentage of older patients who are likely to present with more harms.

In order to achieve success, the Trust recognises the commitment to openness and transparency and more importantly has a real appetite for improvement. The data gained from the thermometer will be clearly documented on wards to help achieve this drive for improvement as well as being communicated across the organisation and to the Trust Board. This will allow us to identify areas of concern so that we can improve and move forward to harm free care.

Priority three: Pressure ulcers

Avoidable hospital acquired pressure ulcers (commonly called pressure sores) remain a key indicator of the quality of nursing care.

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.

Weekly audits and reviews were commenced in 2011/2012 and have continued to have a positive effect on the reduction of hospital acquired pressure ulcers. In the last twelve months the trust has seen a reduction in the level of pressure ulcers by 111 pressure ulcers with only two of the most severe type of ulcer.

Moving forward, our tissue viability team remain committed to the delivery of education and continued improvement in prevention of hospital acquired pressure ulcers and has planned training, education and competency based assessments to improve staff knowledge and skills.

Priority four: Administration standards

The Trust has a particularly busy administrative department. Over 600 whole time equivalent staff send over 220,000 appointment letters a year, booking over 600,000 clinical attendances and 100,000 inpatient admissions annually. This service now needs to change for a number of reasons. The quality of service provided is inconsistent, with a quarter of complaints to the Patient Advice and Liaison Service (PALS) relating to basic clinical administration. Our manual processes also need to be more consistent and require standardisation allowing appropriate career structures and progression for staff.

Improving the patient experience in all aspects of our services means getting things right first time. This ensures consistent high quality service, freeing up clinicians to be able to treat patients and ensuring that the service develops and supports its staff. A first class administrative service therefore has a big role to play in creating a better patient experience and improved clinical care. Our plan for making these administrative improvements involves:

- reviewing how our clinical administrative teams are allocated as well as the policies and procedures they follow
- introducing new technology to help raise the standards of service we provide to our patients
- forming ‘clinical offices’ – single points of access for groups of specialties.

There will be new quantitative standards set for administrative work. We aim to lower appointment re-bookings from 25% to less than 10% and shrink the clinic letter turnaround from up to four weeks to less than four days. We also aim to improve the availability of medical records. We are moving progressively on to an electronic platform to allow integrated and improved clinical record keeping and this in turn improves the patient experience and care.

One of the new technologies set to be introduced in 2013/14 is the use of self check-in terminals. These will enable patients to check in using touch screen and bar code technology as well as allowing doctors to call through clinics.

They will result in reduced crowding in wait areas and improvement in patient confidentiality amongst other benefits. Staff will be available to help use the machines and receptionists will still be an option for anyone who prefers to check-in that way.

Priority five: Liverpool Care Pathway with an emphasis on dignity, respect and compassion

The Trust aims to provide excellent end of life care to patients, and encourages the use of the Liverpool Care Pathway (LCP) to support this. The Liverpool Care Pathway for the dying is an integrated care pathway aimed at improving the quality of care for patients in the last few hours/days of life. It is a multi-professional document that guides professionals to provide the best standards of care by transferring the hospice model of care into the acute setting where currently 58% of deaths occur. The LCP incorporates care before and after death, ensuring a dignified death and the provision of appropriate support to relatives and friends.

Whilst there has been much discussion in the media the effective and appropriate use of the LCP allows patients to die in comfort and dignity. It must however be applied appropriately and discussed with the patient and their families in order to ensure every confidence in its approach.

We aimed to increase anticipatory prescribing for patients identified as dying (this means prescribing medications which may be needed to treat pain or other symptoms before they arise). An audit in 2012 showed that 81% of patients identified as dying had all the correct medications prescribed. Although this is an improvement on the previous figure of 67% there is still clearly room for further improvement.

We aimed to improve completion of the LCP paperwork since previous audits highlighted that only parts of the LCP were fully filled in. The 2012 audit showed that completion of sections regarding care before death had improved, but the after death sections had not. The results from this year we need to continue to work to improve our performance.

Priority six: Complaints to Trust Board

Following the recent publication of the Francis Report the Trust at all levels is focussed on ensuring that we are sensitive to any early warning signs indicative of failure of care standards.

It is clear that an important early indicator can be the nature, quality and trend of complaints received by the organisation.

Because of this the Trust Board now analyses a complaint at each of its public board meetings and we are focussed 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 all complaints responses in order to ensure care issues are addressed throughout the Trust.

The Trust also has a comprehensive computerised incident reporting system (IR) All staff are encouraged actively to report and incidents on the system. These are then categorised and investigated so that trends can be understood and appropriate actions taken.

Any serious incidents undergo a formal root cause analysis and are reviewed by a panel of senior executives chaired by the Medical and Nursing Directors. The cases cannot be closed until evidence of the appropriate action has been given and may be externally validated. Outcomes are fed back in to the clinical directorates and across the Trust as appropriate.

A key area of concern and complaint for patients during the year has been management of both outpatient and inpatient appointments in response to this the Trust is making changes to its administrative processes to ensure that the issues highlighted by patients are addressed as outlined in priority four.

STATEMENTS RELATING TO THE QUALITY OF NHS SERVICES PROVIDED BY BARNET AND CHASE FARM HOSPITALS NHS TRUST

This section contains eight statutory statements concerning the quality of services provided by 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 2012/13 Barnet and Chase Farm Hospitals NHS Trust provided 40 NHS services. Barnet and Chase Farm Hospitals NHS Trust has reviewed all the data available to it on the quality of care in all of these services. The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by Barnet and Chase Farm Hospitals NHS Trust for 2012/13.

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.

STATEMENT TWO: PARTICIPATION IN CLINICAL AUDIT

During 2012/13, Barnet and Chase Farm Hospitals NHS Trust was eligible to participate in thirty seven national clinical audits and two national confidential enquiries. The Trust participated in 95% of national clinical audits (35/37) and 100% of national confidential enquiries it was eligible to participate in.

The national clinical audits and national confidential enquiries in which Barnet and Chase Farm Hospitals NHS Trust was eligible to participate during 2012/13 are listed in the table below, highlighting those that the Trust participated in during this period and the number of cases submitted to each audit or enquiry.

NATIONAL CLINICAL AUDITS FOR INCLUSION IN QUALITY ACCOUNTS 2012/13

Name of audit / confidential enquiry	Data collection 2012/13	BCF participation.
Adult community acquired pneumonia (British Thoracic Society)	**Yes**	1/12/2012 - 31/5/2013. Barnet SITE - 47 cases collected and data upload commenced- none committed (closing date 05.2013). CFH - 27 uploaded so far, several more notes to go through.
Adult critical care (Case Mix Programme – ICNARC CMP)	**Yes**	April 2012 – March 2013: 476 at CFH and 395 at BH were submitted.
Emergency Laparotomy * Contract awarded to The Royal College of Anesthetists (03.07.12)	**No - see comments**	New Audit. Awarded to RCoA in July 12. Data collection to commence in 2013/14.
Emergency use of oxygen (British Thoracic Society)	**Yes**	CFH: Oxygen audit 40 patients audited - approx 6 cases were on oxygen at the time of the audit. BH: 6 cases submitted
National Joint Registry (NJR)	**Yes**	Quarterly reports published. The Annual report published does not breakdown data by Trusts, but collectively on prosthesis. Surgicentre Chase Farm Hospital: the total number submitted/uploaded to NJR data base = 384 for knee 215 for hip 157 for shoulder 11 for elbow 1 total consented for NJR only 226 and outstanding NJR form needed to be submit/upload: for Shoulder 15 for elbow 1 for knee 57 for hip 52
Non-invasive ventilation - adults (British Thoracic Society)	**No - see comments**	To commence in March 13.
Patient Outcome and Death (NCEPOD) (also known as Medical/Surgical Clinical Outcome Review Programme)	**Yes**	1) Subarachnoid Hemorrhage: Information submitted on identified patients. 2) Alcohol Related Liver Disease: Organisational Audit Complete 3) Bariatric Surgery - N/A
Renal colic (College of Emergency Medicine)	**Yes**	Both sites submitted 50 cases each (100%).
Severe trauma (Trauma Audit & Research Network)	**Yes**	BCF has been submitting data since April 12. To date, 124 cases uploaded have been approved by TARN. 11 cases are awaiting approval by TARN and there are still approximately 45 cases

Name of audit / confidential enquiry	Data collection 2012/13	BCF participation.
		still to be entered onto TARN for Jan - March 2013 (awaiting notes and discharge).
National Comparative Audit of Blood Transfusion - programme contains the following audits: a) O neg blood use b) Medical use of blood c) Bedside transfusion d) Platelet use	**Yes**	Audit of the medical use of red cells completed. Blood transfusion audits undertaken regularly as part of Trust Blood Transfusion Policy.
Potential donor audit (NHS Blood & Transplant)	**Yes**	106 patients audited (April12 - Jan13). Updated data will be available from May.
Bowel cancer (NBOCAP) (Subscription funded from April 2012)	**Yes**	BCH has the highest number of patients in our Cancer Network. In the time period August 2011 to July 2012: 246 new tumour records were added (although the date of diagnosis may fall outside of the time period) 332 new treatment records were added (although the data of treatment may fall outside of the time period) There were 202 patients with a diagnosis within the time period, although their records may have been added outside of the time period.
Head and neck oncology (DAHNO) (subscription funded from April 2012)	**Yes**	Nov 2011 to Oct 2012 = 119 patients submitted - awaiting verification by DAHNO Nov 2010 to Oct 2011 = 105 patients submitted, 104 patients accepted - verified by 2011 DAHNO report
Lung cancer (NLCA) (subscription funded from April 2012)	**Yes**	244 cases submitted, which is the highest number in the network and possibly highest in London.
Oesophago-gastric cancer (NAOGC) (subscription funded from April 2012)	**Yes**	For patients diagnosed between 1 April 2011 and 31 March 2012. All upper GI surgery is now performed in Specialist Centres (UCLH). BCF contributes to the audit from the Upper GI cancer MDT.
Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	**Yes**	186 cases for Barnet and 45 cases for Chase Farm were entered onto the NICOR database to date for the year since April 2012.
Cardiac arrhythmia (HRM)	**Yes**	Audit formally known as Cardiac arrythmia. 345 procedures for calendar year 2012 and 312 for financial year 2012-13 up to 13th March 2013 were entered for Barnet site only.

Name of audit / confidential enquiry	Data collection 2012/13	BCF participation.
Heart failure (HF) (subscription funded from April 2012)	**Yes**	All patients (up to 20 cases per month) with an unscheduled admission to hospital with heart failure From RD 15/11: The National HF Audit requires monthly returns and sends out reports annually. This Trust has actively contributed to the audit and will continue to do so. Lead to forward returns data.
National Cardiac Arrest Audit (NCAA)	**Yes**	Do not participate as insufficient returns of cardiac arrest forms.
Peripheral vascular surgery (VSGBI Vascular Surgery Database, NVD)	**Yes**	Procedure undertaken at Specialist units only. .
Adult asthma (British Thoracic Society)	**Yes**	Awaiting data from leads.
Asthma Deaths (NRAD)	**Yes**	3 cases identified. Cases reviewed and questionnaires submitted.
Bronchiectasis (British Thoracic Society)	**Yes**	Awaiting data from leads.
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	**Yes**	Did not participate in this audit.
Diabetes (Paediatric) (NPDA)	**Yes**	160 cases submitted.
Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services.	**Yes**	Data collection commenced in January 2013. Deadline Dec 2013.
Pain database	**Yes**	Did not participate in this audit.
Fractured neck of femur (CEM)	**Yes**	BH submitted 36 cases (72%) and CFH submitted 50 cases (100%).
Hip fracture database (NHFD)	**Yes**	2011/12 - BH 100% and CFH - 99% data entered. Info from NHFD will be available April for 2012-13. Leads will have data. To date 178 patients have been added to database for CFH and 281 patients for BH.
National dementia audit (NAD)	**Yes**	80 cases have been submitted. Final report due 18th Feb 2013.
Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits: a) Sentinel stroke audit b) Stroke improvement national audit project	**Yes**	Commenced December 2012.

Name of audit / confidential enquiry	Data collection 2012/13	BCF participation.
Elective surgery (National PROMs Programme)	**Yes**	Info from ICS: BCF submitted data up to Sept. Results will be available in Feb. Oct - Dec data will be available in May. Apr - Jun = 224 Qs of 280 eligible episodes. (80% returns).
Child Health (CHR-UK) (Also known as the Child Health Clinical Outcome Review Programme)	**Yes**	Zero BCF cases identified by CHR-UK as meeting the audit inclusion criteria, therefore no submissions.
Epilepsy 12 audit (Childhood Epilepsy)	**Yes**	Data collection commenced January 2013.
Maternal infant and perinatal (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome Review Programme)	**Yes**	Cases reported as they happen. No BCF cases identified / selected by (MBRRACE-UK) as yet.
Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	**Yes**	All NNU admissions were included in audit dataset.
Paediatric asthma (British Thoracic Society)	**Yes**	18 cases submitted.
Paediatric fever (College of Emergency Medicine)	**Yes**	BH submitted 48 cases (96%) and CFH submitted 50 cases (100%).
Paediatric pneumonia (British Thoracic Society)	**Yes**	

Barnet and Chase Farm Hospitals NHS Trust was not eligible to participate in the audits listed below in 2012-2013 as the Trust does not provide these services.

Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	N/A
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A
Coronary angioplasty (subscription funded from April 2012)	No	N/A
Adult cardiac surgery audit (ACS)	Yes	N/A
Paediatric intensive care (PICANet)	Yes	N/A

Renal replacement therapy (Renal Registry)	Yes	N/A
Renal transplantation (NHSBT UK Transplant Registry)	Yes	N/A
National audit of psychological therapies (NAPT)	Yes	N/A
Prescribing in mental health services (POMH)	Yes	N/A
Suicide and homicide in mental health (NCISH) (also known as Mental Health Clinical Outcome Review Programme)	Yes	N/A
Carotid interventions audit (CIA) (subscription funded from April 2012)	No	N/A.
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	N/A
Parkinson's disease (National Parkinson's Audit)	Yes	N/A

ADDITIONAL INFORMATION

The Trust did not participate in this year's national diabetes audit as the data held on our existing system is not adequate or specific to the audit. A new audit specific database has been agreed and we intend to submit data to the next audit round.

In addition to national audits the Trust undertakes a local annual audit programme in response to its own perceived 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 Trust has recently sponsored and designed a new clinical audit database to ensure we have consistently of approach, learn from and close the loops generated by our internal audit programme.

STATEMENT THREE: PARTICIPATION IN CLINICAL RESEARCH

The Trust is currently an active member of University of Central London (UCL) Partners which is one of five accredited academic health science systems in the UK. The Trust will continue to work in collaboration with UCL Partners.

For commercial research, we are one of the key partners supporting the pilot UCL Harmonisation project for commercial R&D. We are an active member of the Central and East London Comprehensive Local Research Network (CEL CLRN) and a very active albeit small partner.

There have been over 50 projects which have been launched to date. UCL Partners are currently involved with the following programmes:

- **Cancer**
- **Cardiovascular**
- **Child Health**
- **ENT**
- **Eyes and Vision**
- **Immunology and Transplantation**
- **Infectious Diseases**
- **Liver and Digestive Health**
- **Mental Health and Wellbeing**
- **Neuroscience**
- **Women's Health**

We are continually monitored by the CEL CLRN for our metrics of recruitment to NIHR studies and portfolios and have monthly returns and updates on our recruitment to studies.

The Trust has two specific service level agreements to have both due diligence support for administrative, contractual and legal aspects of conducting R&D work at our location as well as innovation partnership, education and training needs for investigators. These are with the Joint Research office at UCL and the R&D unit at Royal National Orthopaedic Hospital.

Our close links allow joint working and specialist advice as needed.

First dedicated Director of Research

In December 2012 the Trust approved and appointed its first dedicated Director of Research to promote its key aspirations for harnessing research.

His appointment was in recognition of the Trust's ambitions to meet the following aspirations:

1. To create a cultural shift in a busy district general hospital that research is part and parcel of day to day clinical practice, with opportunities for self-development and recognition as clinicians, with early exposure to leading edge technologies, opportunities of access for patients to potential new treatments and a source of revenue for the NHS
2. Raise the profile of R&D in our Trust and externally for our patients and partners from that of a fringe activity

3. Build R&D partnerships with larger more active organisations to act as mentors
4. Bring R&D into the trust board agenda as an innovation theme as part of QIPP
5. To foster the enthusiasm of young Consultants wanting to do research with sufficient start up resources and administrative support
6. To build a team of research staff capable of harnessing our R&D potential and sustaining R&D growth.

This will allow us to:

- Enable patients to access the best new therapies in clinical trials
- Harness the funding opportunities of research into district general, non-academic hospitals in partnership with academic institutions
- Find, evaluate and promote clinically and cost effective new therapies to enhance NHS efficiency in providing care
- Enable local scientists, entrepreneurial clinicians and other designers to find, create, and discover their latest breakthroughs in the NHS setting.

The Trust also has an intellectual policy and processes to help initiate intellectual property projects through our prior collaboration with NHS Innovations Team. Although we have not previously had any significant IP within the Trust, the mechanisms exist via our partnership with UCL partners to support this process.

The Trust has an IT system with electronic patient records which is of the highest standard nationally. The system has been in place and active since 2001 with continual and progressive updates. The system is both a repository for research and innovation and supports these on-going activities fully. It is the backbone of our aspiration to reduce the NHS Green footprint by becoming paperless.

STATEMENT FOUR: USE OF CQUIN PAYMENT FRAMEWORK

Quality and Innovation (CQUIN) scheme targets 2012/13

The Trust agreed a number of national, regional and local quality improvement targets with Co-ordinating Commissioners (NHS North Central London) and the London Specialised Commissioning Group under the Commissioning for the CQUIN scheme.

The Trust's improvement programme consisted of:

Nationally Mandated

- Venous thromboembolic Assessment
- Venous thromboembolic Audit - Prophylaxis
- Patient Experience
- Dementia - Dementia Screening
- Dementia - Risk Assessment
- Dementia - Referral for Specialist Diagnosis
- NHS Safety Thermometer

Regionally Agreed

- Enhanced Recovery Programme (ERP) (improving the patient pathway for planned surgery)
- ERP- National Database
- Enhanced Recovery - Directed Fluid Therapy for Colo-rectal Surgery
- ERP - Emergency Laparotomy Audit
- Enhanced Recovery - Directed Fluid Therapy for Emergency Abdominal Surgery
- Enhanced Recovery - Reduction in Length of Stay

Locally Agreed

- Cancer Staging
- Smoking – supporting people who wish to stop smoking
- Alcohol – to identify assess and refer patients with alcohol issues
- COPD Bundle of Care

London Specialised Commissioning Group

- NICU - Neonatal Community Nurse Provision
- NICU - Appropriate Admissions
- Implementation of Specialised Services Clinical Dashboards
- Neo-natal Intensive Care

The Trust continues to improve its performance year on year in relation to the CQUIN targets, and is working with commissioners to develop further quality targets.

STATEMENT FIVE: STATEMENTS FROM THE CQC

Barnet and Chase Farm Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is compliant without conditions at all locations. The CQC has not taken enforcement action against the Trust as of 31 March 2012.

The Trust has participated in special reviews or investigations by the CQC relating to the following area between 1 April 2011 and 31 March 2012: The CQC national inspection programme for termination of pregnancy (clinical services reviews) relating to the Abortion Act 1967 during March 2012. The Trust was found to be meeting all the essential standards of quality and safety inspected.

ADDITIONAL INFORMATION

In 2012, the Trust was subject to a number of unplanned inspections and was found to non-compliant for the following CQC Essential Standards of Quality and Safety:

Outcome 9 – Medicines Management (CQC Inspection date: 25/04/12)

Outcome 13 – Staffing and Outcome 21 – Records (CQC Inspection date 20/08/2012)

The Trust put together and implemented action plans relating to these outcomes and improvement work was monitored by the Trust CQC compliance working group and overseen by our Quality and Safety, which reports progress to the trust board. Following implementation of action plans agreed with the CQC, further unannounced inspections were undertaken as follows:

26/09/2012: Outcome 9-Medicines Management: The Trust were judged as meeting the standard and now compliant.

13/02/2013: Outcome 13-Staffing and Outcome 21-Records: The scope of the inspection was extended across a number of wards and significant positive improvements were commented upon. Overall, the Trust was judged to now be meeting both outcomes and compliant.

STATEMENT SIX: DATA QUALITY

Barnet and Chase Farm Hospitals NHS Trust submitted records during 2012/13 M9 (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:

98.2% for admitted patient care
98.9% for out-patient care
92.9% for accident and emergency care

The percentage of records in the published data which included the patient's valid general medical practice code was:

100% for admitted patient care
100% for out-patient care
100% for accident and emergency care

STATEMENT SEVEN: INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

Barnet and Chase Farm Hospitals NHS Trust achieved Level 2 or higher for all 45 requirements which form part of the Information Governance Toolkit and therefore the assessment score for 2012/13 is rated as **Satisfactory**. The score of 86% for 2012/13 marks an improvement on the score for the previous year's assessment of 84%.

ADDITIONAL INFORMATION

Information Governance defines the good practice guidelines necessary to ensure that organisations and individuals deal with information legally, securely, efficiently and effectively in order to deliver the best possible care. Information Governance incorporates Confidentiality Practice, Data Protection, FOI, Information Security, Records Management, Information Quality and Good Practice IG Governance.

The Information Governance Toolkit (IGT), which was devised by the Department of Health, is a compulsory web-based tool designed to enable organisations to self assess their performance against law and central guidance and key aspects of information governance, including Data Protection, FOI and Common Law Confidentiality requirements. The overall aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. In excess of 200,000 organisations now complete the IGT annually.

STATEMENT EIGHT: CLINICAL CODING ERROR RATE

Barnet and Chase Farm Hospitals NHS Trust was subject to the payment by results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

40% primary procedures coded incorrectly
19% secondary procedures coded incorrectly
10% primary diagnoses coded incorrectly
17% secondary diagnoses coded incorrectly

The error rates will appear magnified because the sample size was very small for the admitted patient care audit. For example, there were only four primary procedures coded incorrectly but they make up 40% of the statistics, whilst only two secondary procedures were coded incorrectly but they make up 19% of the statistics.

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.

REVIEW OF QUALITY PERFORMANCE DURING 2012/13

During 2012/13 the Trust once again provided high quality clinical services. In this part of our quality accounts we review our performance against our key quality priorities for 2012/13 and provide examples that illustrate how individual services and specialties are focused on quality improvement. We also provide key data relating to our performance.

PERFORMANCE AGAINST OUR KEY QUALITY OBJECTIVES

In the 2011/12 quality accounts, we set five key quality improvement objectives. These were:

Priority one: Improving stroke care
Priority two: The Liverpool Care Pathway (LCP) for the dying patient
Priority three: Prevention and management of pressure ulcers
Priority four: Access to services for people with learning disabilities – working in partnership with the Acute Learning Disability Liaison Nurse and the local Community Learning Disability Teams to ensure improved outcomes for patients with a learning disability
Priority five: Infection Control – maintaining standards

On the next pages, we outline how we performed against these objectives.

Improving stroke care

During 2011/12 our TIA (Transient Ischaemic Attack) service at Barnet Hospital was awarded Gold accreditation. This was presented by the Cardiovascular and Stroke Network and local commissioners, in recognition of the team providing the highest quality of service to our patients. It also made us the first Trust in the sector to be accredited with this standard.

As part of our aim to maintain this level of care for these patient, the Trust is part of the national Accelerating Stroke Improvement (ASI) programme which highlights key areas of work including: direct admission to a stroke unit and time spent on a stroke unit, timely brain scan and psychological support.

Our progress in these areas during 2012/13 has been as follows:

Our patients now have almost immediate access to brain imaging 24 hours a day, seven days a week. We constantly audit our TIA clinic response times and this study identified that we are seeing more patients in this clinic and we are currently reviewing our staffing arrangements to ensure we can meet the extra demand.

We are reviewing psychological support as there is no neuropsychologist in our hospital, although many stroke units do employ one on a part time basis. Instead, we do routine mood assessments and treat when required.

We have set up weekly Multi Disciplinary Team meetings (MDT) and daily board rounds on the ward with the whole team present. The MDT are involved in all discharge decisions about the patients to ensure they go home with the appropriate care and community support if required.

The Liverpool Care Pathway (LCP) for the dying patient

This remains a priority for the Trust (see priority five), as we aim to provide excellent end of life care to patients, and encourages the use of the Liverpool Care pathway to support this.

The LCP incorporates care before and after death, ensuring a dignified death and the provision of appropriate support to relatives and friends. Government policy reinforces the need to prioritise the delivery of high quality care at the end of life.

We aimed to increase anticipatory prescribing for patients identified as dying (this means prescribing medications which may be needed to treat pain or other symptoms, before they arise). An audit in 2012 showed that 81% of patients identified as dying had all the correct medications prescribed. This is an improvement on the previous figure of 67% but we clearly still need to improve.

We aimed to improve completion of the LCP paperwork since previous audits highlighted that only parts of the LCP were fully filled in. The 2012 audit

showed that completion of sections regarding care before death had improved, but the after death sections had not. The results highlight again that we need to continue to work to improve our performance.

Case study

Mr X was an 85 year old man with heart failure and kidney failure. He was admitted to hospital with worsening breathlessness and oedema (swelling of the body with fluid) and was found to have end-stage heart and kidney failure. He'd already had all possible treatment for the heart failure, despite which he was getting worse. Mr X and his family understood that he was going to die within a few days from the heart failure. He was breathless, nauseous, and anxious. He and his family agreed that he wanted the best end of life care, with his comfort as the main aim, and that to help achieve this, the LCP should be commenced. In agreement with Mr X we stopped doing blood tests and measuring observations (e.g. temperature and blood pressure) to allow him to rest. He was given medication for the breathlessness, nausea and anxiety and became much more comfortable. He died peacefully a short time later. His family were pleased that he was able to be comfortable and dignified at the end.

Prevention and management of pressure ulcers

Avoidable hospital acquired pressure ulcers (commonly called pressure sores) remain a key indicator of the quality of nursing care.

The Trust gives high priority to this and a zero tolerance approach to avoidable pressure ulcers has been implemented with significant focus being given to this area of care.

Weekly audits and reviews were commenced in 2011/2012 and have continued to have a positive effect on the reduction of hospital acquired pressure ulcers. In the last twelve months the trust has seen a reduction in the level of pressure ulcers by 111 pressure ulcers with only two of the most severe type of ulcer.

Moving forward, the tissue viability team remain committed to the delivery of education and continued improvement in prevention of hospital acquired pressure ulcers and has planned training, education and competency based assessments to improve staff knowledge and skills.

Access to services for people with learning disabilities – working in partnership with the Acute Learning Disability Liaison Nurse and the local Community Learning Disability Teams to ensure improved outcomes for patients with a learning disability

Over recent years there have been a number of hard hitting reports highlighting the failures in the care and treatment of people with a learning disability within acute hospital settings. The first report *Death by Indifference*

(Mencap 2007) documented the 6 lives of people with a learning disability who died in NHS care.

Following an investigation into the report by Sir Jonathon Michaels *Healthcare for All* (2008) it concluded that *'people with learning disabilities have higher levels of unmet need and receive less effective treatment'.* The *Six Lives Progress Report* (2010) again emphasized the improvement required in acute hospitals to ensure that access to health services is equitable. More recently the updated Mencap report *Death by Indifference – 74 and counting* (2012) and the *Confidential Inquiry into premature deaths of people with learning disabilities* (2013) concluded that *premature deaths could be avoided by improving the quality of the healthcare that they receive.* The reports identified many shortcomings, the most significant being a failure to make reasonable adjustments to services in order to meet the individual needs of patients. They did, however, also identify examples of good practice and key recommendations for all of the agencies involved in caring for people with learning disabilities and their families.

Building on the findings and recommendations of the reports, the Trust has improved its partnership working with the local Community Learning Disability Teams and the Acute Liaison Nurse. This was positively demonstrated in a recent case with a patient who required an intensive chemotherapy regime.

The Acute Liaison Nurse supported the clinicians to apply the Mental Capacity Act 2005 and assess the patient's capacity to consent to the treatment. The Acute Liaison Nurse was able to organise meetings with the family and health and social care community professionals to ensure the gentleman's best interests were considered at each stage of his treatment. The Acute Liaison Nurse worked with the ward staff regarding reasonable adjustments and how they could make small changes to the way they provided care taking into consideration the patients' learning disability. The reasonable adjustments included easy read information, ensuring consistency of staff, providing a quiet area away from the other patients and allowing the patient to bring in computer games and DVD's. The patient successfully accessed all of the investigations, procedures and treatments required and is currently in remission.

Infection Prevention and Control – maintaining standards

Infection Prevention and Control continues to be a high priority for us and our patients.

In 2012/13 our Intravenous Working Group focussed on improving Intravenous line care; in particular central lines, which has resulted in the development of a bespoke central line insertion pack so that all these devices are put in using a standard approach. This has been supported by targeted education for all staff who insert and looks after central lines.

Our Matrons and Heads of Nursing have developed a Care Bundle to reduce the incidence of hospital acquired pneumonia and this will be launched in

2013/14. The Matrons have also revised our daily ward and department cleanliness checklist which our ward and department leaders use every day.

We launched our Olympic themed 'Going for Gold' Campaign in April 2012; setting our local reduction targets (based on our national objectives) for both MRSA and *Clostridium Difficile*.

We did not achieve our MRSA trajectory. Our goal was to have no more than four reported cases. We had seven reported cases. This year we continued to reduce incidents of *Clostridium Difficile* seeing a 42% reduction in cases from 2011/12.

This reduction has been achieved by carrying out an in-depth investigation of all cases so that we can learn the lessons from each case and share these widely with our clinical teams. We have also focussed on antibiotic prescribing; implementing ward rounds with a consultant microbiologist and pharmacist.

Hand Hygiene for all our staff remains a priority. We have gone back to basics with hand washing techniques, doing a series of road-shows around the wards using observations of hand washing practice and talking to staff about how to take of their hands using a special machine to test how the contaminated the skin is.

FOCUS ON QUALITY AND IMPROVEMENT

We want to provide the highest quality service to our patients. As one of the largest healthcare providers in North London with a catchment population of 500,000 potential patients, we recognise the importance of conducting research and training the healthcare professionals of tomorrow. In this section, we provide some examples of how we have continually improved the quality of service we provide over the past year.

Some quality improvement highlights from the last 12 months:

Trust scores highly in annual PEAT Assessments

The Trust scored highly in the 2012 Patient Environment Action Team (PEAT) Assessments. These examine the areas of environment, food, and privacy and dignity that all have an impact on a patient's wellbeing during their treatment.

The results show that Barnet Hospital scored a 5 (for 'Excellent') on both Environment and Food, whilst Chase Farm Hospital scored a 4 (for 'Good') and a 5 for these two areas respectively. Both hospitals scored a 4 on Privacy and Dignity.

The PEAT Assessments cover the whole of a hospital site, including both inpatient and outpatient areas. National publication of all hospitals' PEAT scores will take place in July. This is the last year that the Assessments will be made in their current form; they will be replaced in 2013 by a new patient-led inspection programme.

Extra car parking to be provided at Barnet Hospital and extended bus route is also now in effect

As part of the Barnet, Enfield and Haringey Clinical Strategy implementation plan a building and remodelling programme is underway to accommodate the extra patients and visitors that will be attending Barnet Hospital and the additional staff.

Following a further review of car parking requirements, the Trust will now provide an extra 200 car parking spaces on the fallow land at the front of the hospital.

To further aid accessibility to Barnet Hospital and improve patient experience before and after their care, a popular bus route through Barnet has also been extended slightly so that it now stops directly outside the hospital.

Cancer services praised by patients

The publication of the National Cancer Patient Experience Programme's 2012 report showed the Trust's cancer services to be of a very high standard, with notable progress made since last year's report and areas of improvement highlighted for staff to work on.

The survey looked at adult patients (aged 16 and over) with a primary diagnosis of cancer who had been admitted to NHS hospitals as an inpatient or day case patient and discharged between 1 September 2011 and 30 November 2011. Of the 972 patients who returned questionnaires for the survey, 89% rated their care as excellent or very good. This is the highest score across all NHS trusts in North Central London. Of the 55 questions that were comparable to questions in the previous year's survey, the Trust showed improvement in 37 of them. We were also in the top quintile of surveyed trusts for 11 questions (up from four in the previous year) and in the bottom quintile for 15 questions (down from 23 in the previous year).

Comments made by patients included: "Always aware that the best professional care was being provided, it's truly outstanding", "The nurses and doctors at Chase Farm were very supportive and kind", and "All staff were polite, efficient and professional. This applies to Chase Farm and Barnet Hospitals".

Areas for improvement identified in the report included a decrease in the number of patients who felt they were able to get understandable answers to important questions (from 92% to 88%), only 20% of patients being asked about taking part in cancer research although 50% would have liked to, and only 31% of staff asking a patient what name they preferred to be called by.

Introducing a sub-speciality gastrointestinal medical rota

As part of the introduction of our new Medical Model the Trust has now implemented a fully functioning 24/7 Consultant delivered GI Bleed rota. The outcomes from this will become part of our annual audit programme but we believe this is a major step forwards in the management of this critically sick patient cohort.

Audit of our emergency services

The Trust takes very seriously the feedback we received following an external review and audit into our emergency services in 2012. We appreciate that the audit has taken note of the state of transition our emergency services currently find themselves in and the report understands the proposed implementation of the Barnet, Enfield and Haringey Clinical Strategy in late 2013 will enable us to better meet all key national standards.

In the interregnum we have in place robust plans to continue to provide safe and high quality services prior to the implementation of the strategy.

PERFORMANCE DATA

The Trust measures many aspects of its performance and this data is regularly reviewed throughout the organisation. At board level we review a dashboard each month that includes some of our key measurements (metrics) in the areas of patient safety, clinical effectiveness, patient experience and operational performance. This section contains a sample of the key metrics that the trust board currently reviews on a monthly basis

Key Performance Achievement 2012/13

Domain	Healthcare Targets Domains and Indicators	2012/13 Performance	2012/2013 Target
Quality	% Urgent Referrals seen within 14 days**	93.39%	93.00%
	% Urgent Referrals seen within 14 days - Breast Symptomatic**	94.01%	93.00%
	% Cancers treated within 31 days of Decision to treat**	98.41%	96.00%
	% Cancers treated within 62 days of Referral**	87.47%	85.00%
	% Consultant Upgrades treated within 62 days**	98.81%	90.00%
	% Screening Services treated within 62 days**	96.37%	90.00%
	% Subsequent treatments treated within 31 days of DTT - Drugs**	100.00%	98.00%
	% Subsequent treatments treated within 31 days of DTT - Surgery**	97.73%	94.00%
	Total time in A&E - 95% of patients should be seen within 4hrs	94.95%	95%
	Percentage of Patients that have spent at least 90% of their time on the stroke unit	92%	80%
	Percentage of high risk TIA patients who are treated within 24	78%	60%
	% Delayed Discharges	3%	3.50%
Womens Health	% Maternities Breastfeeding	85.72%	78.00%
	% Maternities not Smoking	93.00%	90.00%
Access	% Diag. Tests. Excl Audiol. waiting > 6 weeks**	0.31%	< = 1%
	% Audiology tests waiting > 6 weeks	0%	< = 1%
	RTT Waiting Times 95th Percentile - Incomplete*	24.59	36 Weeks
	RTT Waiting Times 95th Percentile - Admitted*	23.31	27.7 Weeks
	RTT Waiting Times 95th Percentile - Non-Admitted*	15.31	18.3 Weeks
	RTT Waiting Times Median - Incomplete*	5.35	7.2 Weeks
	RTT Waiting Times Median - Admitted*	9.43	11.1 Weeks
	RTT Waiting Times Median - Non-Admitted*	5.26	6.6 Weeks
	18 Weeks - Admitted 90% Target*	90.3%	90%
	18 Weeks - Non-Admitted 95% Target*	98.5%	95%
Patient Experience	% Ops. Canc. at last minute	0.67%	0.80%
	% Canc.Ops not Re-Admitted within 28 days	0.00%	5.00%
	Number of Mixed Sex Breaches	135	0
	Number of Never Events	5	0
Safety	Clostridium Difficile – meeting the Clostridium Difficile objective	19	33
	MRSA – meeting the MRSA objective	7	4

** March 2013 Performance*

*** Feb 2012/13 YTD Performance*

As can be seen from the table (*demonstrated as graphs in updated draft)* above, the Trust has continued to perform well in many key areas including cancer, cancelled operations and Accident and Emergency

Never Events

It is important that any health care organisation recognises and acts appropriately upon its findings. It is of particular concern to the organisation that we had five never events during 2012/13. These included three maternity cases in relation to retained swabs, medication administration errors and incorrect administration of a gas.

However the Trust has already implemented changes with regard to swabs and gas administration and is working on a program in relation to medication errors with recognition of the eventual need for an electronic prescribing

process when our electronic platform programme is appropriately advanced. This is expected to occur within the next eighteen months.

Root cause analysis investigations are currently being undertaken the findings to be presented to the Trust panel and a report will be sent to North Central London Commissioning Support Unit and NHS Trust Develop Authority in due course.

Mixed Sex Breaches

All our mixed sex breaches during 2012/13 were due to step down in the Intensive Care Units and High Dependency Unit. This has led to changes in our pathways arrangements.

MRSA

As mentioned previously we did not achieve our MRSA objective. Our goal was to have no more than four reported cases. We had seven reported cases. A full root cause analysis has been carried out on all cases and we are committed to a zero tolerance process with regard to this area of our work and ongoing staff training and education at all levels.

Trust has better than expected mortality rates

The Trust was pleased to receive a special mention in the Dr Foster Good Hospital Guide. One reason for this is that it has been identified as having better than expected mortality rates in comparison to other health providers. Mortality rates at the Trust have now been successfully kept down for three years in a row. Another reason is that the Trust has shown better than expected outcomes for deaths in low risk groups associated with the Pneumonia severity index.

The Trust's mortality rates were praised again later in 2012/13 by official Government figures released earlier this month have shown Barnet and Chase Farm Hospitals to be amongst 11 trusts with fewer than expected death rates for their local population.

The data was collected over two years, from July 2010 to June 2012, by the Health and Social Care Information Centre. The new summary hospital-level mortality indicator (SHMI) rate has been calculated by comparing the number of patients who die at a trust's hospitals – and for the first time including those who die within 30 days of discharge – with the number who would be expected to die, given the sort of population it serves. Important factors will include whether the population is especially elderly and whether the area is deprived and likely to have more people in poor health.

FRANCIS REPORT

The NHS London Chair has written to all London Trust chairs asking them to summarise the steps their trusts are taking to ensure that staff and patient views are listened to and inform the Trust's views on the quality of its services. The Chair has responded as follows:

Staff Experience

The Trust will build on the programme of 'Big Conversations' with staff by developing a programme of quarterly focused conversations supported by an increased deployment of Executive and Non executive safety walk-rounds on both sites. We will increase the use of the staff tracker system and we have extended this to doctors.

We continue to monitor the annual staff survey results and focus specific work on any areas where concerns have been identified. We will shortly introduce regular 'Schwartz Centre Rounds' to empower staff to share their experiences of delivering and improving patient care in the Trust. We have good evidence that our staff are both free and willing to use our whistle blowing policy and will review the policy in the light of the Francis report to ensure its ongoing fitness for purpose. All these activities will be reported to the Trust Board.

Patient Experience

The Trust will strive to achieve and maintain an increased response rate on outpatient experience trackers, which are deployed throughout both our sites. We will continue to work with our partners and stakeholders to ensure that any concerns that are raised are dealt with promptly and systematically.

We will undertake a comprehensive analysis of complaints at an individual and aggregate level to ensure we are aware of specific issues, 'hotspots' and trends. We will reinstate our 'Meet the Matron' meetings in the community at least quarterly and widely distribute patient and public feedback to the organisation. We have refreshed our Patient Experience Strategy in response to the CNO strategy, Dignity for all, Death by Indifference and we are now undertaking a further review in light of the Francis Inquiry.

We will increase the patient and relative representation on our Patient Experience Group. We will continue to encourage meetings with complainants and continue to give a full audio recording of these meetings to complainants – a successful initiative which has been well received by complainants and which has already resulted in a fall in follow up issues being raised. We will introduce patient stories at our Trust Board meetings.

We will develop, publicise and promote a 'Tell us how you feel' campaign to seek further feedback. All these activities will be reported to the Board.

THE VIEWS OF OUR STAKEHOLDERS

The views of our patients, local community and staff are essential in helping us maintain and develop high quality clinical services. In developing our quality accounts, we undertook a series of engagement exercises to ensure we fully engaged our various stakeholders and partners as much as possible in developing these accounts.

(For expanding on in future drafts)

OUR RESPONSE

(For future drafts)

DIRECTORS' STATEMENT

(Completed once agreed)

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Title:	**Quality Account 2012-13 - DRAFT**
Report to:	Overview and Scrutiny Committees
Date:	May 2013
Security Classification:	
Purpose: To review quality data, consider suggested priorities for 2013-14, and suggest further content prior to publication.	
Sponsor:	Mary Sexton
Author:	Clara Wessinger
Report History	annual
Budgetary, Financial/Resource Implications:	Quality priorities may require resource consideration
Equality & Diversity Implications:	None
Trust Objectives & Risk Implications – link to Board Assurance Framework and/or Corporate Risk Register:	The content of this report will be discussed by stakeholders and provide a public account of the quality of the services provided by the trust.
Action required:	To provide comments and consider priorities for 2013-14

CONTENTS

STATEMENT FROM THE CHIEF EXECUTIVE

Despite the financially challenging year, 2012 - 2013 has been a successful year in several ways for Barnet Enfield and Haringey Mental Health NHS Trust. Enfield Community Services have now been integrated into the Trust allowing the Trust to provide a broader range of integrated services to improve the health and wellbeing of our local population and enabling people to lead as active and fulfilling lives as possible.

The Trust had three strategic objectives for 2012 - 2013 and we have made significant progress towards these. The first is to continue to develop excellent services, staff and facilities to improve patients' experiences and deliver the most clinically and cost-effective services possible. We have made progress towards this objective by expanding our community teams and Recovery Houses are operating effectively in each borough. The Trust has invested in our infrastructure with the installation of new technologies in both our computer and telephony systems. Communication with staff has improved with the introduction of a brief newsletter emailed out each week updating staff on current projects and achievements and encouraging staff participation in many projects. This has contributed to a 61% response rate for staff completing the Staff Survey Questionnaire, which is a huge improvement on last year's figure of 45% and indicates that Trust staff are amongst the most highly motivated and receive more support from their managers than staff in other mental health trusts in England. Our low readmission rates, home treatment team assessments of patients in crisis and follow-up with patients discharged from hospital shows that we are performing better than average to provide our patients with safe care in their home environment.

Our second objective is to provide better integrated and more holistic services through integrating physical and mental health services, working in close partnership with patients, carers and other partner organisations. We have selected three quality priorities for 2012 – 2013 to promote improvements in this area. The Trust acknowledges that this objective has only been partially met. By focusing on patient identified care goals and therapeutic engagement, and through feedback from surveys, we are confident that we are working in closer collaboration with our service users empowering them to make decisions regarding their care. However, we recognise that work is required to strengthen our relationship with carers. This has been an ongoing area of focus for us but, with the cooperation of our partner agencies, we are now in the process of embedding effective systems to involve, help and most importantly support carers in their invaluable role in the recovery of our service users. Our third quality priority focused on communication and collaboration with our GP colleagues. We will continue to focus on making improvements in this area next year.

Finally, our third objective is to develop new opportunities. The Trust has received recognition of the quality of our memory services as services in Enfield and Haringey have successfully been accredited as part of the Memory Services National Accreditation Programme (MSNAP) which is managed by the Royal College of Psychiatrist's Centre for Quality. Building on the staff survey and the Trust's commitment to listening and supporting staff, we have been accepted as one of ten organisations who are taking part in wave three of a national initiative known as Listening into Action (LiA). This programme marks a fundamental shift in the way we lead and work, putting staff – the people who know the most – at the centre of change. More importantly, it empowers individuals and teams to get on and make change happen, giving "permission" to take action with the full support of the Trust.

The Trust are reflecting carefully on the findings of the Francis report into Mid -Staffordshire Hospital and the appalling standards of care for patients there and must ensure how, in an increasingly busy NHS, we continue to provide a consistent, caring and compassionate service within the resources available to us. Our commissioners and stakeholders will continue to expect improvements in the clinical and cost -effectiveness of our service. I am confident that Barnet, Enfield & Haringey Mental Health Services will achieve these targets without compromising on quality of care. I am proud to be able to say that I work with a staff group that always puts patients at the centre of everything we do and is motivated, committed and innovative.

Maria Kane
Chief Executive

SUMMARY OF PRIORITES

Follow-up on our 2012-2013 priorities

The Trust, following a stakeholder meeting in May 2012 agreed the following three priorities to improve the quality of care across our Trust.

Priorities for 2012 – 2013	
Safety - Improve communication with GPs *(pg 11)*	Partially Met
Experience - Improve and monitor therapeutic engagement *(pg 15)*	Met
Effectiveness - Improve focus on patient identified care goals *(pg 19)*	Met

Priorities for 2012-13 were developed with input from staff, service users, carers, partnership organisations and members of the public in our Stakeholders Workshop in 2012.

At this workshop it was agreed that the Trust should continue to focus on further developing the previous year's priorities: improving therapeutic engagement between staff and service users and their carers; improve our partnerships with primary care; ensuring all service users have an identified care goal.

- **Safety**
  To improve communication with GPs we aimed to provide information regarding discharge and care plan reviews, update GPs on service users with serious mental illness, and work with patients and GPs to improve the physical health of our service users. Whilst we have met some of these targets, there is more work to be done to further develop and effective process of shared care. A substantial amount of ground work has been undertaken throughout the year with the cooperation of and in collaboration with our partner GPs to implement new schemes to be able to deliver quality and safe care to our patients. These schemes are now being imbedded and we are expecting to be able to report further improvements in the coming year.

- **Experience**
  We are happy to report that we have been able to improve our therapeutic engagement with service users and help service users to formulate patient identifiable goals over all of our services.

- **Effectiveness**
  To help further measure service user's recovery, all service users are encouraged to identify individual recovery goals and that these are recorded and reviewed regularly.

Where are we going?
Our priorities for 2013-2014

Priorities for 2013 – 2014
Safety Improve communication with GPs
Experience Carers Strategy / Triangle of care
Effectiveness PROMS

- ***Safety***
  We will continue to monitor our communication with our GP colleagues to ascertain if the new schemes which are now being implemented and imbedded improve the care delivered to our patients from both the Trust's perspective and those of our GPs. Communication protocols, new discharge and referral templates are being introduced; a new telephony system is now in place in the Trust which will enable provision of a tailored access point enabling GPs to receive accurate direction to services.

- ***Experience***
  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***
  The Trust has met its own target in Patient Identified Care Goals for the past two years and therefore has elected to prioritise development of its Patient Reported Outcomes Measures. Patients will be given the opportunity to rate their own perception of their level of wellbeing and recovery, providing clinicians with feedback to ascertain the effectiveness of clinical treatment.

Where are we now?
Summary of 2012 - 2013 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 national benchmarks.

Safety		2010 - 2011	2011 - 2012	2012 - 2013	National
GP Communications *(pg 11)*	Discharge letters within 1 week of discharge from inpatient services – based on audit sample of **484**	55%	75%	79%	n/a
	Discharge letters within 2 weeks of discharge from community services – based on audit sample of **369**			96%	
	Dementia medication reviews– based on audit sample of **109**			97%	
	Care Plan review update sent to GP – based on audit sample of **491**			54%	
	Confirmation to GP of community services assessment – based on audit sample of **640**			90%	
	Long term conditions physical health checks followed up in collaboration with GP– based on audit sample of **329**			91%	
Patient Safety Incidents - *(pg 13)*	Number of incidents reported monthly - based on a total of **5665**	369 pcm	408 pcm	472 pcm	
	Percentage patient safety incidents of which were severe or death - based on a total of **2288** incidents in 2012-13.			0.2% Severe or Death	0.8% Severe or Death
7-day follow up after discharge from inpatient care - based on **1500** service users discharged from inpatient services in 2012-13. *(pg 13)*		99.98%	99.81%	99.40%	97.44%
Experience		**2010 - 2011**	**2011 - 2012**	**2012 - 2013**	**National**
Therapeutic engagement - based on service peer reviews which include assessment of service environment, patient records, and staff and patient interviews. *(pg 15)*		59%	72%	96%	n/a
Patient and Carer Experience - *(pg 15)*	Based on **287** responses to national mental health survey		66%	67%	64%
	Based on **12,021** responses to internal patient and carer survey in 2012-13.	MH: 81% ECS: 90.5%	MH: 77% ECS: 90.5%	All Services 87%	n/a
Staff Survey - Staff would recommend this Trust - Based on **774** responses to national staff survey in 2012-13. *(pg 17)*		66%	65%	70%	71%
Home Treatment Team Assessment – the percentage of admissions to acute wards for which home treatment teams provided initial assessment in 2012-13 out of 1404 inpatient admissions. *(pg 18)*		n/a	n/a	92.72%	98%

Effectiveness		2010 - 2011	2011 - 2012	2012 - 2013	National
Patient identified care goals – based on an audit of 5837 patient records indicating development of patient identified goals and involvement in care planning. *(pg 19)*		n/a	93%	94%	n/a
Patient Reported Outcomes *(pg 19)*	Psychological Therapies services patient reported outcomes	62%	55%	65%	52%
	Enfield community services patient reported outcomes			72%	N/A
Emergency Readmissions– Based on **25** emergency readmissions out of **1499** admissions in 2012-13. *(pg 21)*		n/a	4%	1.7%	10%

You Said, We Did…

Tom's Club

The care of dementia patients has always been a top priority for the Trust so we established a support group for people with dementia and their carer called 'Tom's Club, an information and therapeutic support group for carers and people with dementia. The club provides an invaluable service for carers as they focus on providing information and support about local services and cognitive stimulation based activities for the people with dementia. There are also healthcare professionals on hand to offer advice and support to those who need it.

The club was set up by the Admiral Nurse Service (specialist dementia nurses) with the support of Mrs Jean Harmer, the widow of ex Tottenham footballer, Tom Harmer after whom the club is named.

Kayleigh Orr, Project Worker for Tom's club, said: "We are delighted that the original Tom's club has proved such a success and that we have been able to expand the clubs across the Borough of Haringey. The original Tom's Club in Tottenham runs in collaboration with Age UK Haringey who work alongside us to provide volunteer support. This Tom's Club has been expanding on a monthly basis and we now have 30 members who attend on a regular basis. Our second Club, which runs in Crouch End, is more focused on carers who have yet to access many of the service in the Borough. This Club has developed in partnership with the local authority and 16 members who currently attend. Our members tell us that the clubs give them the opportunity to meet people in a similar situation, share concerns with others, find health and support from health professionals. We can also give them information about new services, activities and research programmes that they can become involved with. In fact, our member's responses have been so positive that they are asking for Tom's Club to run more regularly!"

Not only has Tom's Club been recognised as a valuable service by carers but has also been cited as a good practice case study by the NHS Institute of Innovation and Improvement. Also, Tom's Club was recently invited to showcase its' work at the 7th UK Dementia Congress in Brighton on the theme of 'Celebrating Good Practice in Changing Times.'

Forensic Employment and Education Service

Forensic patients in the community are getting invaluable support to get back into everyday life through education, training and employment. The Trust has employed Teresa Clark, a full time Employment, Training and Education Advisor (ETEA) through Certitude, an organisation that specialises in providing personal support and social care to people with mental health needs and learning disabilities. The service has been commissioned for one year, with the aim of getting at least 20 service users into voluntary placements and 8 into paid employment.

Every service user referred to the service is met with to ascertain their interests and objectives, therefore any opportunities offered to them are personally tailored. Some service users have already been placed in volunteer roles and training. Delroy currently works at the Science Museum once a week as a volunteer ambassador. On his first morning starting his role Delroy said: "I'm a bit nervous, but very pleased I'm getting the opportunity to work somewhere like the Science Museum."

As well as helping service users into voluntary placements, Teresa also helps people with other interests. One clients expressed an interest in fishing so he now attends a fishing club where he can socialise and meet new people, a very important part of recovery. In addition to the placements, Certitude will also be taking on two service users from those they've worked with and train them to become Education, Training and Employments Advisors, as well as providing an NVQ level 3 in advice and guidance.

Getting Forensic patients, who have both criminal records and a mental illness into placements and employment can be challenging. Organisations are encouraged to give people a chance and we support both the organisation and the client by working closely with them providing on-going support whilst the service user is on placement to make the most of the opportunity for both.

When service users are ready to look for paid employment, they will get help with CV writing, interview skills and interview clothing. In essence, the aim of the service is to build confidence, professional skills and social skills, helping Forensic patients make a successful transition into life within the community.

Young Parent's Project 10th Year Anniversary

The Mayor of Enfield, Kate Anolue and MP David Burrowes joined young parents, staff and supporters to celebrate the achievements of the Young Parent's Project on their 10th Anniversary. The project, part of Barnet Enfield and Haringey Mental Health NHS Trust, enables young parents aged 12-18 to prepare for parenthood through practical and emotional support so they have the knowledge and skills to care for their new infant.

The project offers outreach and group support. Young parents can access emotional and practical support on a range of subjects including ante natal care, breast feeding, nutrition, child development and sexual health. One of the most valued services is the Wednesday lunch club, a 'one stop' shop for help and advice. Young parents attending the lunch club meet other young parents and get help on a range of issues, including advice on education, finances and housing, without the stigma sometimes experienced in other settings.

The Mayor of Enfield, Kate Anolue, who was presented with a bouquet of flowers by the daughter of one of the young parents, said: "My background is in midwifery, so this wonderful project is very close to my heart. Being a young parent is not easy, so the support the project provides is so important. They are helping ensure young parents can move forward with their lives and reach their full potential."

David Burrowes MP, spoke to some of the young parents and staff at the event. He said: "I'm really pleased to be able to hear first-hand what this project means to young parents in Enfield. The work it continues to do in getting young parents back into education and reduce teenage pregnancies is vital. I'd like to congratulate the service on their achievements over the last 10 years, and support them in continuing their good work."

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.

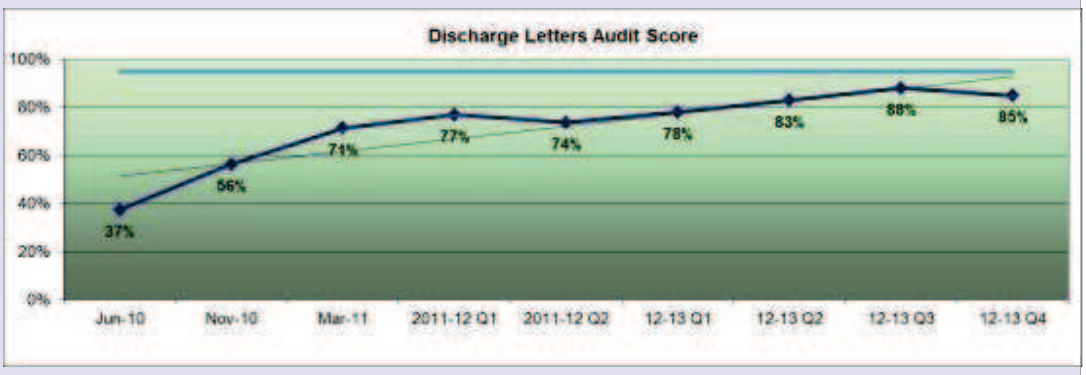
PATIENT SAFETY

GP Communication

Why did we choose to focus on this?	At our Stakeholders meeting on 8th May 2012 it was agreed that the Trust's 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 (targets for each standard are listed below), 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?	We have agreed with our commissioners that the following points in patients care require specific standards of communication/follow-up with our GP colleagues.

Standard	Target	Compliance	Audit sample
Community dementia discharge letter	90%	96%	369
Dementia medication reviews	90%	97%	109
Inpatient discharge letter	95%	79%	484
Care Plan review update	95%	54%	491
Confirmation of community services assessment	90%	90%	640
Long term conditions physical health checks	75%	91%	329

We are able to demonstrate that we are meeting targets with some aspects of communication with GPs, particularly in Dementia care and monitoring of physical health conditions. We acknowledge that we are not yet meeting our targets with regards to inpatient discharge and CPA review letters. We have audited discharge letters to GPs over the last three years and have seen a trend toward improvement. The chart below tracks the timeliness and compliance with agreed content of discharge letters from 2010 to date.



Funding for Primary Care Academies has been agreed with our Commissioners and one workshop in each Borough was conducted in March 2013. An annual programme has been prepared, with monthly sessions to be held in each borough throughout the year. Each session will cover a mental health topic chosen based on feedback from our GPs.

A link worker pilot has been initiated in each borough. This scheme appoints a mental health clinician to provide sessions within the GP practice and advice and expertise to GP colleagues. Initial evaluation of the Link Worker scheme as submitted by GPs indicates both green shoots of growth evidencing increasing levels of satisfaction but that also further work is required. Based on the feedback received, recommendations and actions plans are being generated to continue the Trust's on-going efforts to improve satisfaction with, and experience of its services by Primary Care and Service Users.

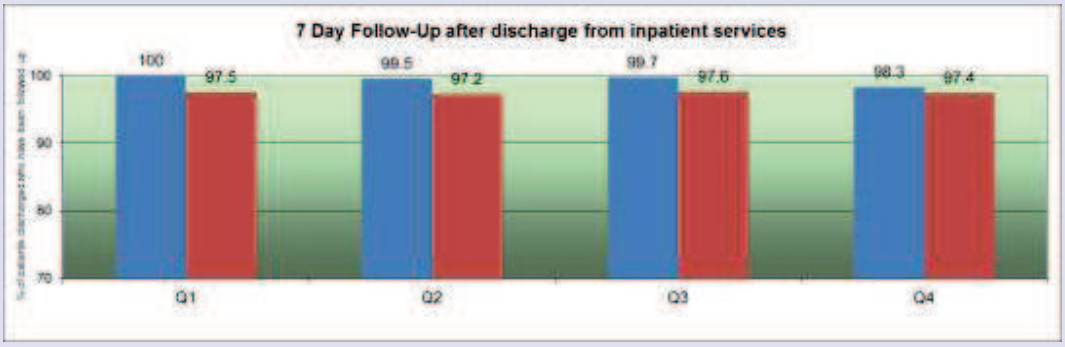
What needs to improve?	1. Primary Care Satisfaction will be added as a standing agenda item on the Operational Management Group, Senior Management Group (SMG) and Trust Board Part 2. 2. Defined quality objectives regarding length of time from referral to assessment to be set, implemented and monitored. 3. Standardised inpatient Discharge letters, assessment and care review letters to be implemented (with effective monitoring arrangements). 4. Every staff member to have their contact details, including mobile telephone number, printed at the end of all email correspondence. – Regular audit to be undertaken and reported at SMG. 5. Service Manager contact details to be included at the foot of teams members email correspondence, allowing GP's to escalate an issue immediately so enabling swift resolution. 6. Internal audit of team's responsiveness to telephone communication, answering, helpfulness, professionalism and follow up. 7. Provision of a 9am to 9pm telephone 'Hot line', enabling GP's to receive accurate direction to services out of hours. Access phone numbers and consultant advice line to be checked by Executive team, and communicated to Clinical Commissioning Groups (CCGs). 8. All GP's to be issued with the Medical Directors PA contact details. 9. 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. 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 an improvement on 2011-12 rates of incident reporting. To participate and analyse data collected from the patient Safety Thermometer to help drive improvements in patient safety across the Trust.
What did we achieve?	We have reported a total of 5665 incidents in 2012-2013 against 4902 incidents in 2011-12. This shows an improvement on last year's total of 4902 incidents reported. The percentage of patient safety incidents resulting in severe harm or death for the Trust is 0.2% for 2012-13 which is below the national average of 0.8%. NHS Safety Thermometer has been submitted monthly since July 2012 by community and dementia services. Barnet Enfield and Haringey have reported 91% harm free, which is in keeping with the national average of 91% harm free.
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. Action plans are requested where preventative actions to avoid repetition are identified. 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?	Both internal auditing and national reporting indicate that the Trust is achieving 99.4% against a national compliance rate of 97.44%. National target for this indicator is set at 95% compliance. This figure is based on performance data of 1500 service users discharged from inpatient services in 2012-13. 
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 through means of telephone or through carer 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

Therapeutic Engagement

Why did we choose to focus on this?	At our Quality Account stakeholders workshop in May 2012 it was agreed that the Trust's should continue to focus on improving our therapeutic engagement with service users. The therapeutic relationship reflects the core values of the trust being kindness, compassion, honesty integrity, openness and creating a safe friendly environment.
What was our target?	To help our staff develop skills in supervision to reflect on their practice and extend training in Talkwell, a tool to help staff build better relationships with service users. To use quality initiatives such as productive community to prepare staff to have better conversations with service users who are prescribed medicines.
What did we achieve?	Therapeutic engagement has been monitored through the use of internal inspections based on the Care Quality Commissions outcome four schedule which assesses the quality of interaction between nurses and patients. These inspections include interviews with staff, service users, and review of records and environment of the ward or clinical area. Every team in the trust is inspected on a rolling basis throughout the year. Average compliance with this standard is 96% in 2012-13 based on a total of 278 inspections. Many initiatives were implemented throughout the year and in particular staff development and training programmes to strengthen staff understanding of meaningful engagement with service users. The Productive Community project was rolled out to Psychosis service line teams. Dementia care mapping was implemented as was a new programme of therapeutic activities tailored to meet the differing needs of our service users.
What needs to improve?	We will maintain high quality of engagement through continued monitoring and continuing to support staff in development of skills and awareness.
How we will continue to monitor and report?	We will continue to monitor through practice standard lead inspections undertaken with input from peer colleagues. We will continue to monitor the quality of the therapeutic relationships, and we will continue to use quality initiatives to drive this forward.

Patient and Carer Experience

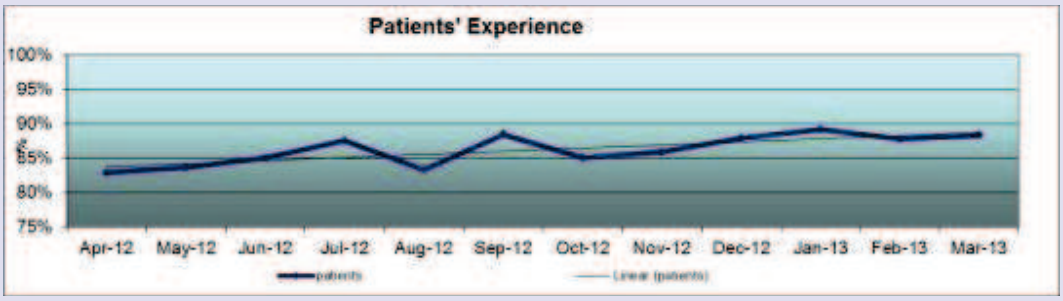
Why did we choose to focus on this?	To improve the quality of services that the Trust delivers, it is important to understand what service users think about their care and treatment. One way of doing this is by asking people who have recently used their local health services to tell us about their experiences. BEH participates in the annual postal National Community Mental Health Service User Survey, as well as conduction our own real-time internal surveys.
What was our target?	To maintain scores at the average national for mental health services in London. Internal survey target has been set to 80% satisfaction.

What did we achieve?

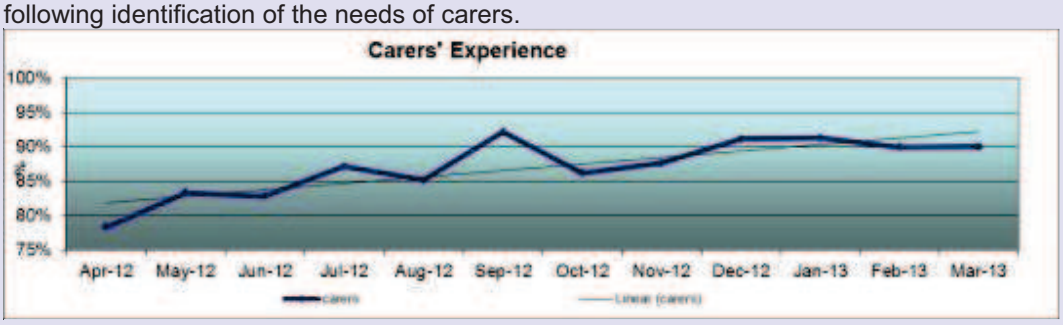
287 patients in the Trust completed the National Community Mental Health Service User survey in 2012, equating to a 34% response rate compared to a National rate of 32%. The overall Trust score is in line with the national and London-wide average scores.

2012 Mental Health Survey Results London and Urban MH trusts	BEH	CANDI	CNWL	East London	NELFT	Oxleas	SLAM	SWLSG	West London	Average
Overall	6.7	6.6	6.3	6.5	6.3	6.6	6.1	6.5	6.2	6.4
How would you rate the care you have received from NHS Mental Health Services in the last 12 months?	6.8	6.9	7.2	7	6.6	7.1	6.9	6.7	6.8	6.9
Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?	6.5	6.3	5.5	6.1	5.9	6.1	5.3	6.3	5.5	5.9
Patient's experience of contact with a health or social care worker during the reporting period.	8.3	8.3	8.8	8.4	8.4	8.4	8.5	8.3	8.5	8.3

Internal survey of 10,801 patients across all service lines indicates a rise in patient satisfaction within our services.



1,220 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. Much work has been accomplished throughout the year in surveying the needs of carers and a new strategy is being evolved following identification of the needs of carers.

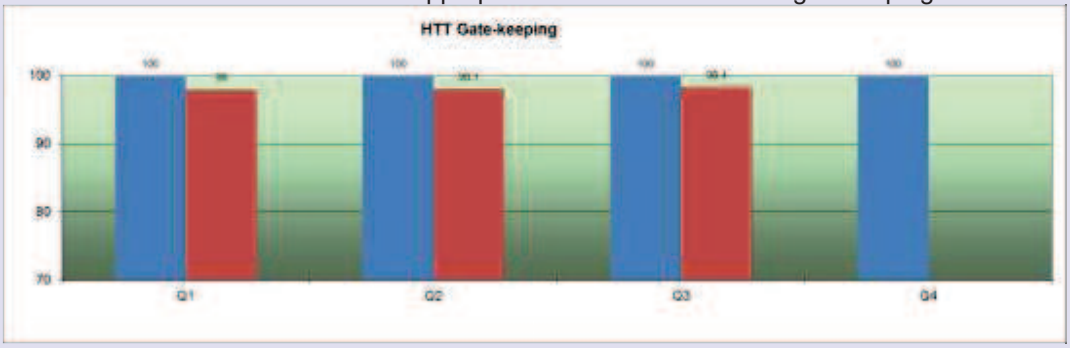


What needs to improve?	Teams in Dementia wards have begun to post “you said – we did” boards to inform patients and carers of the initiatives which have been developed based on feedback from surveys. This initiative has been shared with all services and will be supported and monitored in future service peer reviews.
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 fed to clinical governance groups.

Staff Survey: Would staff recommend this trust?

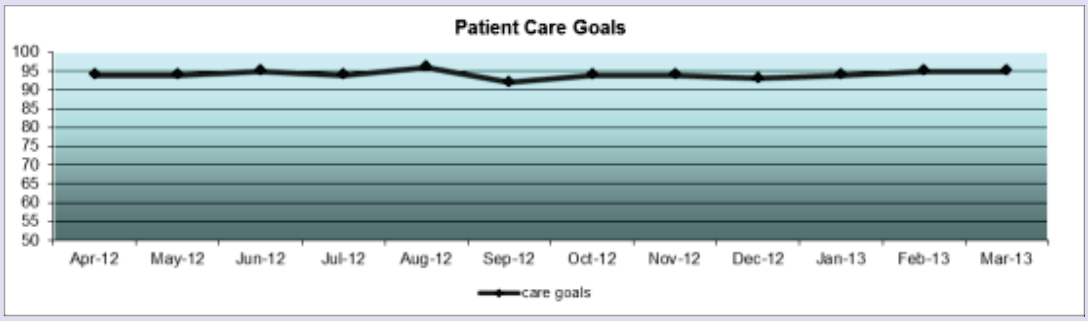
Why did we choose to focus on this?	Barnet Enfield and Haringey Mental Health NHS Trust employs 2500 WTE staff (just over 2,800 individuals) and one of its values is to support its staff to be the best they can be. Training and continual support by appraisals and supervision allow staff to feel heard and valued in their workplace. 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. To achieve scores within the nation average.
What did we achieve?	774 members of staff completed the 2012 National NHS Staff Survey and 70% reported that they would recommend the Trust as a provider of care to their family or friends. This compares to a national average of 71%. There were five major areas where staff experience has improved and these were in the areas of percentage of staff appraisals, support from immediate managers, effective team working, and well-structured appraisals in the last 12 months and also the percentage of staff able to contribute towards improvements at work. Staff experience deteriorated in two areas: percentage of staff reporting errors, near misses or incidents witnessed in the last month and staff receiving health and safety training. The circulation of “Take 2” a two minute update delivered by email to each member of staff every week helps to keep staff up to date with Trust news and events has been hugely successful and has led to an increased readership of Trust Matters which gives more details on issues highlighted in Take 2.
What needs to improve?	Building on the staff survey and the Trust’s commitment to listening and supporting staff it has now joined up to a yearlong initiative ‘Listening into Action’. This 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.
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.

Home Treatment Team Assessment

Why did we choose to focus on this?	The function of the Home Treatment Team (HTT) 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?	100% of inpatient admissions to be reviewed by the HTT.
What did we achieve?	The following data is extracted from the patient record system and cross checked with team managers to ensure all cases have been reviewed by the home treatment team prior to admission. This data shows that all appropriate cases have received gatekeeping. 
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

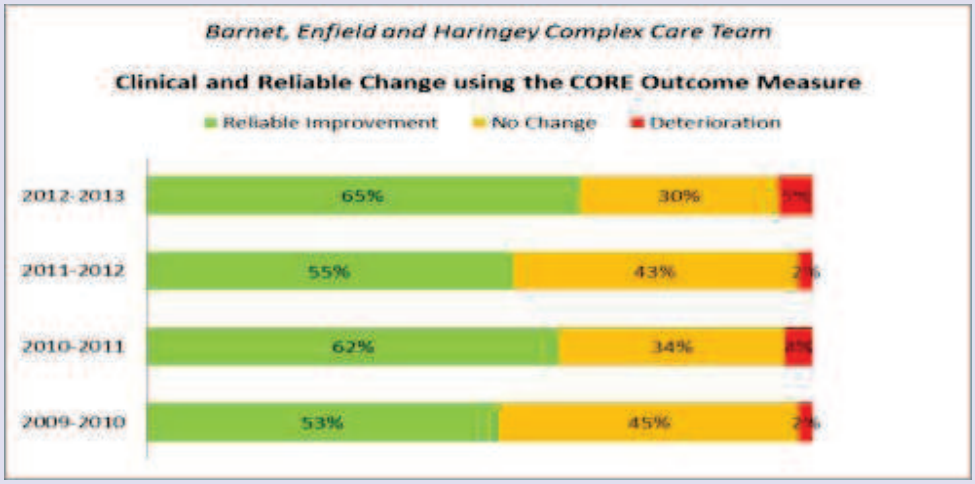
Patient Identified Care Goals

Why did we choose to focus on this?	At our Quality Account Stakeholder workshop in May 2012 we were asked to further assess if service users are meeting their goals and aspirations. It was agreed that service users would be supported to develop individual recovery goals, and they would be supported to achieve these.
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 5837 patient records over the financial year indicated that 94% of patients had patient identified goals together with personal involvement in care planning. 
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?	Although the Trust is not continuing to have this area as a priority for the coming year, as we have met out targets, monitoring will be maintained through the ward and community quality assurance process to ensure that this remains an important issue and scores remain high.

Patient Reported Outcomes

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. We are currently using CORE which is considered to be the best measure in understanding local services and one where the Trust can benchmark our services against other Trusts. We have also developed our Meridian system and provided access to many other services within our organisation allowing staff and team's real time information to measure their effectiveness.
What was our target?	The Trust's objectives were to develop more tools and make these available to more services.
What did we achieve?	The following graph shows the percentage of clients who made clinical and reliable change during treatment within the Barnet, Enfield and Haringey Complex Care Teams, which is a service operating within the Severe and Complex Non-Psychotic Service Line of Barnet, Enfield and Haringey Mental Health Trust. Outcome data is routinely collected at the start and end of treatment for all patients treated in

this service who are on a Single Intervention Treatment or receiving phased treatment as part of the Complex PTSD Service or OCD Treatment Track. Data is not currently collected for those patients on CPA.
The data below is representative of those patients who have completed therapy between April 2012 and April 2013 and this data is benchmarked against data collected by the service in the previous three years.
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.
'Reliable improvement' refers to those clients who have made a reliable change in their pre and post scores. 'No change' refers to those clients who have not made any measured change in therapy but also includes those clients who may have made small changes which is not sensitive enough to be deemed statistically reliable (i.e. the result could have happened by chance).

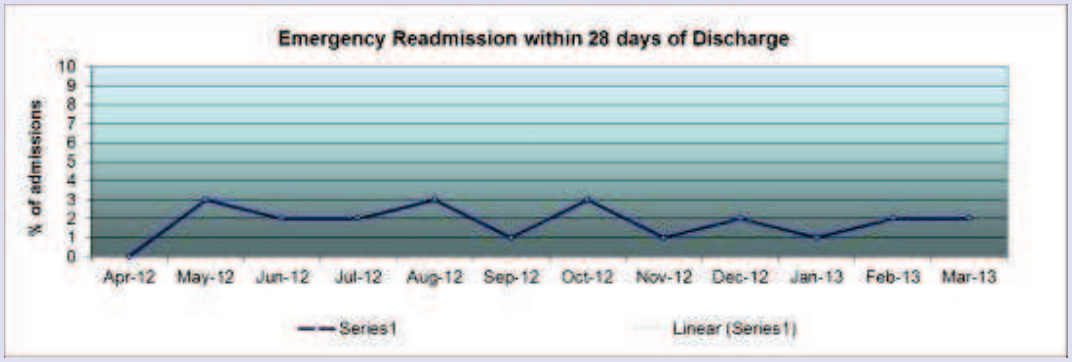


Enfield Community Services Patient Reported outcome measures were monitored using an outcome survey at end of treatment in the following services: Lymphoedema, Nutrition and Dietetics, Stroke Rehabilitation Service, Community Physio, and Adult Therapies (SALT). 517 surveys were conducted. As this outcome measure is designed for the services specifically, it is not possible to benchmark. These figures will provide the service with internal benchmarking upon which to measure improvement in following years.

Question	% of patients who reported positive outcomes
Do you feel that some/all of your symptoms have improved since we saw you?	66.51
Have you experienced an increased range of movement since we first saw you?	63.19
To what extent have you been able to resume your normal daily activities?	65.24
Do you feel more independent with footwear and clothing since we first saw you?	89.1
Do you feel your confidence in your ability to manage/cope with your condition/symptoms has increased since we first saw you?	69.52
Do you feel you have a greater understanding of your condition/symptoms than you did when we first saw you?	77.17
Do you feel less anxious about your condition than you did when we first saw you?	90

What needs to improve?	The Trust is in the process of implementing the use of standardised patient reported outcome measure tools as required in preparation for payment by results. The PROM tools selected for use in BEH are The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) for mental health and EQ-5D for community services. EQ-5D is a standardised measure of health status developed by the EuroQol Group to provide a simple, generic measure of health.
How will we continue to monitor and report?	Tue trust will develop systems to input and analyse data to provide clinicians with data relating to change in patient self-reported status using the agreed tools.

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?	Based on figures for quarter 2 2011-12 provided by the Audit Commission, the national average for readmission rates is 10%. Our aim was to reduce the rate of emergency readmissions to inpatient services and to maintain rates at or below the national average.
What did we achieve?	The figure below illustrates the rate of emergency readmissions within 28 days of discharge. During 2012-2013 there were 25 emergency readmissions out of 1499 planned admissions and whilst the figures vary, the rates remain under the national average of 10%. 
What needs to improve?	The psychosis and crisis and emergency service lines have commissioned an in-depth analysis into the reasons for emergency readmission and this will be discussed across service lines.
How will we monitor and report?	Performance is monitored through monthly service line performance meetings and at Board Committee level.

QUALITY STATEMENTS

During 2012 - 2013 Barnet Enfield and Haringey Mental Health NHS Trust provided eight NHS services in seven 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 2012- 2013 represents 100% of the total income generated from the provision of NHS services by BEH for 2012-13.

National Audits

During 2012 - 2013 Barnet Enfield and Haringey Mental Health NHS Trust participated in 5 of 6 national clinical audits applicable to the services provided by the Trust.

TOPIC	Participation by BEH		National participation	
	# of patients	# of teams	# of patients	# of teams
Prescribing high-dose and combination antipsychotics: acute/PICU, rehabilitation/complex needs, and forensic psychiatric services	21	316	722	9537
Prescribing for people with a personality disorder	2	31	437	2600
Screening for metabolic side effects of antipsychotic drugs	18	240	372	6078
Prescribing antipsychotic medication for people with dementia	10	160	482	12790
Prescribing for ADHD in children, adolescents and adults	0	0		
National Audit of Psychological Therapies	Data not yet available from Royal College of Psychiatrists			

Local Audits

The reports of 38 local clinical audits were reviewed by BEH in 2012– 2013. For full reports of local audits visit our trust website.

Barnet Enfield and Haringey Mental Health NHS Trust intends to take the following actions to improve the quality of healthcare provided (examples):

- Clinical staff to receive level one smoking cessation training to promote physical health in mental health patients – completed December 2012
- Discharge checklist to be updated to include sending and uploading of discharge letter onto patient record – completed January 2013
- All teams to agree return targets for monthly audits and patient surveys and monitor against these targets in service line meetings – completed March 2013
- Carers Strategy to be reviewed in collaboration with partner agencies and service line leads implemented across the trust – on-going – due for completion in May 2013
- You Said We Did posters to be presented in clinical areas with feedback from patient surveys – completed in DCI wards – to be monitored in 2013

- PTMVA monitoring form to be added to incident reporting system to ensure adequate information regarding restraints is recorded following incidents of violence – to be completed in 2013
- Memo regarding capacity assessments to be circulated to staff and records updated to reflect guidance – completed December 2012
- All teams to use care review checklist to ensure care plans reflect standards – completed and monitored 2012
- Psychosis teams to write to GPs for updates on physical health checks and update patient record accordingly – completed December 2012
- Side effects monitoring tool to be completed and uploaded onto RIO – completed and monitored 2012

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.

The Care Quality Commission has not taken enforcement action against BEH during 2012-13.

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.

Research

Participation in clinical research demonstrates BEH-MHT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

BEH-MHT was involved in conducting 40 research studies in the last financial year, out of 40 studies 24 studies were funded and 16 were unfunded, which is a 22.5% increase compared to the previous financial year, when the Trust ran 31 research studies (20 unfunded and 11 funded). It is also important to note that the number of funded studies has doubled in the last financial year (increase from 11 funded studies to 24), generating more income to the Trust and providing more opportunities for patients to access novel treatments and high quality research.

The number of patients receiving NHS services provided by BEH-MHT in 2012/2013 financial year that were recruited during that period to participate in research approved by a research ethics committee was 231.

The Trust is a research site for qualitative, case-control and cohort studies and randomised control trials. We currently host DeNDRoN and the MHRN North London Hub adopted projects and have established connections with pharmaceutical companies via both research networks and directly through the Trust's research staff.

Our research activities are facilitated through most of our services, covering almost all service

lines with the Trust participating in a range of studies using different methodologies including, large-scale evaluative clinical trials to determine the effectiveness of new treatments whether developed within or outside of the Trust.

The Trust actively participates and supports research generated by its own clinicians as well as researchers from outside the organisation. Most qualitative studies are carried out by Trust staff who canvass service users', carers' and other NHS professionals' perception of service provision with the aim of improving services. Clinicians employed by the Trust have published 11 publications in peer reviewed journals over the past year, please see attached document with the publication list.

Below is a list of research projects the trust is currently involved in, with website links for further details:
IMPACT: www.impacttrial.org.uk
SHIFT: http://ctru.leeds.ac.uk/shift
OASIS: www.dsru.org/oasis<http://www.dsru.org/oasis
MOSAIC: http://www.iop.kcl.ac.uk/sites/neuroscience/?id=254
PARADES: www.nottingham.ac.uk/chs/research/projects/parades/index.aspx
STEPS-B: http://www.ucl.ac.uk/steps-b/
SAFEWARDS study: http://public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=11269

CQUIN

A proportion of Barnet Enfield and Haringey Mental Health NHS Trust income in 2012 - 2013 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 2012- 2013 and for the following 12 month period are available in the following document on our website: link to added when available

Hospital Episode Statistics

Barnet Enfield and Haringey Mental Health NHS Trust submitted records during 2012 - 2013 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: 99% for admitted patient care; and 99.7% for outpatient care. The percentage of records in the published data which included the patient's valid General Medical Practice Code was 100% for admitted patient care; and 100% for outpatient care.

Information Toolkit

Barnet Enfield and Haringey Mental Health NHS Trust score for 2012 - 2013 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 6.38%.

AGENDA ITEM 12

Meeting	Health Overview and Scrutiny Committee
Date	9 May 2013
Subject	**Member's Item**
Report of	Scrutiny Office
Summary	This report informs the Committee of a Member's Item and requests instructions from the Committee.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Status (public or exempt)	Public
Wards Affected	All
Key Decision	N/A
Reason for urgency / exemption from call-in	N/A
Function of	Health Overview and Scrutiny Committee
Enclosures	Appendix A – Health Overview and Scrutiny Framework Effective Scrutiny for Better Outcomes
Contact for Further Information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATIONS

1.1 The Committee's instructions on the Members' Item are requested.

2. RELEVANT PREVIOUS DECISIONS

2.1 None.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The Overview and Scrutiny Committees/Sub-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 2012/13 Corporate Plan are: –

- Better services with less money
- Sharing opportunities, sharing responsibilities
- A successful London suburb

3.3 The work of the Health Overview and Scrutiny Committee supports the Corporate Plan 2012/13 objective of supporting residents to live healthy and independent lives through it's role as a "critical Friend" reviewing the provision of health and social care services by the council and health partners as they seek to deliver the Health and Well-being Strategy, promoting prevention and the integrated commissioning of services.

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

5.1 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.

5.2 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.

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.

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

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.

8.2 Council Constitution, Overview and Scrutiny Procedure Rules, Paragraph 8.1 states that "Any member of an Overview and Scrutiny Committee shall be entitled to give notice to the Head of Governance that he/she wishes an item relevant to the functions of the Committee to be included on the agenda for the next available meeting of the Committee. On receipt of such a request, the Head of Governance will ensure that the item is included on the next available agenda".

9. BACKGROUND INFORMATION

9.1 Councillor Geof Cooke has requested that a Member's Item be brought to the committee in relation to bus services at Finchley Memorial Hospital. Councillor Cooke has requested an update on discussions between the

relevant NHS body and Transport for London (TfL) regarding the need for a bus service calling at Finchley Memorial Hospital in view of the distance from existing stops including the distance from the entrance in Granville Road to the hospital building. In particular, he has requested that consideration be given to providing a service by a small hopper type bus similar to that operating elsewhere in the borough.

9.2 Councillor Cooke has also requested an update any previous consideration by the Health Overview and Scrutiny Committee on bus services in the context of reorganisation of health services between Barnet Hospital and Chase Farm Hospital, in particular the complete lack of any direct TfL service from any part of Barnet to Chase Farm.

9.3 The Committees instructions are requested in relation to the requests outlined at 9.1 and 9.2 above. Members are requested to take into account the Health Overview and Scrutiny Framework Effective Scrutiny for Better Outcomes attached at Appendix A when determining the most appropriate route for this request.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Health Overview and Scrutiny Framework
Effective Scrutiny for Better Outcomes

This framework was originally presented to and discussed by members at the Aging Well Scrutiny Framework workshop on 30 January 2012 and is designed to aid Scrutiny members in deciding and scoping their future work programme. It is based on four principles:

- Issues chosen for Scrutiny should be recognised as being of sufficient importance to the community to warrant expending scarce resources in investigating it.
- There should be a clear understanding by everyone concerned of what is being investigated.
- The investigation should be asking questions that have not been asked before. That is to say the issue has not been replicated elsewhere (even if in a slightly different form). This includes other Overview and Scrutiny committees.
- The outcomes from this investigation will make a real difference to the community.

The framework takes into account Barnet's Ageing Well Strategy, the Centre for Public Scrutiny's work on health and health scrutiny and good practice guidelines for Overview and Scrutiny.

Stage 1: Scoping Your Review

The first point of consideration for considering an item for scrutiny should be whether or not something has already been identified as an issue. Ideally an issue should not be considered unless it is "exceptional".

What constitutes "exceptional"- why are we embarking on this review?

When considering if something is exceptional we should consider the following points:

- Is the issue relevant or important?

- Is it supported by robust evidence and judged against strict principles?

- Exceptionality could be judged on the basis of whether the issue is referenced in past and current strategies, for example, the Joint Strategic Needs Assessment (JSNA) or Health and Well-being Strategy, national and local research and policy data.

- Exceptionality identifies either fault lines in the construction of these strategies and documents which have led to "gaps" in identifying need and risk, or highlights a new issue that has subsequently arisen.

- As members use the Cabinet Forward Plan, the Corporate Plan and the strategies of local health partners' and other sources such as petitions, and Council motions to construct long and short-list for work programmes, the majority of these would not be considered exceptional.

Therefore in identifying exceptionality members should consider:

- Issues that have a high public interest or where there is severe press/public pressure to investigate an issue not identified within the Corporate Strategies and documents (whether this be as a result of an individual's experience or the failure of a whole service). However, the argument for exceptionality still has to be made.

- Is the level of need/risk exceptional compared to datasets elsewhere?

- Are the conditions within the community exceptional compared to a similar community elsewhere?

- When considering a new or existing service would it/does it differ significantly from a comparable service (either within the Council or elsewhere) in terms of outcomes or benefits to the community?

If these questions can be answered positively then you have a case for exceptionality.

Note: Whenever an issue is put forward for consideration, it is expected that members are already aware of the existing evidence which supported the original identification of the issue (for example, ward deprivation indices, morbidity statistics, level of complaints).

Stage 2: Defining your Question

Once the issue has been identified then *the question* needs to be defined. A common failing of previous scrutiny reviews is that the terms of reference are too broad or that the investigation is complex, lengthy and poorly focused. The resulting recommendations frequently lack robustness, are easily misinterpreted and equally easily rejected.

Your proposed question should clearly identify specific *key lines of enquiry* (KLoE).

Example: Complaints about the provision of dementia nursing care at home, in care and in hospital are rising significantly.

Sample question:

How could the patient journey for dementia sufferers be improved?

Are there specific steps that the Council and its health partners need to make to ensure that early stage dementia sufferers and their carers are adequately supported in the borough?

Sample KLoEs

- What support do sufferers and their carers really want?
- Have organisations, agencies, community, voluntary sector considered provision of this in their operations strategy?
- How could the quality of life be improved and what longer-term savings could be made as a result of adequately supporting this target group?

Stage 3: Is the Health Overview and Scrutiny Committee the Best Means of Investigating the Issue?

HOSC is not always the best route when investigating an issue. It may be that other organisations such as LINk (soon to be healthwatch), Citizen's Advice etc are better placed to collate individuals' concerns and bring them to the attention of the relevant organisation.It could be that the issue has already been considered and addressed by the Acute Health Trust for example, or revised guidelines issued to GPs by the BMA.

Your time and resources are limited so focus on questions that have not been asked before either by the Council or its partners. That way you can be sure that you will make a difference.

The flow chart below provides a visual guide for helping you evaluate the appropriateness of issues to be taken forward to Scrutiny.

Stage 4: Start Your Review

By following this process you would have already done a significant amount of the groundwork required for good scoping of your investigation. You will be presenting issues and topics for scrutiny that have not been duplicated elsewhere and help ensure that the council delivers one of the key corporate objectives of delivering better services with less money.

Issue Evaluation Flow Chart