MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

WEDNESDAY 16TH MAY, 2012

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

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

Chairman: To be appointed at Annual Council Meeting on 15 May 2012
Vice Chairman: To be appointed at Annual Council Meeting on 15 May 2012

Councillors

To be appointed at Annual Council Meeting on 15 May 2012

Substitute Ward Members

To be appointed at Annual Council Meeting on 15 May 2012

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

Aysen Giritli – Head of Governance

Governance Services contact: John Murphy, Overview and Scrutiny Officer, Tel: 020 8359 2368

Media Relations contact: Sue Cocker 020 8359 7039

CORPORATE GOVERNANCE DIRECTORATE

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AGENDA ITEM 6

Meeting	Health Overview & Scrutiny Committee
Date	15 May 2012
Subject	**North Central London Joint Overview and Scrutiny Committee (JHOSC) Minutes**
Report of	Overview and Scrutiny Office
Summary	For the Committee to note the minutes of the JHOSC meeting held on 27 February 2012.

Officer Contributors	John Murphy, Overview and Scrutiny Officer
Status (public or exempt)	Public
Wards affected	All
Enclosures	Minutes of the JHOSC meeting of 27 February 2012
Reason for urgency / exemption from call-in	Not applicable
Key decision	No

Contact for further information: John Murphy, Overview and Scrutiny Officer, 020 8359 2019

1. RECOMMENDATION

1.1 That the Committee note the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting held on the 27 February 2012.

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

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.
- The Council is required to give due regard to its public sector equality duties as set out in the Equality Act 2010 and as public bodies, Health partners are also subject to equalities legislation; consideration of equalities issues should therefore form part of their reports.

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

6.1 None in the context of the report.

7. LEGAL ISSUES

7.1 None in the context of the report.

8. CONSTITUTIONAL POWERS

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution; the Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution).

9. BACKGROUND INFORMATION

9.1 The North Central London Joint Health Overview & Scrutiny Committee met on 27 February 2012. The minutes are attached for the Committee's consideration.

10. LIST OF BACKGROUND PAPERS

10.1 None.

Legal – NB
Finance – JH/MC

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NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a meeting of the **JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **MONDAY 27 FEBRUARY 2012** at 10.00 a.m. in the Committee Room 1, Town Hall, Upper Street, N1 2UD

MEMBERS OF THE COMMITTEE PRESENT:
Councillors Alison Cornelius, Barry Rawlings and Graham Old (L.B Barnet), John Bryant (Vice-Chair) (L.B Camden), Alev Cazimoglu (L.B Enfield), Gideon Bull (Chair) and Dave Winskill (L.B Haringey), and Alice Perry (L.B Islington)

OFFICERS:
Hannah Hutter and Shama Sutar-Smith (L.B Camden), Melissa James (L.B Barnet), Rachel Stern (L.B Islington), Rob Mack (L.B Haringey), Linda Leith (L.B. Enfield)

ALSO PRESENT:
Jeremy Burden, Director of Contracts, NHS North Central London
Alastair Finney, Interim Programme Director, NHS North Central London
Martin Machray, Head of Communications and Engagement, NHS North Central London
Dr Douglas Russell, Medical Director, NHS North Central London
Liz Wise, Quality, Innovation, Productivity and Prevention Director, NHS North Central London

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

MINUTES

1 WELCOME AND APOLOGIES
Councillor Gideon Bull (Chair) welcomed all those present to the meeting.

Apologies were received from Cllr Martin Klute (L.B Islington) Cllr Anne-Marie Pearce (L.B Enfield).

2 URGENT BUSINESS
There was none.

3 DECLARATIONS OF INTEREST
Councillor Gideon Bull declared that he was an employee at Moorfields Eye Hospital but did not consider it to be prejudicial in respect of the items on the agenda. Councillor Alison Cornelius declared that she was a Chaplain's assistant at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda

4 MINUTES

RESOLVED:
THAT the minutes of the meeting held on 16 January 2012 be agreed.

TO NOTE: All

Matters arising:

In response to a question regarding the delayed letter to the Secretary of State on behalf of the Committee regarding financial arrangements once NHS North Central London had been dissolved the Committee noted that the letter had now been sent. A copy of the letter had been circulated to members.

In respect of the work to implement the transformation of CAMHS (time 5), it had been suggested at the previous meeting that Councillors Alison Cornelius and Gideon Bull be invited to attend the next meeting young people's project board's as observers. The young people had indicated that they would be happy for the Members to attend a future meeting of their project board, once it was further established. The board was currently seeking a suitable venue for their meeting on 7 March. It was asked that the three Local Authority leads be invited from Barnet, Enfield and Haringey to attend the next meeting to present on education and CAMHS services (including new CAMHS model within the three boroughs.
ACTION BY: Rob Mack (Scrutiny Officer)

Statistics on the number of instances of maternity units at either Barnet or Chase Farm Hospital being temporarily closed had not yet been provided but a letter had gone to the Chief Executive of Barnet and Chase Farm Trust requesting these and emphasising the importance of this data. From next year, data on suspensions of maternity services would be available on a site by site basis rather then just by NHS trust, as was currently the case. The data on midwife to patient ratios would be chased up.
ACTION BY: Rob Mack (Scrutiny Officer)

It was noted that, as specified in the minutes, a letter had been sent to the Chief Executive of London Councils requesting that they take up the issue of the lack of an additional allowance for London CCGs to fund commissioning support services. Martin Machray reported that a letter had gone out to London NHS trusts on the indicative funding of £25 per head of population outlining management costs and that an additional communication had been provided outlining commissioning budgets.. A fuller briefing would be available later that week, on allocation of commissioning budgets.
ACTION BY: Martin Machray, NHS North Central London

5 NHS NORTH CENTRAL LONDON PRIMARY CARE STRATEGY 2012 TO 2016

Martin Machray, Head of Communications and Engagement and Dr Douglas Russell, Medical Director, NHS North Central London presented the report to the Committee.

Primary care was a fundamental part of the NHS and included self care, community services and social care. The British primary care system was seen as an international example of a care system that could be delivered in a cost effective way funded from taxation.
In the discussion the following points were made:

- There were still five individual borough work streams but NHS North Central London (NCL) did not operate in silos.
- NCL needed to speak on a level that local people could understand to ensure clear communication.
- The issue of CCGs commissioning services from themselves had been raised as a potential conflict of interest and it was clear that GPs did not want to be seen as serving their own self interest.
- It was clear that there needed to be greater capacity and improved capability at a local

level to enable truly integrated care.

- It was possible that some hospitals would lose income under the new arrangements.
- It was proposed that care packages would be delivered by one integrated team. The purpose of this approach was to utilise funds most effectively – so it was not about providing the team with more funding but more effective ways of working which therefore use funds more efficiently.
- Some of the existing regulatory functions would go to the National Commissioning Board.
- A specific Medical Director had been appointed to develop primary care in Enfield in recognition of the scale of improvements required within the borough. He/she would be in post from 1 April.
- Members welcomed the paper and noted that the Whittington Health had already taken over provision of community services for Islington and Haringey. They noted that not all acute trusts were proposing to develop their services in this particular way. They felt that consideration needed to be given as to how all hospitals within the cluster fitted into the model of integrated care.
- The IT system that the Whittington Health was developing in partnership with other partners were intended to integrate with existing systems.
- Members queried the process used to assess where the £47.5million should be spent. It was stated that there were gaps in data and NCL were aware of missing cases in some areas.
- CCG commitment to the strategy was needed. Members noted that the Joint Board of CCGs had committed to the document.
- In the event that the Bill was not passed by parliament, the cluster arrangement would continue and there would be a legacy for a successor organisation.
- The CQC had responsibility for regulating providers and the Department of Health and Commissioning Board would hold CCGs to account.
- The medical profession was largely self regulating and there were powers to find doctors in breach of their contracts if they did not meet their performance standards.
- GP practices' performance could be variable in their performance in correctly coding patients and population turnover was also an issue.
- If savings targets were met then there would be approximately £30-£40million available for reinvestment between primary and secondary care.
- Members expressed concern as to who would monitor the implementation of the primary care strategy and whether assurances could be given that it would continue after NHS NCL had ceased to exist. Members noted that the CCG had helped build the strategy and, as part of their authorisation procedure, they needed to be signed up to the strategy.
- A representative of the Local Medical Committee expressed concern that the CCGs did not represent GPs overall and that any legacy plan should be owned by those who would take over running of services.
- There was an existing NHS complaints system and all patients would still have the right to choose their registered doctor.

The Chair thanked Dr Douglas Russell and Martin Machray for their presentation.

RESOLVED:
That the report and presentation be noted.

TO NOTE: All

6 BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - IMPLEMENTATION

Alastair Finney, Interim Programme Director, NHS North Central London made a presentation to the Committee which gave an update on progress, details on a communications review and future developments on relation to the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

Primary Care was vital to future care planning and the PCTs had always agreed that the changes should not be made to the hospitals until the primary care changes were in place.

The advice from NHS London confirmed the risks that would arise were the A&E to close before the maternity unit. A capital business case needed to be submitted to the Department of Health and would require sign off before any works could proceed. The scheduled end date was Autumn 2013, provided there were no significant obstacles.

In the discussion the following points were made:

- The timeline had been drawn up in consultation with the trusts involved. It was a tight timescale and assumed the capital approval process was not held up. Once the Department of Health had approved the business case, work could start in three months time.
- There was a contingency plan that allowed for a delayed process of an additional 15 months. The fall back timetable gave a completion date of early 2015.
- A resident of Enfield reported that he had attended the North Middlesex Board meeting and they had stated that their outline business case had been submitted but Barnet and Chase Farm's (BCF) had not. In response the Committee were advised that Barnet and Chase Farm's outline documents were also due to be submitted that week and the changes would not take place until this was done.
- The JHOSC should consider the risk assessment documents. This could be arranged and the business case would also be available for viewing once it was complete.
  ACTION BY: Alastair Finney, NHS North Central London
- The spend for hospital works was around £100 million capital. The primary care spend would need to be assessed on a borough by borough basis.
- The details on spend would be included in the business case. An extra £12million of funding had been put into primary care that year and the majority of this had gone to northern boroughs to support the BEH plans.
- Although the cluster would not be around after 2013, the CCGs were part of the programme although the status of all organisations was subject to the Bill going through Parliament.
- The CCGs were at different stages of development and there needed to be awareness of how funding would be allocated.
- The need to address public transport when considering major service change was raised. It was the view of the Chair that there had been an inability on the part of TfL to engage effectively with the change programme. It was noted that the process for making transport link changes, even to move a bus stop, could never meet the pace of change required, even when TfL could see the need.
- Branding was not the key consideration for the process and it was more important that people were aware that provision of good quality primary care was the main message.
- It was important to recognise the efforts of staff in primary care services and the impact of negative messages regarding current provision.
- There should be better involvement of patients' and residents' groups.

- GPs in Enfield and Barnet had been marginally in favour of the proposals, with a clear split by borough.
- The Committee would like more information on proposals for the development of primary care services that would support the proposed changes.
- Councillor Cornelius reported an issue of concern regarding a neighbour who had been referred to A&E at Barnet. Officers noted the issue.
- It was suggested that the proposals should be considered by local health and wellbeing boards.
- The business case on this issue did not include land sales. The Committee would welcome an item on NHS Estates. **ACTION BY: Rob Mack (Scrutiny Officer)**

The Chair thanked Alastair Finney for attending.

RESOLVED:

1. That the risk assessment documents and business case be shared with the JHOSC
2. That the issue of how NHS estates will be managed and administered following the implementation of the Health and Social Care Bill be referred to a future meeting of the Committee.

TO NOTE: Martin Machray, NHS North Central London

7 FURTHER DEVELOPMENT OF THE NHS NORTH CENTRAL LONDON STRATEGY AND QIPP PLAN 2013/14 - 2014/15/MONTH 9 FINANCE UPDATE

Liz Wise, the Quality, Innovation, Productivity and Prevention Director, NHS North Central London gave a presentation on the QIPP Plan Performance.

The JSNA case for change had been published in October representing the key points from all five borough JSNAs. The five borough JSNAs would be circulated to the Committee again. **ACTION BY: Liz Wise, NHS North Central London**

The financial position as of month nine was good with further savings of £3.8million secured taking the deficit to £11million. It was hoped that NCL would finish the year in balance.

All five boroughs were now forecasting that they would be able to achieve their total or better, with better than expected performance in Haringey. This was in part due to the receipt of returned top sliced funding of 2% from NHS London.

In the discussion the following points were made:

- Members highlighted that improvement in actual terms was £1.1million. Officers stated that this was against a very ambitious programme of savings and it was a vote of confidence from NHS London that they had released the additional funds.
- Some areas had experienced a high level of demand and activity, particularly around Barnet and Chase Farm and the Royal Free.
- There would be a raised QIPP challenge to come and it was linked to the Primary Care Strategy with a very strong multidisciplinary approach.
- Members expressed concerns about the capital programme underspend and the prospect that some of that funding may be lost if not spent. Officers recognised that there was a risk that the money may be lost and stated that the onerous approval process for works was a possible factor in this. An estates strategy was being drawn up but there was a debate on what would happen. The Committee noted that funds could not be used on GP premises.

- All capital spends required approval via the Department of Health and NHS London no matter how small they were.
- Members requested a briefing on the underspend and the capital needs.
  ACTION BY: Liz Wise, NHS North Central London
- The strategic financial objective was to have all Trusts in balance by 2012-13 with the cluster in as strong a financial position as possible by the end of 2012-13.
- Progress had been made on identifying the contribution savings from projects and programmes would make with a predicted figure of around £84million. That still left a gap and clarity was needed on what these projects would provide.
- The Operating Plan would be delivered by the end of March.
- The proposed capital spending was not outlined in the report and the members would like to see more information on this.
  ACTION BY: Liz Wise, NHS North Central London

The Chair thanked Liz Wise for attending.

RESOLVED:
That a briefing on the capital programme, its potential underspend and any measures to address this be circulated to the Committee.

TO NOTE: Liz Wise, NHS North Central London

8 CONTRACT MANAGEMENT OF ACUTES

Jeremy Burden, Director of Contracts, NHS North Central London gave a presentation to the Committee.

The team managed 17 contracts many of which operated on standardised specifications. Although specifications could be varied, the majority were mandated by the Department of Health. Although acute services had started to lower bed numbers, there had been a rise in consultant to consultant referrals.

In the discussion the following points were made:

- Coding charges and out of contract services were a monthly challenge
- Payment by results had created a coding issue. Whilst there was guidance on how trusts should code activity, this could also sometimes allow them to code in a way that maximised their income.
- It was recognised that payment by results had helped to lower patient waiting times and meet other performance targets
- In response to a question about the implications of early discharge from hospital, officers advised the Committee that the clinically right approach for the patient was the focus. For example, some stroke pathways led to early discharge but it had to be right for the patient in their individual case.
- Where Barnet and Chase Farm had struggled with A&E targets, they had received support from an urgent care support team who had helped to review discharge planning and reach a system-wide multi-agency solution. The problem in that instance had been down to diversions from other hospitals and issues about how the hospital was working. Now that the hospitals and social services were working better together, patients could be discharged more efficiently.
- There had been an increase in the number of ambulances arriving at both Barnet and

Chase Farm hospitals and both had seen a significant drop in performance. However, Barnet had recovered more quickly.

- The contracts covered were not outside of main providers, for example hospices were not covered.
- The Committee would like to see the activity data for each site of Barnet and Chase Farm hospitals.
  ACTION BY: Jeremy Burden, NHS North Central London

The Chair thanked Jeremy Burden for attending.

RESOLVED:
That activity data for each site of Barnet and Chase Farm hospitals be shared with the Committee.

TO NOTE: Jeremy Burden, NHS North Central London

9 NHS NORTH CENTRAL LONDON TRANSITION UPDATE REPORT

Martin Machray, Head of Communications and Engagement, NHS North Central London gave an update to the Committee.

In the discussion the following points were made:

- Barnet and Islington CCGs had received authority for medicines management to be delegated. Enfield would have the slowest possible transition as they had the largest deficit.
- Members queried whether the CCG per capita amounts were calculated on past figures or if they could be revised in the light of changes to deprivation levels.
- There was an assumption in the Bill that public health would move over to local authorities. However other bodies were also asking for additional funding to cover these responsibilities.
- The baseline estimate spend for public health had been made by the Department of Health according to PCT spend in 2010/11. Barnet had been more disadvantaged by the settlement than most other boroughs, having the lowest amount per head of population of any borough other than Bexley. The settlement was decided at national level so any lobbying would need to be targeted there. There was a significant gap between the top and bottom settlement with a range of 3% to 50% across the boroughs. The Committee would like to compare per capita settlements against the current spend so they could assess the drift. They requested a specific briefing on the issue.
  ACTION BY: Martin Machray, NHS North Central London

The Chair thanked Martin Machray for attending.

RESOLVED:
That a briefing be submitted to a future meeting of the Committee on the baseline funding estimates for local authorities in the cluster.

TO NOTE: Martin Machray, NHS North Central London

RESOLVED:

10 FUTURE WORK PLAN

The Committee gave its consideration to a report outlining its future work plan.

The issues around vascular surgery had been the subject of a number of presentations. The end of process report would be for information only.

The indicative timings for the next meeting were as follows:
CAMHS – 45 minutes
QIPP Performance – 10 minutes
Estates management – 45 minutes
Oral Surgery – 10 minutes
Vascular Surgery – 10 minutes
BEH MHT Quality Account – 30 minutes

Martin Machray stated that there may not be enough information available about estates management to progress the item at the next meeting.

It was proposed that the risk register item should come to the meeting on 28 May. It was suggested that this be circulated in advance so that members could take a view on the agenda.

The Committee would write to the Chair of the GLA Transport Committee querying the proposed placed on ambulances using the designated Olympic lanes and asking that they raise the concerns of the Committee in their meeting with Transport for London on 13 March. Councillor Winskill agreed to draft a letter on behalf of the Committee.

ACTION BY: Councillor Winskill

The future meeting dates were as follows:

16 April – Haringey

28 May - Enfield

9 July (moved from 16 July) – Barnet

RESOLVED:
THAT subject to the above amendments, the report be agreed.

TO NOTE: All

The meeting ended at 1.25pm

CHAIR: Councillor Gideon Bull

MINUTES END

AGENDA ITEM 7

Meeting	Health Overview and Scrutiny Committee
Date	16 May 2012
Subject	**London Trauma Services**
Report of	Scrutiny Office
Summary	The appendices to this report presents the committee with an update on London Trauma Services including data analysis for incidents that trigger the London major trauma decision tree, and the London Trauma Office Annual Report 2010/11.

Officer Contributors	John Murphy, Overview and Scrutiny Officer
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 1 – London Ambulance Service Trauma Information Appendix 2 – London Trauma Office Annual Report 2010/11
Contact for Further Information:	John Murphy, Overview and Scrutiny, Tel: 020 8359 2368

1. RECOMMENDATIONS

1.1 **The committee discuss and note the information presented in relation to Trauma Services as set out in Appendices 1 and 2 of this report.**

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 21 February 2011, Agenda Item 6 – Stroke and Trauma.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2012/13 Corporate Plan are: -

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

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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

- The Council's leadership role in relation to diversity and inclusiveness; and

- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

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

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

6.1 None in the context of this report.

7. LEGAL ISSUES

7.1 None in the context of this report.

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

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

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

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

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

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

9. BACKGROUND INFORMATION

9.1 The Committee received a presentation from the Director of the London Trauma Office on the work of the four Trauma networks following its launch in April 2010. Members were informed that since April 2010 these networks had saved an additional 37 lives.

9.2 The Committee were provided with data relating specifically to Barnet, which showed that between May – August 2010 thirty four patients triggered the decision tree used to identify patients that may benefit from conveyance to a specialist major trauma centre. The Committee were informed that 97 per cent of Barnet patients were correctly conveyed to the appropriate clinical unit. Members sought further information on triage for head injuries and the frequency this occurred. The committee were informed that the trauma service deals with a number of head injuries although very few are transferred to specialist units. The Trauma Service is Consultant led and has in place a number of processes to assess a patient's condition. The committee requested that an update be provided by the London Trauma service at a future meeting.

10. LIST OF BACKGROUND PAPERS

10.1 None

Cleared by Finance (Officer's initials)	**JH/MC**
Cleared by Legal (Officer's initials)	**NB**

London Ambulance Service NHS
NHS Trust

Trauma information for the Barnet Overview and Scrutiny Committee

Data analysis has been completed for incidents during the period April to July 2011 for patients who trigger the London major trauma decision tree. The London major trauma decision tree enables ambulance crews to identify patients in the prehospital environment who are likely to have a high Injury Severity Score (ISS) and who may benefit from conveyance to a specialist major trauma centre instead of being conveyed to the nearest accident & emergency department. The definition of major trauma is an ISS over 15 however an ISS can only be calculated after a full hospital assessment of the patient's injuries. The patients who trigger the major trauma decision tree at the scene of an incident will therefore not always be found to be major trauma patients when they are assessed in the hospital. For convenience all patients who have triggered the major trauma decision tree are referred to below as major trauma patients.

Data is presented below for patients where the incident location has been determined to be within the boundaries of the Barnet primary care trust along with figures for the London Ambulance Service area as a whole.

Number of trauma tree positive April to July 2011

Barnet	LAS-wide
41	1525

Correct conveyance

A patient is determined to have been correctly conveyed if they trigger the major trauma decision tree and are conveyed directly to a major trauma centre. If they are taken to a local trauma unit (A&E), this is considered to be an incorrect conveyance unless the patient's airway cannot be maintained, the patient is in cardiac arrest or a pre-hospital doctor determines that a trauma unit is appropriate. The LAS performance target is 90 per cent correct conveyance of major trauma patients. Two major trauma patients in Barnet PCT refused to be conveyed to a major trauma centre despite attempts by ambulance crews to persuade them this was the most appropriate destination for their injuries this accounts for the 95 per cent figure.

	Correctly conveyed	Correctly conveyed to a MTC	Correctly conveyed to a trauma unit	Incorrectly conveyed to a trauma unit	Patient refusing a MTC
Barnet	95%	95%	95%	0%	5%
LAS-wide	97%	97%	<1%	2%	<1%

Patient destination

Major trauma patients may go to one of four major trauma centres or if they have an isolated head injury they may alternatively have been conveyed to one of three designated trauma units which have neurosurgical facilities. St Mary's MTC has been fully in operation since January 2011; Charing Cross is no longer a designated neurosurgical trauma unit as of November 2011. The figures below relate only to those patients who were correctly conveyed.

	King's College MTC	St George's MTC	Royal London MTC	St Mary's MTC	Royal Free Neurosurgical Trauma Unit	Charing Cross Neurosurgical Trauma Unit	Queens Romford Neurosurgical Trauma Unit
Barnet	0%	0%	16%	84%	0%	0%	0%
LAS-wide	19%	14%	38%	27%	<1%	<1%	1%

Travel times to hospital (minutes)

Travel times are shown only of patients correctly conveyed directly to a MTC or a trauma unit with appropriate neurosurgical facilities. The trauma networks are designed so that patients should not normally be more than a 45 minute road journey by ambulance away from a major trauma centre. One patient conveyed from Barnet PCT area had a 51 minute journey to hospital due to heavy traffic conditions; this appears to be caused by gridlocked traffic in the Barnet area involving a lorry rolling over on a major arterial route. All other patients from Barnet in this time period had journeys of less than 35 minutes.

	Directly to MTC or neurosurgical trauma unit	
	Range	Mean
Barnet	11-51	21
LAS-wide	1-74	15

Mechanism of injury

Figures are shown below for patients who triggered the major trauma decision tree. Blunt trauma refers to injuries where the patient strikes or is hit by an object that does not penetrate the body. Examples include road traffic collisions, falls from height and crushing injuries. Penetrating trauma refers to injuries where an object pierces the skin, including stabbings, gunshot wounds and impalements. The category of other injuries includes burns, hangings and drownings. Please note that due to the nature of major trauma, patients may sustain injuries which fall into more than one category.

	Blunt trauma	Penetrating trauma	Other injuries
Barnet	65%	33%	2%
LAS-wide	64%	32%	4%

Case Study

Southern End of Barnet

1742 - 999 call

1755- Ambulance on scene

38 year old male, motorcyclist bike skidded in wet, flipped over handle bars, lost consciousness for 2 minutes. Lying in road opening his eyes to speech and confused. Pain whilst breathing oxygen levels low. Significant facial injuries and injuries to left arm.

Oxygen administered, patient immobilised to protect spine, pain relief given.

1815 - Ambulance leaves scene to major trauma centre.

1850 - Ambulance arrives at hospital met by consultant lead trauma team. Chest drain inserted as emergency

1900 - CT scan post chest drain

Major Trauma ward and on to specialist maxillofacila input.

Multiple complex facial fractures. Fracture of the right 3rd rib with associated lung injuries and pneumothorax (collapsed lung) . Four rib fractures on left.

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NHS

London Trauma Office

Hosted by London Specialised Commissioning Group
on behalf of London's PCTs

Annual Report
April 2010 – March 2011

Foreword

The system of care for seriously injured Londoners has been transformed through the advent of the London Trauma System. This report reflects the achievements of the system in its first year of operation.

London's trauma system consists of four trauma networks. Three of the networks went live in April 2010, with seriously injured patients being taken to one of three specialist major trauma centres at The Royal London Hospital, Whitechapel, St George's Hospital, Tooting and King's College Hospital, Denmark Hill. The system was completed in January 2011 when the fourth major trauma centre at St Mary's Hospital Paddington became fully operational.

There have been significant improvements in both the processes of care and patient outcomes since the networks went live. There is now a consultant available 24/7 in the major trauma centres to immediately assess and treat these seriously injured patients. In addition they have rapid access to scanning facilities and operating theatres to enable correct diagnosis and treatment to take place within short time frames.

All of these improvements mean that an additional 58 Londoners who were expected to die of their injuries have survived. We are very proud of this and of all the achievements of the first year of the system. This has involved an enormous amount of hard work and dedication from all those people working in major trauma care. I would like to thank all those who have contributed to this success and look forward to the ongoing development of the system.

Dr Fionna Moore
London Trauma Director

CONTENTS

LONDON TRAUMA OFFICE
From November 2011
Portland House, Stag Place
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Executive summary

- In 2009 a Joint Committee of all 31 PCTs in London made a decision to commission four trauma networks in London to ensure effective care for seriously injured people
- The networks comprise a Major Trauma Centre (MTC) for those with the most serious injuries, linked to a number of local Trauma Units (TUs). The four MTCs are located at:
  - The Royal London Hospital, Whitechapel
  - St George's Hospital, Tooting
  - King's College Hospital, Denmark Hill
  - Imperial College – St Mary's Hospital, Paddington
- Three of the four trauma networks in London went live on April 6th 2010, with the fourth at St Mary's Hospital fully operational from January 2011
- A triage tool ensures those people with potentially the most severe injuries (major trauma) are taken by ambulance crews directly to a specialist MTC, bypassing their local hospital
- In the first year of operation over 4,000 patients triggered the triage tool, and had the benefit of direct conveyance to a MTC and immediate specialist treatment
- Mean travel time from scene of the incident to a major trauma centre was 16 minutes
- Once in the MTC a consultant is available 24/7 to treat these patients immediately, backed up by rapid access to imaging and specialist surgical teams
- There has been a significant reduction in the time to CT scan – the median time to CT in MTCs ranges from 36 to 60 minutes from admission. This enables more rapid decision making about the need for emergency surgery and ultimately better outcomes for patients
- 58 Londoners are now alive who were expected to die of their injuries when their chances of survival are compared to data on similar patients nationally
- Of the patients taken directly to a major trauma centre 32% have an injury severity score of greater than 15 (major trauma) and a further 12% have moderately serious injuries (ISS 9 -15).
- The predominant cause of injury is through road traffic collisions, followed by falls from a height and stabbing injuries
- Quarterly performance visits to the networks have driven a number of improvements in patient care, including better collaboration between orthopaedic and plastic surgical teams when operations are carried out on people who have suffered severe open fractures
- Through collaboration with the London Deanery innovative new trauma courses are being development which will provide the best trained trauma workforce in the country
- Protocols for how the trauma networks function in a major incident have been drawn up and tested through collaboration with NHS London Emergency Preparedness team so that the daily benefits of networks are built upon and realised in a major incident
- Robust data on issues around rehabilitation has been compiled indicating for the first time the degree to which some rehabilitation services are not delivering for patients. Commissioners and trauma networks are using this data as a basis for improvement in rehabilitation
- Significant support has been given by the London Trauma Office to the emerging Regional Trauma Networks nationally to ensure that the learning that has taken place in London is shared for the benefit of injured patients in other regions

Background

Following publication of *Healthcare for London: a Framework for Action* in July 2007, the Healthcare for London (HfL) programme was set up by London PCTs and NHS London to develop and implement its recommendations, one of which was to improve major trauma services for London.

Subsequently proposals were developed to devise a trauma system in London composed of trauma networks. Further to these, a public consultation was undertaken on these proposals. On 20th July 2009 the Joint Committee of PCTs (JCPCT) comprising all London PCTs and SW Essex PCT, approved the proposals and took the decision to designate four major trauma centres (MTCs) each within its own trauma network, at the same time agreeing to invest in the new model of care.

The four major trauma centres were identified as:

- The Royal London Hospital, Whitechapel
- St George's Hospital, Tooting
- King's College Hospital, Denmark Hill
- Imperial College – St Mary's Hospital, Paddington

Following an external assessment and assurance process undertaken in January 2010, three of the four networks went live on April 6th 2010. The North West Trauma Network with a MTC at St Mary's Hospital had a later planned start date. In the interim, transition arrangements for North West London ensured patients were taken to the most appropriate location based on their injuries. St Mary's went live as a MTC 24/7 on 11th January 2011 completing the four networks which make up the London Trauma System.

Each major trauma centre sits within a trauma network, linked into a number of trauma units (TUs). Some trauma networks extend outside of London and include trauma units and take trauma patients from neighbouring SHAs where clinically appropriate and supported by the relevant commissioners.

The London Specialised Commissioning Group was given lead responsibility to implement commissioning proposals for major trauma, whilst working with the London PCT clusters who commission the trauma units. It is believed that major trauma commissioning will move to the NHS Commissioning Board over the next 18 months - this has yet to be confirmed.

As part of the London Trauma system the JCPCT supported the creation of the London Trauma Office (LTO). This is led by a part-time Clinical Director (Dr Fionna Moore, Medical Director of London Ambulance Service), and a full-time Trauma System Manager (Tracy Parr). The London Trauma Office has oversight of the ongoing development of the system and co-ordinates the overall performance management of the major trauma model. This is undertaken on a network basis in conjunction with local cluster commissioners.

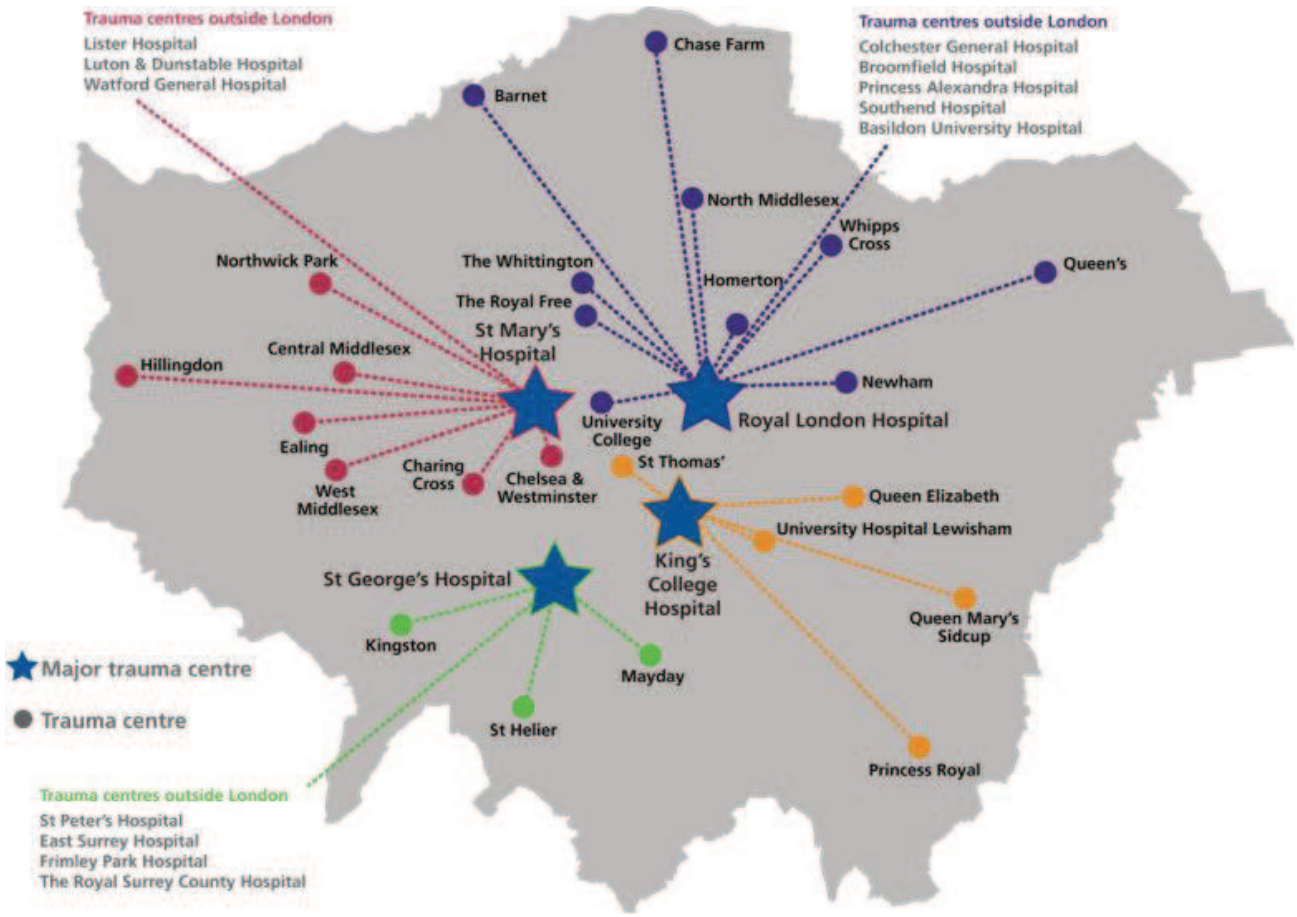
In support of the system a new triage system was introduced by the London Ambulance Service (LAS). With the establishment of the system, potential major trauma patients are taken to a major trauma centre for definitive treatment by the resident specialist major trauma team. The National Audit Office Report[1] published in 2010 reported that the literature[2,3] suggested that where trauma systems had been introduced, in-hospital mortality reduced by 15 to 20 per cent. On the basis of an estimate of 3,000 deaths in hospital from major trauma each year, this suggested an additional 450 to 600 lives could be saved each year across England. As the system develops it is estimated that there will be around 100 additional lives saved in London annually, with improvement in outcomes for many more.

This is a report on progress within the London Trauma System in its first year of operation April 2010 – March 2011.

Keith Willett, National Clinical Director for Trauma Care:

"I am delighted to see the enormous progress that has been made in London since the system went live last year. I am hugely impressed by the work and commitment of all those involved in developing the networks. Seriously injured patients across the capital now have access to a world class trauma system."

The London trauma system



Major trauma patient – severely injured in motorcycle accident October 2010:

"I was very pleased to have been taken directly to a hospital which had all the specialists I needed to treat my injuries."

[1] National Audit Office (2010), *Major Trauma Care in England*.

[2] Celso B, Tepas J, Langland-Orban B, Pracht E, Papa L, Lottenberg L, Flint L. (2006), A systematic review and meta-analysis comparing outcome of severely injured patients treated in trauma centers following the establishment of trauma systems, *Journal of Trauma* 60(2): 371-378.

[3] NC Mann et al (1999). Systematic review of published evidence regarding trauma system effectiveness. *Journal of Trauma* 47: S25-S33.

Trauma data – the Trauma Audit Research Network

The severity of trauma is described using the Injury Severity Score (ISS), an internationally recognised system which ranges from 1 to 75.

In England and Wales this data is collected and validated through a national organisation, the Trauma Audit & Research Network (TARN). An ISS score of more than 15 describes the group of patients with the most serious injuries, known as major trauma. The JCPCT made its decision to commission four MTCs based on an estimated range of patients of ISS >15 of between 1200 and 2000 per annum. This would give each MTC between 300 and 500 patients with ISS>15 per year.

There are a large number of data fields collected through the TARN electronic data collection and reporting system (eDCR) of which ISS is one component. In addition to ISS, the eDCR enables the collection of data on processes which demonstrate potential improvements to patient care such as time to CT scan. We now have data for the full year April 2010 to March 2011 from the MTCs which is described later in the report.

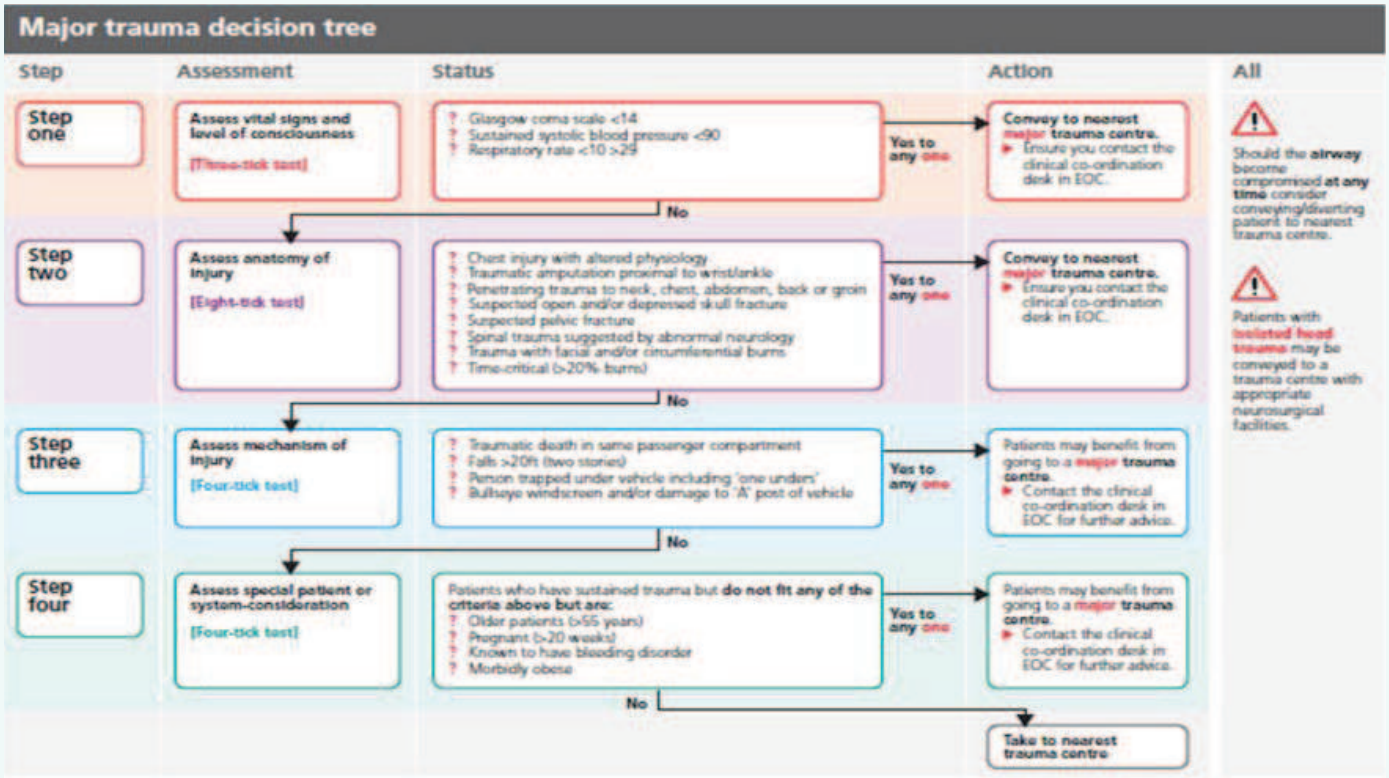
There are specific inclusion criteria for patient data to be submitted to TARN:

- Admission to Intensive care
- Hospital admission > 3 days
- Death during admission
- Transfer for specialist care

Injuries are then coded centrally and an ISS score attributed to each individual patient.

Evaluation of the Trauma Triage Tree

Patients who have been injured are assessed by LAS crews using the triage tool shown below. It gives an indication of which patients may have sustained major trauma, although major trauma cannot be diagnosed until patients have gone through a full diagnostic assessment in a MTC. To understand the effectiveness of the triage tool, data has to be manually triangulated from three different sources. This is a manual process and very time-consuming. Using this method we have detailed data from the first six months of operation (April to September 2010).

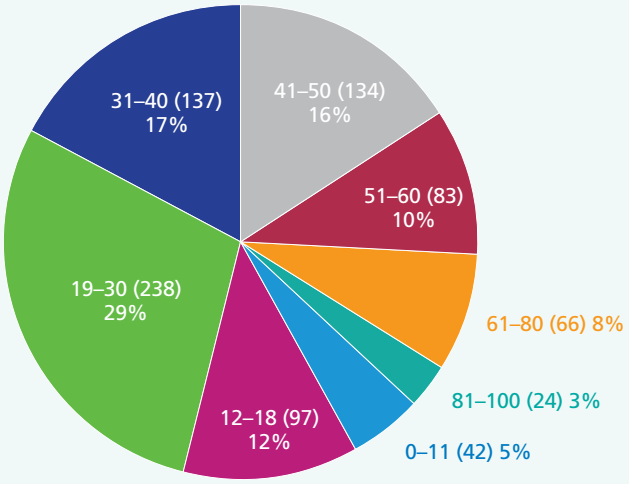


The Trauma Patient Population

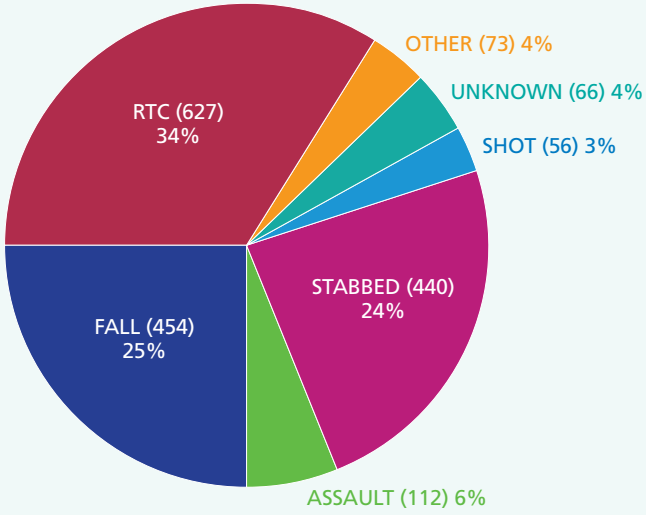
Major trauma is primarily a disease process affecting young men. This is shown in the profile of patients who trigger the tree and who fulfil the criteria for submission to TARN. 74% of these patients are male, 26% female. Nearly half (46%) of these patients are between 19 and 40 years of age.

The predominant injury mechanism (34%) is through road traffic collisions (including car occupants, pedestrians, cyclists and motorcyclists). Falls make up 25% of the triage positive patients with stabbing contributing another 24%.

All TARN eligible patients by age 06/04/2010 to 30/09/2010, n=821

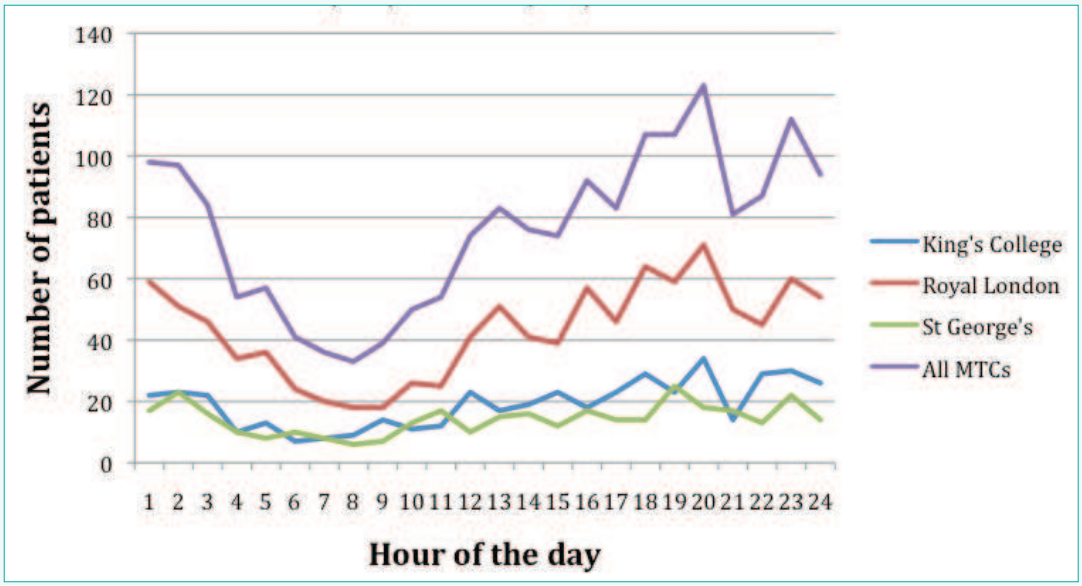


Triage Tool positive patients by injury mechanism 06/04/2010 to 30/09/2010, n = 1,828



The time of day when triage positive patients present to MTCs shows remarkable similarity across all the three networks during this period. The least busy time is just before the morning rush hour. This builds to a peak at around 2100h which diminishes in the early hours of the morning.

All MTCs Triage Tool Positive patients by time of admission 06/04/10 to 30/09/10, n=1,828

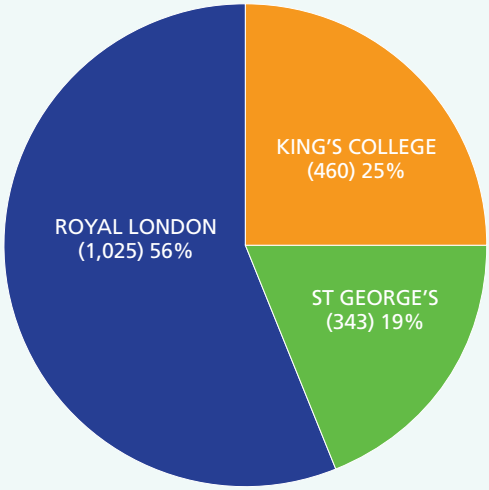


The Royal London Hospital was given the largest network, as it was the most established centre prior to formal designation. It was receiving 56% of all the triage positive patients before St Mary's went live. King's College and St George's received 25% and 19% of the total number of patients respectively. This number does not include patients who required secondary transfer. Data is currently being analysed to understand the impact of the fourth major trauma centre on activity in the other centres.

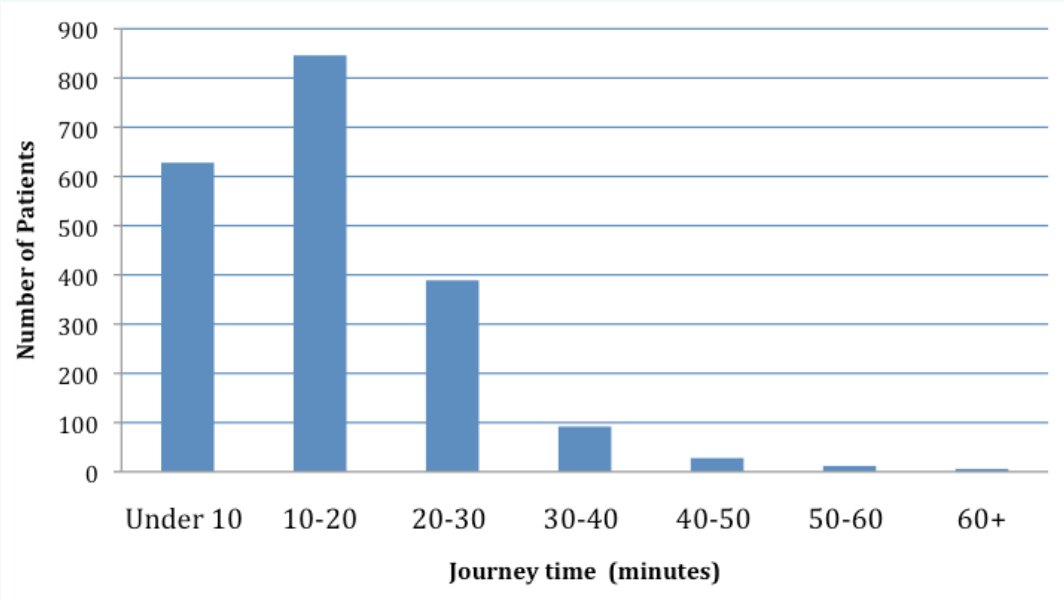
Ambulance Journey Times

The establishment of the London Trauma System was based on a maximum ambulance journey time of 45 minutes. Data is collected on all ambulance conveyances for patients who bypass to a MTC. Of the 2001 patients in this data set, 1,474 (74%) of patients reached the MTC within 20 minutes rising to 1,863 (93%) within 30 minutes. In total, 1,955 (97%) of all patients arrived within 40 minutes. The remaining 3% patients had significant clinical reasons why they had prolonged journey times, such as spinal injuries which necessitated slower driving conditions. The mean journey time to a MTC was 16 minutes with a median of 14 minutes. Data has kindly been supplied by London Ambulance Service Clinical Audit and Research Department.

Triage Tool positive patients by destination MTC 06/04/2010 to 30/09/2010 n=1,828



Ambulance journey time from incident to MTC 01/05/10 to 30/11/10 n = 2,001



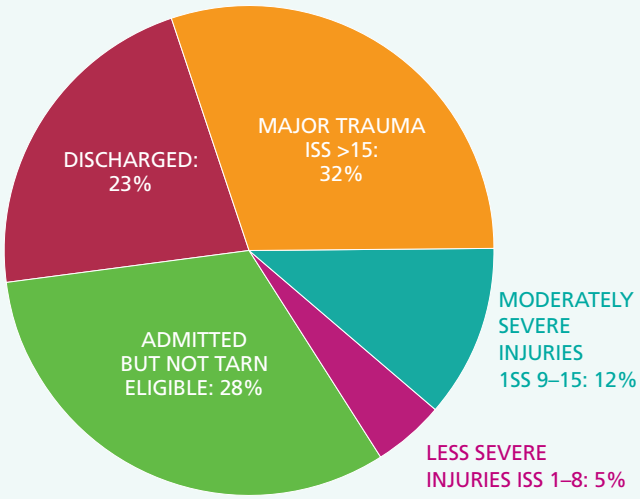
Triage of patients using the Major Trauma Triage Tool

Pre-hospital triage protocols attempt to use a variety of variables to identify which patients warrant immediate transfer to an MTC and which can be safely managed at a local Trauma Unit. Evidence has highlighted the difficulties in trying to identify the severity of injury in the pre-hospital environment. For reasons of patient safety, triage tools are expected to give a degree of over-triage, as this enables the injuries of patients to be assessed within the MTC with immediate access to the numerous services they may require. The most important goal of these systems is to minimise under-triage (seriously injured patients who are not taken to a MTC), which can lead to preventable mortality and morbidity.

The triage tool used in London was developed by a group of experts in pre-hospital care and was based on the tool developed by the American College of Surgeons. It uses a four-stepped approach based on physiological signs, anatomy of the injury, mechanism of the injury and other factors. Patients who trigger the tool on one of the four steps are conveyed to a MTC where they have immediate access to consultant-delivered diagnosis and care.

Initial analysis shows that on average 11 patients a day trigger the tree and are conveyed to a MTC. This equates to over 4,000 patients a year who are benefiting from direct access to a MTC with appropriate expertise and facilities. Of these, 32% of them have major trauma (ISS>15), with a further 12% having sustained significant injuries (ISS 9 – 15). Around a quarter are discharged from the emergency department as they have not sustained any significant injuries. This degree of overtriage is to be expected and represents a margin of safety which enables people with potentially serious injury to be rapidly assessed in the MTC.

Triage Tool positive patients by outcome 06/04/2010 to 30/09/2010 n=1,828



Further evaluation of the London triage tool

It is really important to understand the degree of over and under triage produced by a triage tool. The latter requires robust TARN data collection in TUs. This identifies seriously injured patients who have been incorrectly conveyed to a TU and not transferred. This area of work has been very challenging as the degree of TARN data submission within TUs in London is very poor and does not provide an accurate picture of this patient group. The LTO has been given funding by the Department of Health to undertake an evaluation of the triage protocol. TARN have been commissioned to work with TUs to provide this data from TUs to enable complete understanding of the triage tool. A report will be published during 2011–2012.

Primary bypass into SW London

NHS Surrey has led on a project, in collaboration with the Trauma Network and South East Coast Ambulance Service (SECAmb), to implement primary bypass in St George's for major trauma within and on the M25 in Surrey from March 21st 2011. This benefits patients in this area by giving them direct access to a MTC instead of going to their local Surrey hospital and then having a secondary transfer. The LAS triage decision tree was modified for local use and a checklist developed for the crews to complete at the scene to aid their decision-making. Clinical support was put in place for the crews via a Critical Care Paramedic on call rota.

Formal evaluation of the pilot pathway will be undertaken at the end of the 6 month pilot phase but preliminary findings are as follows:

- 2-3 patients are triggering the decision tree on a weekly basis
- For the 36 patients who were decision tree positive and bypassed to St George's, 10 (28%) triggered step 1 vital signs and level of consciousness, 13 (36%) triggered step 2 anatomy of injury and 13 (36%) triggered step 4 special patient or system consideration. To date, no patients triggered step 3 mechanism of injury.

The decision tree will need reviewing in the light of differing emerging models from other trauma networks. Clinical support will be strengthened with the aid of the Air Ambulance Service within the Emergency Dispatch Centre, and further roll out of primary bypass will be reviewed once the trauma unit designation process is complete across the South East Coast region.

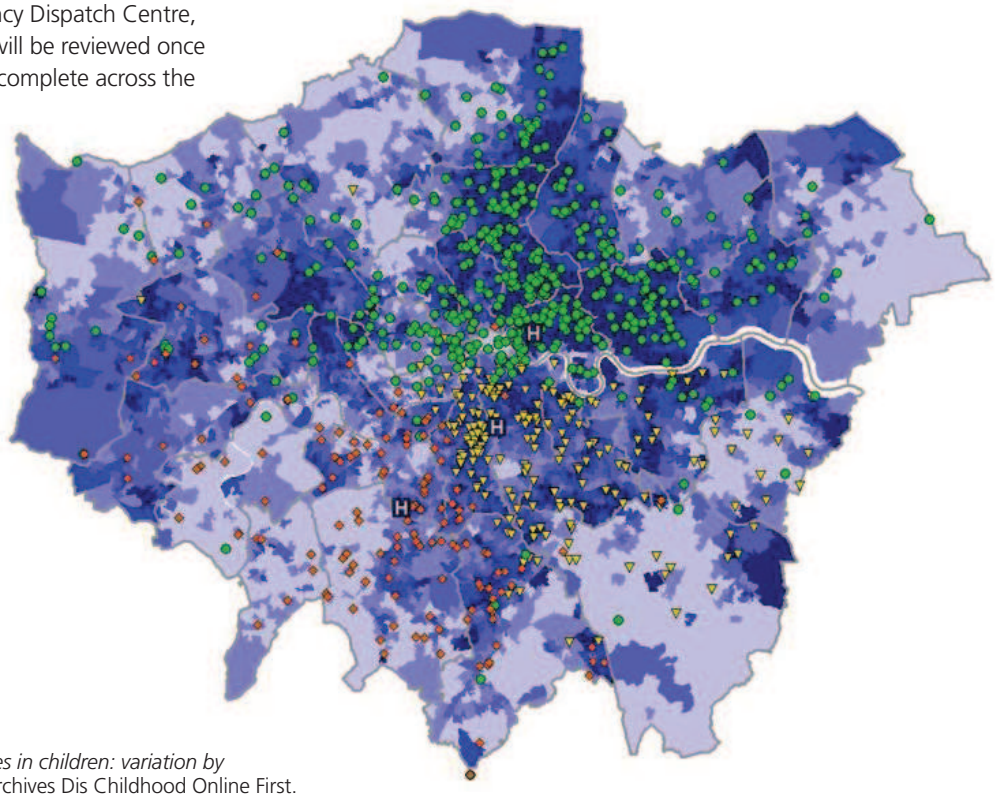
Helicopter Emergency Service (HEMS)

The London Air Ambulance plays an important role in the London Trauma System, taking a senior doctor and specially trained LAS paramedic to cases which the ambulance control centre believes would benefit from this enhanced level of care. The service operates using a helicopter during the day and rapid response cars at night. In April 2010 the service went 24/7 to coincide with the establishment of the London Trauma System.

Major Trauma and Social Deprivation

There is a wealth of literature demonstrating the link between social deprivation and the incidence of major trauma[4,5]. An analysis was undertaken plotting the location of incidents where patients triggered the tree against a map of social deprivation of London. Darker areas represent the most deprived areas, the lightest are the least deprived areas. There is a clear concentration of major trauma incidents in the most deprived areas. Further work to explore these linkages will be undertaken in 2011–2012.

Major Trauma Tree Positive Incidents and Social Deprivation in London



- **Royal London Hospital**
- **King's College Hospital**
- **St George's Hospital**

[4] Edwards P. et al (April 2008) *Serious injuries in children: variation by area of deprivation and settlement type* Archives Dis Childhood Online First.

[5] Silversides J.A. et al (2005) *Social deprivation and childhood injuries in North and West Belfast* Ulster Med J.

Trauma Activity in London April 2010 – March 2011

Data submitted to TARN is now available for the full year since go-live. The total no of patients with ISS>15 in MTCs is 1228, with a further 250 patients of ISS>15 who are taken to one of the two TUs with neurosurgery who are able to treat patients with isolated head injuries (at Queen's Romford and the Royal Free Hampstead).

The three MTCs for which we have one year's data have seen an increase in activity of the most seriously injured patients (ISS>15), with differing degrees of change in activity of patients with ISS<15.

Performance of Trauma Networks

The quality of clinical care delivered is described for the most part through data submitted to TARN by Trusts in the trauma networks. The trauma clinical steering group has devised a set of performance standards for the delivery of trauma care within the networks. Quarterly meetings have been undertaken where a review of specific aspects of performance is undertaken according to the timetable laid out in the performance framework. The London Trauma Office has been working very closely with TARN to modify and refine reports on performance using trauma data submitted by network hospitals to TARN. London has the first regional trauma networks requiring data to be used in this way, so this has required an innovative approach from LTO and TARN working in collaboration. Over the year there has been enormous progress in refining the reports to ensure they deliver the information required in a way that is useful in measuring performance.

MTC	ISS>15 2009–2010	ISS>15 2010–2011	Change in activity
Royal London Hospital	354	559	+205
King's College Hospital	158	298	+148
St George's Hospital	250	310	+60
St Mary's Hospital (Jan – Mar data only)	19	61	+42

Data submission to TARN

The TARN dataset involves collection of a large number of data items. A time lag of up to 3 months from admission is normal. Data completeness is the number of patients reported in each hospital's TARN submission compared to the expected number of patients using Hospital Episode Statistics (HES) data as a baseline. (This is used as a guide only as some hospitals have better resources than others for collecting data, and this may affect the quality and completeness of the data). In the following reports data completeness for each MTC and TU is shown for the period April 2009 – Mar 2010 and April 2010 – Mar 2011. For each network the following data will be shown:

- Completeness of patient data submitted to TARN from each Trust in the network for the year pre and post go-live
- Breakdown of TARN-eligible patients 2009 – 2010 compared with 2010 - 2011
- Most senior doctor in the emergency department receiving triage tool positive patients
- Time to CT scan
- Developments within each Trauma Network

Maralyn Woodford, Executive Director, Trauma Audit & Research Network (TARN):

"As regional trauma networks go live next year the importance of patient care data, submitted to TARN, in demonstrating improvement will become more evident. The collaborative work we have undertaken in conjunction with clinicians and the London Trauma Office this year has enabled refinement in the way data is analysed and presented. This has been invaluable in establishing the effective use of TARN to describe the performance of trauma networks."

North East London and Essex Trauma Network

TARN DATA COMPLETENESS

Trust	April 2009 to Mar 2010	April 2010 to Mar 2011
	Data Completeness %	
Barking, Havering and Redbridge Hospitals NHS Trust	101.8	98.9
Barnet and Chase Farm Hospitals NHS Trust	49.8	52.9
Barts and the London NHS Trust	64.7	98.9
Basildon and Thurrock University Hospital NHS Foundation Trust	97.1	35.1
Homerton University Hospital NHS Foundation Trust	10.9	18.6
Mid Essex Hospital Services NHS Trust	22.9	46.9
Newham University Hospital NHS Trust	5	11.7
North Middlesex University Hospital NHS Trust	0	0
Royal Free Hampstead NHS Trust	9.0	60.6
Southend University Hospital NHS Foundation Trust	40.5	91.6
University College London Hospitals NHS Trust	0.4	55.9
Whipps Cross University Hospital NHS Trust	8.3	16.1
Whittington Hospital NHS Trust	14.3	70.1

- The Royal London Hospital has seen an increase in Trauma Team activations from 1644 in the year before go live to 2160 in the year since the London Trauma System went live in April 2010

TARN-ELIGIBLE PATIENTS ROYAL LONDON HOSPITAL

ISS	1-8	9-15	16-24	25-45	45-75	TOTAL	ISS>15
April 6th 2009 - Mar 31st 2010	60	170	106	218	30	584	354
April 6th 2010– Mar 31st 2011	86	247	225	288	46	892	559
Change in activity (+/-)	+26	+77	+119	+70	+16	+308	+205

MOST SENIOR DOCTOR IN THE EMERGENCY DEPARTMENT

Consultant	STR	Foundation Year/Other	Not recorded
733	26	0	17

Through its TARN data, the Royal London Hospital has demonstrated very effectively the consultant presence for the vast majority of its major trauma patients.

North East London and Essex Trauma Network

TIME TO CT SCAN

6th April – 31st March 2010			
	n	Median time to CT (hours)	Interquartile Range
All patients	549	0.7	0.5 – 1.0
6th April – 31st March 2011			
All patients	777	0.6	0.4 - 1.0

Education:

- The network submitted a successful bid to develop the pan-London Trauma Team Leader Course.
- The Royal London Hospital held a multidisciplinary 2 day major trauma integrated education programme in December 2010 which was very well received. One hundred and twenty people attended from a range of specialties. It is intended that this will be an annual educational conference
- A network damage control surgery course was held for surgical trainees in April with a 2nd course scheduled to take place in November 2011
- A Trauma Surgery Manual is being developed

Paediatrics

- A network paediatric workstream was established in July 2010 which includes representatives from Great Ormond Street Hospital and CATS
- A network paediatric trauma pathway has been developed
- Paediatric trauma data is collected monthly from all hospitals within the Network
- Network paediatric trauma documentation has been developed and is in place across the Network
- Paediatric Anaesthetic Trauma Standard Operating Procedures have been developed at the MTC
- A Paediatric Anaesthetic Trauma Simulation Course has been developed at the RLH and was piloted in May 2011.
- The Paediatric Trauma Simulation Course is in place at the RLH and has been rolled out to Newham Hospital. A phased roll out to the NELETN hospitals is planned

Trauma Units

- Twice yearly multidisciplinary trauma study days take place at Queen's Hospital Romford
- Barnet and Chase Farm Hospitals have appointed a Trauma Education Lead and have developed a FAST scanning course for that will be rolled out to the Network
- In addition they have implemented twice monthly trauma simulation training.
- All patients with an ISS>10 are discussed at monthly trauma governance meetings.
- North Middlesex Hospital has rolled out a 1 day Trauma Life Support Training course that is compulsory for all nurses and junior medical staff working in or attending the ED Alongside this is a compulsory trauma e-learning module for all ED staff and trauma team members
- The Whittington Hospital has developed a repatriation and rehabilitation pathway for trauma patients including a weekly patient-focussed trauma multidisciplinary round
- Trauma head injury training and multiple-site fracture training has also been developed for therapists and nurses at the Trust.

Governance:

- Network governance meetings take place quarterly and include a data review of MTC and TU data, case reviews and an educational session

Research:

- The Trauma Outcomes Unit has been piloting the use of several tools to measure rehabilitation need, dependency and quality of life both during patients' hospital stay and following discharge.
- A Trauma Outcomes Clinic was established in January 2010 to follow up major trauma patients. Patients are being followed up in relation to quality of life issues. The success of the clinic has prompted a bid to be submitted to further investigate patient outcomes
- A retrospective study of nearly six hundred severely injured Trauma patients from 2008–2010 has been undertaken and shows the significant enhancement of patient outcomes with clinician-grade care in the acute phase of resuscitation (e.g. time to emergency diagnostic imaging or time to definitive haemorrhage control). The study provides compelling evidence for best practice recommendations regarding the level of care in major trauma centres.
- A 3-year (£0.5m) proposed programme of work has been developed with the London MTCs to define a core set of ICF data that will be evaluated and implemented across London and inform the future measure of trauma patients' rehabilitation and needs.

South East London Trauma Network

TARN DATA COMPLETENESS

Trust	April 2009 to Mar 2010	April 2010 to Mar 2011
	Data Completeness %	
Guys & St Thomas' NHS Foundation Trust	56.8	40.2
South London Healthcare Trust	0.3	45.5
Lewisham Hospital NHS Trust	4.3	22.5
King's College Hospital NHS Foundation Trust	38.9	90

TARN data collection at Kings continues to improve, and there are now robust systems in place to ensure that all patients are submitted on to TARN. Within the Network, however Trusts are facing ongoing challenges identifying and capturing all TARN eligible patients. King's will be working alongside its Network partners to support the roll out of best practice and improve data completeness in the coming year.

TARN-ELIGIBLE PATIENTS KING'S COLLEGE HOSPITAL

ISS	1-8	9-15	16-24	25-45	45-75	TOTAL	ISS>15
April 6th 2009 - Mar 31st 2010	25	70	77	76	5	253	158
April 6th 2010– Mar 31st 2011	105	170	131	164	15	585	310
Change in activity (+/-)	+80	+100	+54	+88	+10	+333	+153

MOST SENIOR DOCTOR IN THE EMERGENCY DEPARTMENT

Consultant	STR	Foundation Year/Other	Not recorded
348	3	0	11

Provision of a 24/7 on site rota ensures that all patients who present in the Emergency Department as Major Trauma are seen immediately by a consultant. The rota, which is jointly provided by Critical Care and ED consultants, has been running for 18 months and has proven invaluable in the provision of a consultant led service.

TIME TO CT SCAN – KING'S COLLEGE HOSPITAL

6th April – 31st March 2010			
	n	Median time to CT (hours)	Interquartile Range
All patients	209	1.3	0.8 - 1.9
6th April – 31st March 2011			
All patients	456	1.0	0.6 - 1.9

Following the opening of the new CT scanner adjacent to the Emergency Department, King's has streamlined patient pathways to further improve access to and from the scanner – thus reducing waiting times.

South East London Trauma Network

Other developments within the MTC and network

- Fully open Acute Surgical Ward, with 10 Level 1 Trauma beds
- Opening of dedicated CT scanner adjacent to emergency department
- Joint appointment for plastics between King's and Guys and St Thomas' to support trauma patients
- Embedded multi-specialty governance structure across entire network, utilising electronic reporting systems that cross organisational boundaries into pre-hospital care
- Local adaptation of tertiary transfer policy across the Network
- Formalised Secondary Transfer policy now operational
- Daily review of trauma patients from previous day – 7 days a week
- Weekly open forum teaching and education sessions
- Catalogue of Standard Operating Policies to underpin governance structure and training programme for trauma team
- Monthly mortality and morbidity meetings to promote education and development
- Implementation of weekly rehabilitation multidisciplinary meetings and ward rounds, to support the development of patients timely and appropriate ongoing care plans

Plans for 2011/2012

- Development of orthoplastics service across King's and Guys and St Thomas'
- Implementation of Trust-wide CODE RED activation
- Review of rehabilitation provisions, and collaborative working to address ongoing care needs for trauma patients
- Opening of 10 bedded resuscitation department (November 2011)
- Commencement of ICU redevelopment consultation
- Review guidance/ funding for overseas patients
- Launch of electronic Trauma Booklet

South West London Trauma Network

TARN DATA COMPLETENESS

Trust	April 2009 to Mar 2010	April 2010 to Mar 2011
	Data Completeness %	
Ashford and St Peter's Hospitals NHS Trusts	26.0	60.5
Croydon University Hospital NHS Trust	11.7	22.3
Epsom and St Helier University Hospitals NHS Trus	94	78.8
Frimley Park NHS Foundation Trust	72.5	77.7
Kingston Hospital NHS Trust	4.3	26.2
Royal Surrey County Hospital NHS Trust	10.6	26.9
St George's Healthcare NHS Trust	68.3	84.5
Surrey and Sussex Healthcare NHS Trust	2.5	48.9

TARN-ELIGIBLE PATIENTS ST GEORGE'S HOSPITAL

ISS	1-8	9-15	16-24	25-45	45-75	TOTAL	ISS>15
April 6th 2009 - Mar 31st 2010	110	93	110	130	10	453	250
April 6th 2010– Mar 31st 2011	117	145	125	159	14	560	298
Change in activity (+/-)	+7	+52	+15	+29	+4	+107	+48

MOST SENIOR DOCTOR IN THE EMERGENCY DEPARTMENT

Consultant	STR	Foundation Year/Other	Not recorded
195	50	3	14

St George's has a robust 24/7 consultant rota for the emergency department. The data does not appear to reflect, but there were known issues with TARN data collection in the Trust early in 2010. These have now been resolved and the consultant input is now being recorded effectively.

TIME TO CT SCAN

6th April – 31st March 2010			
	n	Median time to CT (hours)	Interquartile Range
All patients	230	1.6	1 – 2.9
6th April – 31st March 2011			
All patients	336	0.8	0.4 – 1.4

South West London Trauma Network

Network developments

- The network appointed a Network Director in 2010
- The secondary transfer policy and the spinal injury pathway were revised .
- The head injury policy has been refined to enable rapid referral of patients with isolated head injury
- A business case has been agreed for a helipad to allow wider access to the MTC
- This has been approved by Trust Board and is going into planning stages
- A new policy for the investigation of serious untoward incidents is currently being designed to enable a more co-ordinated and effective response
- A robust network governance log and closure process has been established enabling incidents to be investigated and acted upon in a timely fashion.
- Bi-monthly governance meetings are being implemented leading to a good system of case review.
- The network will host its first annual trauma network conference this Autumn
- A strong 1, 3 and 5 year strategy for the network is in development and will ensure future-proofing and planning
- An innovative head injury service at St George's hospital under a consultant neurologist has led to a significant improvement in the standard of aftercare.
- There are discussions around potential head injury care outreach from the MTC to the TUs and a network approach to ensure the right patients can benefit from transfer for head injury rehabilitation
- Plans are in place to open two dedicated rehabilitation beds at Queen Mary's Hospital to take patients with a variety of injuries

North West London Trauma Network

TARN DATA COMPLETENESS

Trust	April 2009 to Mar 2010	April 2010 to Mar 2011
	Data Completeness %	
Chelsea and Westminster Hospital NHS Foundation Trust	0	7.7
Ealing Hospital NHS Trust	9.8	26.2
Hillingdon Hospital NHS Trust	15.3	0
Imperial College Healthcare NHS Trust	60.9	101.1
Luton and Dunstable NHS Foundation Trust	0	2.0
North West London Hospital NHS Trust	1.5	6.1
West Hertfordshire Hospital NHS Trust	0	0
West Middlesex University Hospital NHS Trust	2.2	19.6

- Weekly trauma calls have been increasing and have just reached a plateau at about 40/ week.

TARN-ELIGIBLE PATIENTS ST MARY'S HOSPITAL

ISS	1-8	9-15	16-24	25-45	45-75	TOTAL	ISS>15
April 6th 2009 - Mar 31st 2010	8	27	9	10	0	54	19
April 6th 2010– Mar 31st 2011	11	41	33	27	1	113	61
Change in activity (+/-)	+3	+14	+24	+17	+1	+59	+42

MOST SENIOR DOCTOR IN THE EMERGENCY DEPARTMENT JANUARY –MARCH 2011

Consultant	STR	Foundation Year/Other	Not recorded
89	0	0	0

TIME TO CT SCAN

6th January – 31st March 2010			
	n	Median time to CT (hours)	Interquartile Range
All patients	50	2.5	1.6 – 5.2
6th January – 31st March 2011			
All patients	90	0.7	0.5 – 1.0

North West London Trauma Network

Network overview

- A Network Director has been appointed
- A Neurosurgical unit at St Mary's has been established as a new stand alone emergency unit.
- A new spinal team has been established comprising both Neurosurgical and Orthopaedic Consultants.
- A Dedicated Trauma Orthopaedic team established.
- A new 16 bedded trauma ward has been fully opened with daily Consultant led ward rounds with Trauma Consultant of week, Neurosurgical Consultant and ITU Consultant for all level 3 patients.
- Weekly meetings have been established and are well attended.
- A dedicated new imaging centre is established with direct lift access to the emergency department
- Quality measures around time to CT scan are continuing to improve.
- TARN data for the MTC is improving with modest improvement in network. Most TUs have plans in place to achieve the required data collection

Plans for 2011 - 2012:

- To strengthen the Trauma network connections
- To improve TARN data collection in TUs
- To make some of the current locum posts substantive
- An improvement in the research profile

Trauma Network Performance – Injury Specific Audits

During the year, quarterly performance meetings were undertaken to each trauma network led by the London Trauma Director. Other clinical representatives as well as London Specialised Commissioning Group (LSCG) and local commissioners were also in attendance. At each visit TARN data was presented and any issues around the findings from this discussed. In addition, at each visit the network was asked to focus on a specific type of injury such as head injury or open fractures, and present data on how they conformed to national standards for the management of such injuries. These standards are set by bodies such as the National Institute for Clinical Excellence (NICE) and the British Orthopaedic Society Standards for Trauma (BOAST). The timetable below shows the visit content and dates.

Timeline of information collected and visits to networks

Trauma Team Review

All MTCs showed an excellent standard of trauma team response with a consultant present 24/7. There was wide variation in the trauma team responses within TUs, with some having difficulty in providing the level of seniority of personnel required. The Trauma Unit Criteria were revised in 2010, and a further exercise to assess the ability of each TU to deliver the criteria will be undertaken in 2011 – 2012.

Massive Transfusion Protocol

Each MTC was able to demonstrate the presence of an effective massive transfusion protocol and its use in practice. This is a key component of the management of seriously injured patients and significant progress has been made in enabling rapid access to large amounts of blood and blood products. The work of the Trauma Haematology Group has been instrumental in driving this forward.

Head Injury

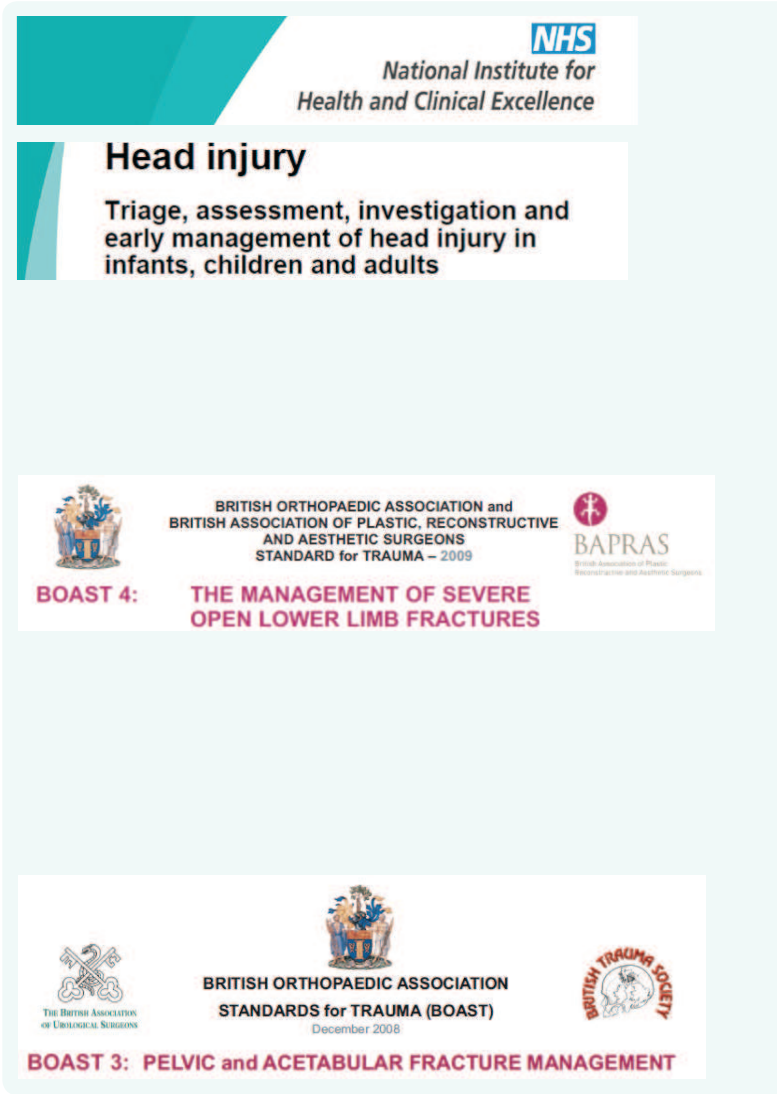
For patients with polytrauma and head injury, the automatic acceptance policy at MTCs is working well. Good examples were given of patients with such injuries being transferred to the MTC following a telephone call to alert the receiving Trauma team in the MTC. In some networks, for patients with isolated head injuries, the pathway remains one of referral through the neurosurgical registrar in the MTC. This continues at times to produce delays in transfer or acceptance at the MTC. Referral pathways are being developed in some networks to facilitate automatic acceptance of these patients. This remains an area where there is room for improvement in access to the MTC – there is ongoing work in this area.

Open Fracture Management

In some networks there was evidence of good compliance with the BOAST standard for open fracture management. This requires timely administration of antibiotics and a joint approach to surgical management involving both orthopaedic and plastic surgeons. Where this was not evident, MTCs have put plans in place for a combined surgical team approach, with new appointments of plastic surgeons in some MTCs. These plans are being monitored as part of the regular performance reviews to ensure the highest standards are being delivered for patients.

Pelvic Fracture Management

BOAST guidelines are also in place for the management of pelvic fractures. These require surgery to be undertaken within a specific time frame as patients get better results and the potential for complications is minimised. There was good compliance with this standard in general, although the ability to undertake complex pelvic surgery is very specialised and some patients will require transfer for definitive surgery.



Patient outcomes

An intended benefit of the London Trauma System is improved survival for patients. In order to show the impact of the system most effectively, data will be required to demonstrate a lowering of risk adjusted mortality across the system (including TU data) over a period of several years. There is insufficient data at present to be able to do this meaningfully - this work will be undertaken as data accrues over time. An example of how this has been undertaken in Victoria Australia illustrates a year on year reduction in the odds ratio for death due to major trauma.[6]

TARN compares outcomes from all hospitals who submit data on patients. A probability of survival according to injury severity is calculated for all patients within the dataset. It quantifies how many patients are expected to survive their injuries compared to the actual number that survive. This analysis gives an early indication of the benefits of having a system of care to treat injured patients. Compared with the outcomes of patients in the national TARN dataset, there have been 58 additional survivors in London since the go-live of the system. We anticipate further additional survivors and will continue to report on these outcomes.

Andy Wapling, Head of Emergency Preparedness, NHS London:

"The London Trauma System has provided the capital with the ability to build on robust major incident plans to enable an even more effective response in the event of a major trauma incident."

Major Incident Planning

In a trauma system, patients are triaged on a daily basis according to their injuries, and ambulance and other personnel are experienced in conveying patients to the most appropriate destination. In a major incident where there are a number of casualties the same principles are applied but on a larger scale. In collaboration with NHS London department of emergency preparedness, guidance has been produced on how the networks should function in a major incident. This includes descriptions of how major incidents are communicated within a network, how the MTC manages patient flows and how patients move within or between networks. A second table top exercise was held in October to test these systems and refine the guidance.

[6] A Cameron P.A . et al, Medical Journal of Australia (2008) 189 pp 546 -500 *A Statewide System of Trauma Care in Australia – effect on patient survival.*

Paediatric Trauma

Paediatric trauma initially fell under the remit of the original Healthcare for London major trauma project. It was then subsumed into the children's and young people's workstream. A report has now been published with recommendations regarding the commissioning of tertiary paediatric services.[7] This includes services such as neurosurgery and paediatric intensive care, both of which are required for seriously injured children. In addition, the national clinical advisory group on paediatric trauma has also published a series of recommendations.[8]

In view of the impetus towards developing tertiary services, a paediatric trauma group was established to take this specific area forward. The group has now completed a service specification for a children's major trauma centre, a paediatric triage protocol and a pathway for secondary transfer of seriously injured children. These products will feed into the wider work being undertaken at London Specialised Commissioning Group on the development of tertiary paediatric care.

Education and Training

Over the last 18 months London Deanery and the London Trauma Office have developed an innovative and highly productive working relationship through a shared commitment to educational excellence and the adoption of novel and effective education commissioning strategies. Capable and well-trained staff ensure that trauma patients across London receive the highest possible quality of care.

The Deanery has funded the development of two courses to support this aim for which networks were invited to tender. The Trauma Team Leader course is being developed by the North East London and Essex Trauma Network. The two South London Networks are jointly producing the Trauma Team Member course. The courses will be fully rolled out across the networks in a phased approach over the next two years ensuring all staff involved in trauma resuscitation have been trained in a consistent and effective manner.

Dr Ian Curran, Postgraduate Dean, Dean of Educational Excellence, Head of Innovation, London Deanery & London Commissioner for Medical & Dental Education:

This expert approach to service development has ensured that high quality educational interventions are delivered and grounded in the needs of the service. Such a collaborative way of working supports service transformation and has wide potential application across the NHS."

[7] Commissioning Support for London Children's and Young People's Project:*London's Specialised Children's Services: Guide for Commissioners*, March 2011

[8] National Clinical Advisory Group: *Management of Children with Major Trauma*, February 2011

Rehabilitation

One of the issues that has been challenging in relation to attempts to improve rehabilitation has been difficulty in gaining data to describe the issues affecting this population. Rehabilitation clinicians from the four MTCs designed a booklet in order to collect data to address this issue. This has provided a large amount of very useful information on which a number of recommendations have been based.[9] The main findings are:

- The most common injuries, both isolated and non-isolated were head injuries (39%) and complex musculo-skeletal injury (28%).
- 72 % of patients required ongoing rehabilitation services on departure from the MTC but 39% of patients did not receive the level of service matched to their assessed need
- Delays in access to services and lack of service existence were primarily accountable for the mis-match
- The least optimal pathway was evident for the most complex patients (those requiring the most specialised services)
- There is a gap in service provision for patients requiring local specialist services which primarily affects patients with complex musculoskeletal injuries
- Pathway transfer delays were identified and accounted for 487 inappropriate hospital bed stay days in the MTC, equivalent to £292,200 during a 2 month study period
- A trauma co-ordinator role appears to have a positive impact on capacity to collect data and handover of therapy care.

A number of recommendations for service providers and commissioners have been made in the report and progress in implementing these will be monitored through the London Trauma Office.

Trauma Haematology Group

A group of haematologists and transfusion practitioners from across London has been established and is working to strengthen the protocols in place to support the management of trauma patients

Vascular Injury Working Group

A group of vascular surgeons from across London has developed pathways and protocols for patients with vascular injury. These will help to standardise care for this group of patients. These are currently nearing completion prior to dissemination across the networks.

Trauma Research Group

A trauma research group has been formed with representation from across London. It has started to scope out research opportunities using the four trauma networks.

Linkages with Local Commissioners

The LTO holds regular meetings to ensure local commissioners are up to date with developments in trauma in their cluster and across London. Commissioners are invited to participate in the performance meetings and receive copies of their feedback reports and action plans.

Sharing experience

The London Trauma System was the first area of England to go live with regional trauma networks. As such, the LTO receives numerous requests for support as other networks develop. The requests number 5 - 10 per week. The service specification, triage protocol and other outputs have been widely used to inform other networks. In addition, a number of bespoke requests for data analysis and questions around specific issues are received.

Presentations have been given on behalf of the London Trauma Office at a number of conferences

- TARN /National Neurotrauma Symposium
- The National Trauma Conference
- The London Trauma Conference
- Regional Trauma Network Conferences

Several clinicians from the Royal London and the London Trauma System Manager were invited by the South Korean Department of Health in 2010 to visit Seoul. Guidance on the establishment of trauma systems was shared with a wide number of interested clinicians.

Darzi Fellow

Within the London Trauma Office an Emergency Medicine Registrar completed a one year secondment as a Darzi (Clinical Leadership) Fellow in 2011. LTO bid successfully for a further fellow who came into post in August 2011. The remit of the fellow is to lead the work on prevention, support educational initiatives and complete collation of the triage evaluation.

Shared Learning Day

To mark the occasion of a year since the system went live, a day to share best practice and learning was held on March 8th 2011. This was very well received and it is hoped to run this as an annual event.

[9] London Trauma Office: *Understanding the rehabilitation needs of the trauma population and recommendations for improvement*, September 2011

Plans for 2011–2012

A number of projects have been completed during the year. There is further work to be undertaken in the next year

- Development and continuation of performance assessment
- Completion of evaluation of the triage protocol
- Refinement and roll out of Trauma Team Leader and Member courses
- Trauma Unit Criteria were revised in 2010. A process to assess how each TU is able to deliver the criteria will be undertaken during the next year
- Work will begin on scoping out an injury prevention strategy
- Further work on patient engagement

Glossary

CT scan

Computerised tomography – a procedure using a large number of x-rays and computer processing to form a three dimensional image of the interior of a region of the body

Major Trauma Centre

A centre which has been designated to accept and treat the most seriously injured patients and which contains all the specialties required to treat these patients

Trauma Unit

A hospital which treats less seriously injured patients from its local area.

Acknowledgements

The achievements listed to date would not be possible without the expert input of a large number of clinicians, managers, commissioners and patients from across London. We would like to thank everyone who has contributed to the establishment and running of the London Trauma System and look forward to further successes.

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AGENDA ITEM 8

Meeting	Health Overview and Scrutiny Committee
Date	16 May 2012
Subject	**NHS Quality Accounts 2011/12**
Report of	Scrutiny Office
Summary	This report presents the Quality Accounts from NHS health service providers. The attached documents set out the quality of service provided by each provider. The committee is asked to scrutinise the Quality Accounts, and to provide a statement to be included in the Account of each health service provider.

Officer Contributors	John Murphy, Overview and Scrutiny Officer
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 1- The Royal Free Hospital Quality Accounts 2011/12 Appendix 2- North London Hospice Quality Account 2011/12 Appendix 3- CLCH Quality Account 2011/12 Appendix 4- Barnet and Chase Farm Hospitals NHS Trust Quality Account 2011/12
Contact for Further Information:	John Murphy, Overview and Scrutiny, Tel: 020 8359 2368

1. RECOMMENDATIONS

1.1 **That, noting the requirement of NHS health service providers to produce Quality Accounts for 2012, the Committee provide a statement for inclusion in each of the Quality Accounts of the health providers set out in the appendices.**

2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 19 May 2011, Agenda Item 7 – Quality Accounts

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2012/13 Corporate Plan are: -

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

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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

- The Council's leadership role in relation to diversity and inclusiveness; and

- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

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

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

6.1 None in the context of this report.

7. LEGAL ISSUES

7.1 Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication. This gives scrutiny committees the opportunity to review the information contained in the report and provide a statement on their view of what is reported. Providers are legally obliged to publish this statement as part of their Quality Account. Providers must send their Quality Account to the appropriate scrutiny committee by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

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

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

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

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

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

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

9. BACKGROUND INFORMATION

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

9.2 The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three

aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

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

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

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

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

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

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

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

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

10. LIST OF BACKGROUND PAPERS

10.1 None

Cleared by Finance (Officer's initials)	**JH/MC**
Cleared by Legal (Officer's initials)	**NB**

RFH Quality Accounts 2011/12

PART 1

INTRODUCTION AND STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It gives me great pleasure to introduce the Royal Free's third set of quality accounts, designed to assure commissioners, patients and our local population that we provide the highest level of clinical care and continuously seek to improve what we do.

This year has been particularly significant because it culminated in our authorisation as an NHS foundation trust from 1 April 2012. This provides us with greater freedom and flexibility to innovate and invest in clinical services, allowing us to expand our critical care facilities, upgrade the imaging department and create a new institute of immunology. Through our new council of governors, we are also able to increase the involvement of patients and the local population in our future plans for high quality clinical care. The foundation trust application process has been very thorough and our authorisation is an endorsement of the quality and sustainability of our clinical services and our plans for the future.

During 2011/12 we can once again point to many achievements. We continued to focus on infection control, with a significant reduction in the number of c-difficile infections during the year. Our hospital standardised mortality rate continues to be among the best in the country. As promised in last year's quality accounts, we greatly improved our out-patient phlebotomy service and have significantly reduced the number of patient falls. We have also introduced a fast-track pathway for patients with a fractured hip which is significantly speeding up the time patients spend in A&E before being moved to the trauma ward.

We continue to promote public health and launched our new Fit at the Free campaign during the year to encourage our staff to take part in healthy activities.

There were a number of successful inspections during the year, the most important of which was a re-inspection by the Care Quality Commission (CQC) of some aspects of the care we provide for elderly patients. We have been working very hard to improve since the CQC's inspection of these services in March 2011. Other successful inspections were of our maternity service at the Royal Free Hospital and our renal service at St John and St Elizabeth Hospital.

The views of our various stakeholders have been very important to the development of these quality accounts and in the choice of our three high-level quality priorities for 2012/13. We have chosen our world class care programme as the top patient experience priority for the next year. This programme is designed to improve many of the areas that patients have told us are unsatisfactory, such as administration, communication with doctors and nurses and the way we give information about patients' conditions.

As the Royal Free London NHS Foundation Trust, we plan to focus even harder on our mission to provide world class care and expertise. Once again, the evidence provided in these quality accounts demonstrates our continuing commitment to providing the highest quality clinical care.

Finally, I confirm that to the best of my knowledge the information provided in these quality accounts is accurate.

David Sloman
Chief executive
Royal Free Hampstead NHS Trust

PART 2

OUR QUALITY PRIORITIES FOR 2012/13

Our mission to provide world class care and expertise reflects our desire to always provide the highest quality service to our patients. Each year we set three quality improvement priorities that are monitored by the trust board. One focuses on patient experience, one on clinical effectiveness and one on patient safety.

In order to set out three quality improvement objectives for 2012/13, we sought the views of our patients, staff and local community. We invited representatives from our commissioners, local LINKs and local councils to events where we were able to discuss quality priorities. We asked for input from our clinical teams and our governors. We asked our members to participate in an online survey and more than 400 gave their opinion of what our quality priorities should be. Finally, the board considered the responses we received and agreed the following three priorities for 2012/13.

Priority 1: World class care

We want to make sure that, as well getting the best clinical care, our patients have a good experience of us when they use our services. We know a number of factors affect the patient experience, such as the quality of administrative processes and how our staff interact with patients. We are also acutely aware that patient satisfaction is fundamentally linked to how happy staff are in their workplace.

As part of our world class care programme, which started in autumn 2011, we have listened to hundreds of our patients and staff members and have worked with them to develop a set of commitments and standards. Over the next year, this work will continue, with all staff taking part in a team workshop to set standards and expectations of each other and to agree priorities for improvement. This will support our aim to deliver world class care to every patient, every day.

We will measure our progress using results from our patient feedback kiosks, which are situated at various locations across the trust, and by national benchmarked surveys.

Staff satisfaction:

We will measure our progress by our performance in the national staff survey and from what staff tell us locally.

We have set ourselves targets for improvement in two areas of the staff survey, in which we have not performed as well as other trusts during 2011/12. These are:

Staff feeling valued by their work colleagues

2011 survey	2012 survey aim
72%	76%

Staff experiencing bullying, harassment or abuse from staff

2011 survey	2012 survey aim
24%	19%

Patient experience :

We will measure our progress by our performance in the national patient survey.

We will set ourselves targets for improvement in relation to two questions in the survey as follows:

- Overall, did you feel you were treated with respect and dignity while you were in the hospital?

- Overall, how would you rate the care you received?

We are currently awaiting the results of the latest patient survey. These are under embargo until May. When we receive these results, we will set specific improvement targets for 2012/13 in relation to our performance in the survey.

These specific targets will be added to the final quality accounts.

This priority is in the area of patient experience.

Priority 2: Further develop our clinical outcome measures

Over the last two years we have been working to develop a set of clinical outcome metrics (measurements) for all our clinical business units. As one of last year's quality account objectives, we said we would publish the full set of metrics. We report on progress towards this goal in section three.

We believe that this work is vital to the trust because it provides a strong focus on delivering excellent clinical outcomes. During next year, we therefore wish to expand this work further.

Our specific aims are to:

- Commence regular performance monitoring of our metrics through the clinical performance committee.

- Expand our portfolio of metrics by, for example, adding additional metrics from the many national clinical audits to which our specialties contribute.

- Work with other trusts in our academic health science partnership, UCLPartners, to develop common clinical outcome metrics that we can use to compare performance between organisations

This priority is in the area of clinical outcomes and is monitored by our clinical performance committee.

Priority 3: Managing the care of the deteriorating patient

We are committed to providing excellent standards of care at every stage of the patient pathway. An important part of this is making sure our staff can recognise when a patient is deteriorating and are equipped with the knowledge and skills to manage his or her care safely and effectively.

The trust has successfully implemented a patient at risk and resuscitation team (PARRT), who respond to the hospital's emergency resuscitation call-outs. This team operates 24 hours a day, seven days a week. The trust also uses an early warning system to promote early recognition of deterioration and to ensure prompt escalation and treatment to prevent patients from deteriorating further. There is collaborative multi professional working between critical care and other expert specialities within our organisation.

Nationally, we know a serious cause of patient deterioration and associated high mortality rates is due to severe sepsis and we are working with staff to raise awareness and education around sepsis. We are developing a pathway to support staff to recognise signs of severe sepsis at an early stage and use an evidence-based "sepsis six resuscitation bundle" to escalate treatment within the first hour. This includes a set actions which staff must undertake to ensure the best outcomes for patients.

This project has been introduced in acute medical wards, renal wards and A&E as pilot areas, with the aim of eventually continuing the improvement work to include all trust areas.

We plan to achieve the following in our pilot areas by April 2013:

95% of staff can demonstrate awareness of recognising and managing severe sepsis.

95% of patients with symptoms that suggest severe sepsis have received the sepsis pathway bundle.

95% of patients who receive the sepsis pathway receive all 6/6 resuscitation bundle interventions.

This priority is in the area of patient safety.

STATEMENTS RELATING TO THE QUALITY OF NHS SERVICES PROVIDED BY THE ROYAL FREE HAMPSTEAD NHS TRUST

This section contains eight statutory statements concerning the quality of services provided by the Royal Free Hampstead 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 1: REVIEW OF SERVICES

During 2011/12 the Royal Free Hampstead NHS Trust provided 27 NHS services.

The Royal Free Hampstead 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 2011/12 represents **95.87% (NB based on month 11 figures)** of the total income generated from the provision of NHS services by the Royal Free Hampstead NHS Trust for 2011/12.

ADDITIONAL INFORMATION

In this context we define each service as a distinct clinical business unit 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 as an isolated entity. Some very specialised services are routinely reviewed as part of the national commissioning group's processes.

STATEMENT 2: PARTICIPATION IN CLINICAL AUDIT

During 2011/12, 42 national clinical audits and two national confidential enquiries covered NHS services that the Royal Free Hampstead NHS Trust provided.

During that period, the Royal Free Hampstead NHS Trust participated in 98% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate in.

The national clinical audits and national confidential enquiries in which the Royal Free Hampstead NHS Trust was eligible to participate during 2011/12 are indicated in the table below.

The national clinical audits and national confidential enquiries that the Royal Free Hampstead NHS Trust participated in during 2011/12 are indicated in the table below.

The national clinical audits and national confidential enquiries in which the Royal Free Hampstead NHS Trust participated, and for which data collection was completed during 2011/12, 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.

NATIONAL CLINICAL AUDITS FOR INCLUSION IN QUALITY ACCOUNTS 2011/12	ELIGIBLE TO PARTICIPATE	PARTICIPATED IN 2011/12	DATA COLLECTION COMPLETED IN 2011/12	RATE OF CASE ASCERTAINMENT (%)
National diabetes audit	√	x	√	0%
National elective surgery PROMs: four operations	√	√	√	70%
Adult cardiac interventions: NICOR coronary angioplasty	√	√	√	100%
MINAP: acute myocardial infarction and other ACS	√	√	√	100%

National heart failure audit	√	√	√	100%
TARN: severe trauma	√	√	√	41-64%
Renal registry: renal replacement therapy	√	√	√	100%
NHS Blood and Transplant: renal transplants	√	√	√	100%
NHS Blood and Transplant: potential donor audit	√	√	√	100%
College of Emergency Medicine: sepsis	√	√	√	100%
College of Emergency Medicine: pain management	√	√	√	100%
RCPCH national paediatric diabetes audit	√	√	√	100%
British Thoracic Society: paediatric asthma	√	√	√	100%
NHS Blood and Transplant: liver transplant	√	√	√	100%
UK carotid intervention audit	√	√	√	100%
National joint registry	√	√	√	101%
British Thoracic Society (BTS): adult asthma	√	√	√	100%
Cardiac rhythm management	√	√	√	100%
National hip fracture database	√	√	√	100%
BTS: paediatric pneumonia	√	√	√	100%
National neonatal audit	√	√	√	100%
VSGBI: vascular surgery database	√	√	√	100%
ICNARC CMPD: adult critical care	√	√	√	100%
Acute stroke (SINAP)	√	√	√	55%
National lung cancer audit	√	√	√	100%

National bowel cancer audit	√	√	√	100%
National comparative audit of blood transfusion: medical use of blood	√	√	√	100%
National comparative audit of blood transfusion: bedside transfusion	√	√	√	100%
IBD: ulcerative colitis and Crohn's disease	√	√	√	100%
National audit of heavy menstrual bleeding	√	√	√	n=68 denominator unknown
Parkinson's UK: national Parkinson's audit	√	√	√	100% in 1 out of 3 modules
ICNARC: cardiac arrest	√	√	√	100%
BTS: bronchiectasis	√	√	√	100%
BTS: pleural procedures	√	√	√	100%
BTS: emergency use of oxygen	√	√	√	100%
BTS: adult community-acquired pneumonia	√	√	x	Still open
BTS: non-invasive ventilation	√	√	√	100%
National childhood epilepsy audit (epilepsy 12)	√	√	√	100%
National pain database: chronic pain services	√	√	√	unknown
National health promotion in hospitals audit: risk factors	√	√	√	100%
National audit of seizure management	√	√	√	100%
National care of the dying in hospitals audit	√	√	√	100%
Paediatric intensive care (PICANet)	x	n/a	n/a	n/a
Congenital heart disease	x	n/a	n/a	n/a

Adult cardiac surgery	x	n/a	n/a	n/a
NHSBT: cardiothoracic transplant	x	n/a	n/a	n/a
Head & neck cancer audit	x	n/a	n/a	n/a
Oesophagogastric cancer	x	RFH patients entered by UCH		
Prescribing in mental health	x	n/a	n/a	n/a
National audit of schizophrenia	x	n/a	n/a	n/a
Total: 50	42	41	41	
CLINICAL OUTCOME REVIEW PROGRAMME (PREVIOUSLY THE CONFIDENTIAL ENQUIRIES)				
NCEPOD: cardiac arrest	√	√	√	89%
NCEPOD: bariatric surgery	eligible for organisational survey only	organisational survey only	√	n/a
NCEPOD: alcoholic liver disease	√	√	x	Not open yet
National confidential inquiry into suicides and homicides	x	x	x	-
CENTRE FOR MATERNAL AND CHILD DEATH ENQUIRIES				
Maternal death enquiry: saving mother's lives	√	x	x	n/a
Perinatal mortality (MBBRACE-UK)	√	x	x	n/a
In addition, the Royal Free Hampstead NHS Trust participated in the following national audits by submitting data in 2011/12				
Maternal and perinatal mortality notification (as substitute for the two above enquiries which did not proceed)				
National colonoscopy audit				
British Association of Urological Surgeons: nephrectomy audit				
The Royal Free Hampstead NHS Trust reviewed the results of the following national audits and confidential enquiries which published reports but did not collect data in 2011/12				
NCEPOD: paediatric surgery: are we nearly there yet? (November 2011)				
NCEPOD: perioperative care: knowing the risk (December 2011)				
College of Emergency Medicine: renal colic				
College of Emergency Medicine: feverish illness in children under five years				

College of Emergency Medicine: vital signs
National mastectomy and breast reconstruction audit (4th report)
National falls and bone health

The reports of 34 national clinical audits (published in the calendar year 2011) were reviewed by the provider in 2011/12 and the Royal Free Hampstead NHS Trust intends to take the following actions to improve the quality of healthcare provided.

- Review and improve arrangements to capture specific data fields which allow risk-adjustment for mortality in national clinical audits.
- Introduce shared multidisciplinary team meetings between colorectal cancer and hepatobiliary cancer teams to review treatment options for patients with colorectal cancer that has spread to the liver.
- Undertake independent mortality case reviews for patients who died following colorectal cancer surgery.
- Extend the enhanced recovery programme.
- Introduce a discharge checklist and discharge asthma management plan for children with asthma admitted as an emergency.
- Take part in regional workshops on care of the dying.
- Define the Liverpool care pathway role within the palliative care team.
- Work with A&E departments in neighbouring trusts to ensure rapid transfer of patients suitable for acute primary coronary angioplasty.
- Extend the acute primary angioplasty service to patients suffering from a different form of heart attack (non-STEMI).
- Introduce a dedicated respiratory team with consultant input to guide use of non-invasive ventilation therapy in patients presenting to acute services.
- Introduce multidisciplinary team discussions (including the intensive care team) to discuss the provision of more invasive forms of respiratory support for patients in whom non-invasive ventilation proves insufficient.
- Introduce arrangements to give oxygen alert cards to patients identified at risk of hypercapnic respiratory failure, alerting future emergency responders of the precautions required when administering oxygen to these patients.
- Expand use of checklists and condition-specific documentation to reduce variations in care (eg care after death).
- Further staff training (eg non-invasive ventilation, care of the dying).

The 25 national clinical audits reviewed by the Royal Free Hampstead NHS Trust in 2011/12 were:

National comparative blood transfusion audit: transfusion practice 2011
National bowel cancer audit 2011
National lung cancer audit 2011
National care of the dying (round three)
National (adult) diabetes audit 2009-10 (June 2011)
National (paediatric) diabetes audit 2009-10 (July 2011)
Trauma audit & research network (2011)
College of Emergency Medicine: vital signs (April 2011)
College of Emergency Medicine: feverish Illness in children under five
College of Emergency Medicine: renal colic
Myocardial infarction national audit project 2010 (Sep 2011)
National angioplasty audit 2010 (Sep 2011)
National audit of cardiac rhythm management
Paediatric asthma (British Thoracic Society) 2011
Adult asthma (British Thoracic Society) 2011
Non-invasive ventilation (British Thoracic Society) 2011
Emergency use of oxygen (British Thoracic Society) 2011
National falls and bone health audit (May 2011)
Paediatric pneumonia (British Thoracic Society) (Sep 2011)
National neonatal intensive care audit
National potential donor audit
UK carotid endarterectomy audit (round three)
National hip fracture database
National mastectomy and breast reconstruction Audit (4th report)
National audit of seizure management in hospitals

The reports of 70 local clinical audits were reviewed by the provider in 2011/12 and the Royal Free Hampstead NHS Trust intends to take the following actions to improve the quality of healthcare provided.

- Review compliance with venous thromboembolism prevention guidelines, in areas where cases occur, through root cause analysis of all cases.
- Consider the attendance of a learning difficulties facilitator at the audiology clinic.

- Improve arrangements for obtaining full medical history prior to hearing clinic visits for adults with learning difficulties.
- Reduce the waiting list for hearing clinics for adults with learning difficulties.
- Restrict the number of different presenters at trial patient education sessions on cochlear implantation.
- Reduce the time from receipt to action of Ear Nose and Throat (ENT) Choose and Book referrals.
- Re-order operating lists to facilitate same-day discharge of major ENT cases.
- Monitor the potential unmet need for children's speech and language therapy services.
- Empower the ward clerk on the hepatology ward to clarify follow-up arrangements.
- Consider using the patient database to prompt dose calculations by body weight for patients requiring immunoglobulin replacement therapy.
- Increase the provision of clinical nurse specialists in the haematuria clinic.
- Establish nurse-led follow-up clinics for cystoscopy and bladder cancer.
- Assess the need among bladder cancer patients for enhanced information about complementary therapies.
- Increase the availability of hand gel in theatres.
- Add pregnancy status to our World Health Organisation (WHO) safe surgery checklist.
- Identify a team member responsible for completing each of the three stages of the WHO safe surgery checklist.
- Update the perioperative care plan, incorporating the WHO safe surgery checklist and pregnancy status.
- Include information about designated storage locations of anaesthetic emergency equipment in anaesthetic trainee induction pack.
- Increase recycling facilities in operating theatres.
- Improve compliance with routine assessment prior to commencing alitretinoin treatment, and with guidance on cessation.
- Pilot a nurse-led diabetic retinopathy clinic.
- Introduce multidisciplinary pressure ulcer risk assessments in orthopaedic patients.
- Consider a trial of home therapy for certain ankle fracture patients.

- Review the nutrition screening tool to prompt use of ward-level nutrition support pathway.
- Introduce end-tidal carbon dioxide monitoring for patients in intensive care who require transfer within the hospital.
- Consider the use of intermittent haemodialysis for selected stable patients on intensive care.
- Ensure the cellulitis pathway is used for patients referred directly to medical teams.
- Develop readmissions avoidance measures within the Triage, Rapid Elderly Assessment Team (TREAT) service.
- Consider the development of a rapid access falls assessment service.
- Develop community nurse and geriatrician roles.
- Expand the TREAT service to seven days with extended hours.
- Encourage referrals to the Post Acute Care Enablement (PACE) service from additional in-patient specialties.
- Introduce medicines passports in appropriate areas (eg health services for elderly people).
- Provide information on induction of labour for expectant mothers.
- Consider routine use of episiotomy for instrumental vaginal delivery.
- Develop a dedicated clinic for perineal injuries following childbirth.
- Undertake further staff training in:
    1. venous thromboembolism prevention, where completion of patient risk assessments is below target
    2. psychological support for bladder cancer patients
    3. prevention of pulmonary aspiration syndrome during Caesarean delivery
    4. high blood pressure in pregnancy
    5. immediate management of compartment syndrome in orthopaedics
    6. ward-level nutrition support pathway
    7. conditions requiring consultant-only discharge from A&E
    8. CT SPECT imaging and CT colonoscopy
    9. Safe use of intravenous radiology contrast media for patients with renal impairment
    10. Safe practice on gonadal shielding for X-ray procedures.
- Review our care pathways/guidelines for a number of conditions and diagnostic interventions:

1. venous thromboembolism, where cases cluster despite compliance with current guidelines
2. trans-rectal ultrasound-guided prostate biopsies
3. pain relief in children
4. high blood pressure in pregnancy
5. preoperative anaemia in patients for major joint replacement
6. specialist nuclear medicine ('MUGA') scanning.

- Expand the use of checklists and condition-specific documentation to reduce variations in care relating to:
    1. anticoagulation following liver transplantation
    2. medical discharge planning and follow-up arrangements (eg hepatology)
    3. triage of referrals to ENT urgent referral clinic
    4. preventative measures against pulmonary aspiration during Caesarean delivery
    5. induction of labour
    6. perineal injury following childbirth
    7. intensive care transfers within the hospital
    8. transient loss of consciousness presenting to A&E.

ADDITIONAL INFORMATION

The trust did not participate in this year's national diabetes audit as the data held on our current database is of poor quality. A new information system has been agreed and the trust intends to submit data to the next audit round.

Results of local clinical audits are reviewed in detail within the directorates. A summary of actions reported from local clinical audits was reviewed at the trust board at its April meeting.

STATEMENT 3: PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided or sub-contracted by the Royal Free Hampstead NHS Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 6,654.

ADDITIONAL INFORMATION

The above figure includes 4,071 patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and 2,583 patients recruited into studies that are not on the NIHR portfolio. Recruitment data for non-portfolio studies has been captured and this has enabled more comprehensive reporting this year.

Since 2009/10 the number of patients receiving NHS services provided or sub-contracted by the Royal Free Hampstead NHS Trust has increased substantially. The figures reported for 2011/12 are more than double those reported for 2010/11. This increase is likely to be due to the work to capture such information, as well as the expansion of the research portfolio at the Royal Free. A target for 2012/13 will be to further improve the capturing of data around recruitment into non-portfolio studies, as the current non-portfolio recruitment data reflects a 61% response rate.

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

STATEMENT 4: USE OF CQUIN PAYMENT FRAMEWORK

A proportion of the Royal Free Hampstead NHS Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free Hampstead NHS Trust and any person or NHS North Central London Commissioning Agency with whom we entered into a contract, agreement or arrangement with through the commissioning for quality and innovation payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically by emailing **rfquality@nhs.net**

ADDITIONAL INFORMATION

Our commissioning for quality and innovation (CQUIN) payment framework for 2011/12 was agreed with North Central London Acute Commissioning Agency as follows:

VTE assessment and prophylaxis
Improving patient experience
Enhanced recovery programme
Care closer to home
Safe care - pressure ulcers
Discharge planning
Consultant assessment in 12 hours
Long-term conditions

STATEMENT 5: STATEMENTS FROM THE CQC

The Royal Free Hampstead 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 Royal Free Hampstead NHS Trust as of 31 March 2012.

The Royal Free Hampstead NHS Trust has participated in special reviews or investigations by the CQC relating to the following areas between 1 April 2011 and 31 March 2012:

The joint Ofsted and CQC inspection for safeguarding in health and social care for the London Borough of Camden, February 2012 and;

The CQC national inspection programme for termination of pregnancy (clinical services reviews) relating to the Abortion Act 1967 during March 2012.

The trust is awaiting the outcome results of both the inspection programmes.

Additional information

On 15 March 2011 the trust was subject to an unplanned inspection by the CQC in relation to outcome one (respecting and involving people who use services) and outcome five (meeting nutritional needs). The CQC reported moderate concerns in relation to both outcomes resulting in compliance

notices being issued. Improvement work was undertaken overseen by our risk, governance and regulation committee, which provided monthly progress reports to the trust board.

The trust declared itself compliant with both standards on 14 July 2012. A further unannounced CQC inspection on 19 July 2012 confirmed that the trust was compliant with both standards.

STATEMENT 6: DATA QUALITY

The Royal Free Hampstead NHS Trust submitted records during 2011/12 to the secondary uses service 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:

- 99.20% for admitted patient care
- 99.27% for out patient care
- 95.57% 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 7: INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

The Royal Free Hampstead NHS Trust information governance assessment report score overall score for 2011/12 was 70% and was graded green.

STATEMENT 8: CLINICAL CODING ERROR RATE

The Royal Free Hampstead 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:

Primary procedures coded incorrectly – 11.5 %
Secondary procedures coded incorrectly – 9.6 %
Primary diagnoses coded incorrectly – 15.5 %
Secondary diagnoses coded incorrectly – 12.0 %
NB please note the above figures may change

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 and not that there was an error.

PART 3

REVIEW OF QUALITY PERFORMANCE DURING 2011/12

During 2011/12 the Royal Free once again provided high quality clinical services.

In this part of our quality accounts we review our performance against our key quality priorities for 2011/12 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 2010/11 quality accounts, we set three key quality improvement objectives. These were:

Priority 1: Improve our out-patient phlebotomy service

Priority 2: Develop specific clinical outcome measures for all our services

Priority 3: Reduce patient falls

Here is how we performed against these objectives:

Priority 1: Patient experience - improve our out-patient phlebotomy service

During the last financial year, the trust has focused on developing a better phlebotomy service for our out-patients. The improvement process was driven by reports from several groups, who highlighted the need for an overall improvement to processes and the environment. As a result of this feedback, and a thorough internal review of the service, recommendations were made and a series of significant improvements were implemented. These included:

Service improvements:

- A new staff rota was introduced and the phlebotomy service is now open from 7.30am to 5.30pm Monday to Friday. All vacant posts have now been appointed to and all staff have now been trained in cannulation.
- A Saturday phlebotomy service was launched on 3 September 2011.It is open from 9am to 1pm.
- 91% of phlebotomy and cannulation staff have now completed customer service training. Continuous monitoring of staff is undertaken to ensure a high quality service is delivered.
- The patient survey carried out in October and November 2011 showed that the main problem was that 39% of patients were waiting 10 minutes or more. A second survey was undertaken in March 2012 which showed an improvement, with only 9% of patients waiting for 10 minutes or more10 minutes or less.
- An upgrade of IT equipment was undertaken on 28 October 2011 to manage the operational and audit requirements in the new unit. Weekly reports are provided that highlight any operational issues. The new blood test room opened on 23 January 2012.

Operational improvements:

- Lean processes of delivering the service have been introduced, which have ensured that waiting time targets are routinely being met.
- The cannulation team has integrated with the phlebotomy team. Having both teams co-located in the facility on the ground floor means that when there is less work on the wards, both teams can do out-patient work.

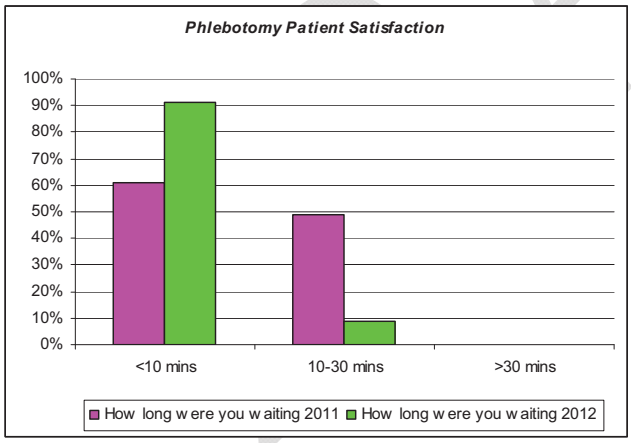
- On a daily basis, two to three phlebotomists work on the renal unit. This results in significant numbers of patients not having to attend the ground floor unit. Not only does this assist with the efficient throughput of other out-patients, but also provides the renal patients with a high quality service and all patients with high levels of satisfaction.

Our target by April 2012 was to ensure:

50% of patients to be seen within 10 minutes
80% of patients to be seen within 30 minutes
100% of patients to be seen within an hour

The audited performance against these targets is as follows

	50% of patients seen within 10 minutes	80% of patients seen within 30 minutes	100% of patients seen within 60 minutes
Old unit	55%	87%	98%
New unit	83%	98%	100%



Priority 2: Clinical effectiveness - develop specific clinical outcome measures for all our services

As reported in last year's quality accounts, we have asked each of our 27 clinical units (specialties) to specify three metrics (measurements) that would provide us with information about clinical performance. We requested that these should ideally:

- be measures of clinical outcome rather than clinical processes
- be measures that can allow comparison with other hospitals
- be measured monthly, quarterly or annually
- include an improvement metric focused on an area in which we need to do better

In addition, we developed nine trust-wide corporate metrics, three in clinical service, three in research and innovation and three in education and training. This reflects our mission to deliver world-class performance in each of these three areas.

In last year's quality accounts we said we would continue to develop our clinical outcome metrics, aiming to make them publically available. We have once again made excellent progress and a list of all the metrics is provided in appendix 1 of these quality accounts.

We will release the full set of metrics in detail in June 2012 to coincide with the publication of our 2011/12 quality accounts. The metrics can be accessed online at **www.royalfree.nhs.uk/outcomes**

NB (this is the preliminary website address. This will be confirmed in the final version of the quality accounts)

Priority 3: Patient safety – reduce patient falls

This year we made the reduction of patient falls our priority in the area of patient safety.

Our target is a 50% reduction in both the overall number of falls and falls that result in harm by April 2012.

During the financial year 2011/12, we developed a falls reduction programme to consolidate work which had already been undertaken. The programme brings together previously independent silos of work to form a comprehensive framework for addressing falls.

Work has focused on the key issues that are relevant to all areas, including improved post-incident review; real-time learning and reporting; improved

safety briefing and handover communication at ward level; reduced variance in staff education; and the development of reliable and useful falls care plan documentation.

Pivotal developments have been the establishment of local ward-based 'falls champions,' who are supported by a bi-monthly training forum. Their role is to support staff in falls prevention by being a training resource and expert in the trust's policies. They also oversee investigations where falls have occurred to identify local learning to prevent reoccurrence. A newly-developed falls page on the staff intranet, Freenet, is also a useful resource, with patient leaflets and tools, templates and guidance for staff.

As part of the falls prevention work we have introduced a post fall review form, and stocks of slippers for patients to use to minimise the risk of slipping while moving around the ward. We have introduced guidance for staff on when a patient requires one-to-one nursing care to minimise the risk of falls and mechanical devices (audible alarms / hip protectors) for high-risk patients to wear. All of these measures have been piloted on wards to ensure their effectiveness before being rolled out across the trust.

Further work is being undertaken to develop a fracture liaison service in collaboration with NHS North Central London (NCL) and increase access to the Royal Free falls clinic. In addition, we are currently developing a physiotherapist-led initial assessment to help patients who have suffered a fracture and are at high risk of further falls in order to avoid future harm and hospital admissions.

NB. Falls data chart to be inserted once March data is completed

FOCUS ON QUALITY AND IMPROVEMENT

Our mission to provide world class care and expertise reflects our desire to always provide the highest quality service to our patients. As a campus of UCL Medical School and founding member of UCLPartners, we conduct important research and train the healthcare professionals of tomorrow. Here are some examples of how we have continually improved the quality of service we provide over the past year.

A guide to quality at the Royal Free

As part of our recent foundation trust application, we undertook an extensive review of our quality governance. This included an assessment of how we performed against the quality governance framework used by Monitor, the independent regulator of foundation trusts. This subdivides quality governance into four main domains: strategy; cultures and capabilities; processes and structures; and metrics.

Based on this assessment and a resulting quality governance memorandum prepared for the trust board, we produced a guide to quality at the Royal Free. This describes how the trust ensures the provision of high quality services for its patients. It describes what quality means for the trust, and how the trust sets a culture of quality and high standards throughout the organisation.

Our quality guide describes the context in which we develop and manage the quality initiatives we describe each year in our quality accounts. We have therefore included the full text of the guide in appendix two.

Improving diagnosis and treatment of heart failure

Heart failure is common. It affects 1% of people in the UK and has a poorer prognosis than many cancers.

However, we know that patients who are referred to specialist heart failure services live longer and are less likely to be readmitted to hospital than those who are not.

In August 2010, the Royal Free was selected by the NHS improvement programme to pilot an in-patient heart failure service for patients admitted to our medical assessment unit ((MAU) which admits patients with a medical problem from A&E).

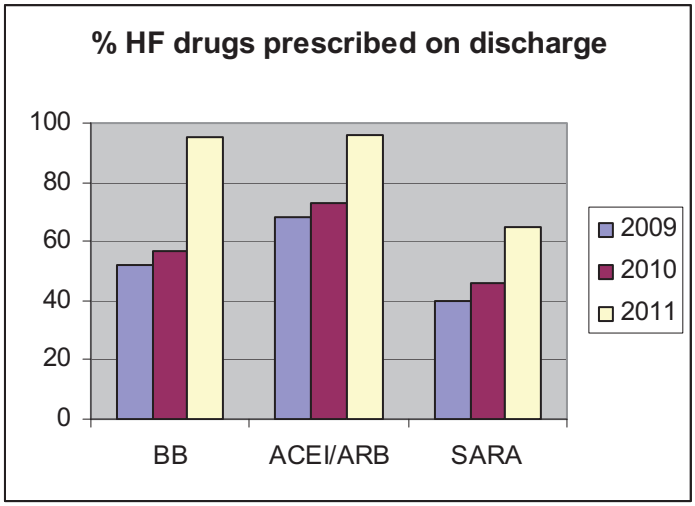
This means that all patients who are admitted to MAU suffering from breathlessness and a raised NT-proBNP (a marker of heart failure) receive a definitive diagnostic test (an echocardiogram) within 24 hours of referral. Previously, this test may have been done as an out-patient after the patient had been discharged.

Dr Carol Whelan, consultant cardiologist and clinical lead for heart failure said: “During 2011-2012, this has brought significant benefits to our patients. Before the pilot, 66% of heart failure patients received an in-patient echocardiogram prior to discharge compared to 100% now. This means patients are being diagnosed earlier and are therefore able to start the correct medication and treatment at an earlier stage, which in turn has had a positive impact on their prognosis and quality of life.”

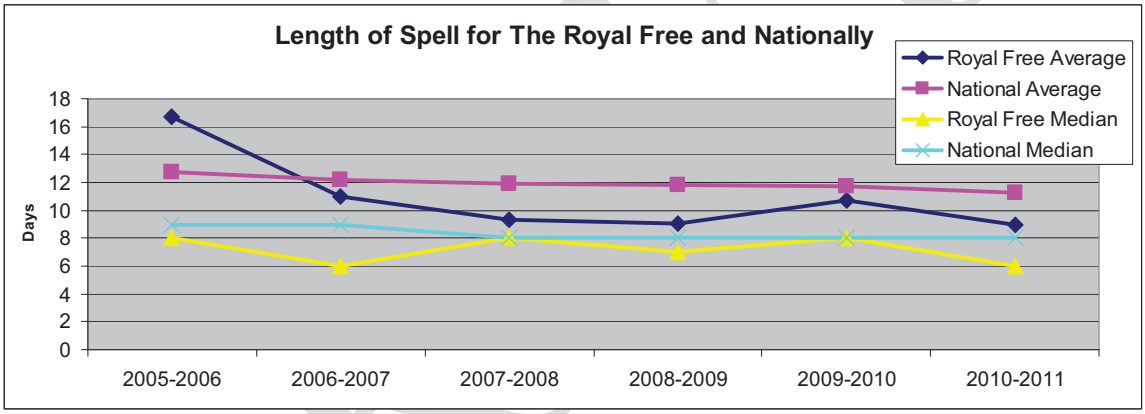
After a diagnosis of heart failure is confirmed, the patient is reviewed by the specialist heart failure team who prescribe the required medication and consider whether advanced treatments such as biventricular pacemakers or implantable cardiac defibrillators are needed. Patients are also invited to a dedicated heart failure clinic following discharge to follow-up on their progress. This approach has led to a reduction in the length of stay and a vast improvement in the percentage of patients receiving appropriate heart failure treatment.

The trust is now looking to provide dedicated heart failure clinics in the community to deliver specialist care closer to home.

The below graphs show how the pilot has improved patient outcomes in terms of the percentage of patients being prescribed heart failure medication on discharge and length of stay.



BB = betablocker
ACEI = angiotensin converting enzyme
ARB = angiotensin receptor blocker
SARA = selective aldosterone receptor antagonist



Improving waiting times for cancer patients

In order to improve outcomes for people diagnosed with cancer, the NHS has set all hospitals providing cancer services eight standards. These relate to timeliness of being seen, diagnosed, treated and receiving subsequent treatments.

The Royal Free has consistently achieved these standards. However, during August and October 2011, the trust failed two standards and was just meeting the target for a third. These were:

- All cancer patients to wait no more than 62 days from urgent GP referral to treatment

- All cancer patients to wait no more than 62 days for treatment following a referral from a screening service
- All cancer patients to wait no more than 31 days from diagnosis to first treatment

The trust board was very concerned about the quality of clinical care being provided and as a result a full review was undertaken. The review examined patient pathways to ensure that early appointments and high quality clinical care were being provided at every stage during the process.

Following the review, immediate action was taken. The trust now ensures that managers and clinicians working in cancer services are provided with detailed information identifying precisely where in the treatment pathway each patient is and how much time has elapsed in relation to each cancer standard.

When bottlenecks are identified, a clear policy sets out three levels of escalation to resolve the issue. The aim is for managers working with their clinical colleagues to intervene, resolve the bottleneck and ensure patients are provided with the care they need in accordance with the eight cancer standards. The highest level of escalation is to a member of the trust board.

As a result of these changes, the trust has achieved compliance with all eight cancer standards every month since October 2011.

NB. Three performance graphs to be inserted when they are available in May – to be obtained from Tony Ewart.

Award-winning diabetes initiative

An award-winning initiative is helping patients with diabetes at the Royal Free to receive safer care.

Our in-patient diabetes team has been providing tools and training to staff across the trust to improve the treatment of hypoglycaemia (a condition that occurs in patients who have diabetes when blood sugar levels are dangerously low) by standardising the prescription of intravenous insulin.

The initiative also aimed to reduce the rates of hypoglycaemia in the hospital by raising awareness of the condition and the importance of referring patients to the specialist diabetes team.

Ruth Miller, clinical lead and lead nurse for diabetes, explained: “We wanted to make sure that all our clinical staff were up to date with their knowledge of prescribing intravenous insulin and of best practice when treating patients with hypoglycaemia. We also needed to raise awareness of hypoglycaemia in general, as it was sometimes seen as an acceptable norm for patients with diabetes to experience this in hospital.

“We developed a number of training tools, which we piloted on five wards between 2008 and 2011. In late 2011, we rolled these out to the whole trust together with a training programme to more than 1,200 staff.”

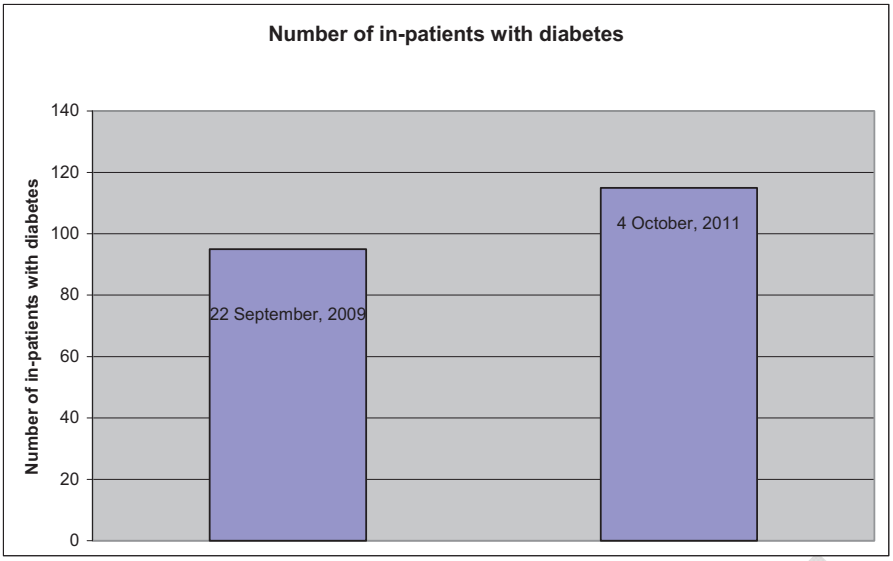
The tools include an insulin sliding scale procedure pack, which provides staff with all the information and tools they need to prescribe intravenous insulin appropriately, a new diabetes management chart (kept at the bedside of all patients with diabetes) and an algorithm to help standardise the treatment of hypoglycaemia.

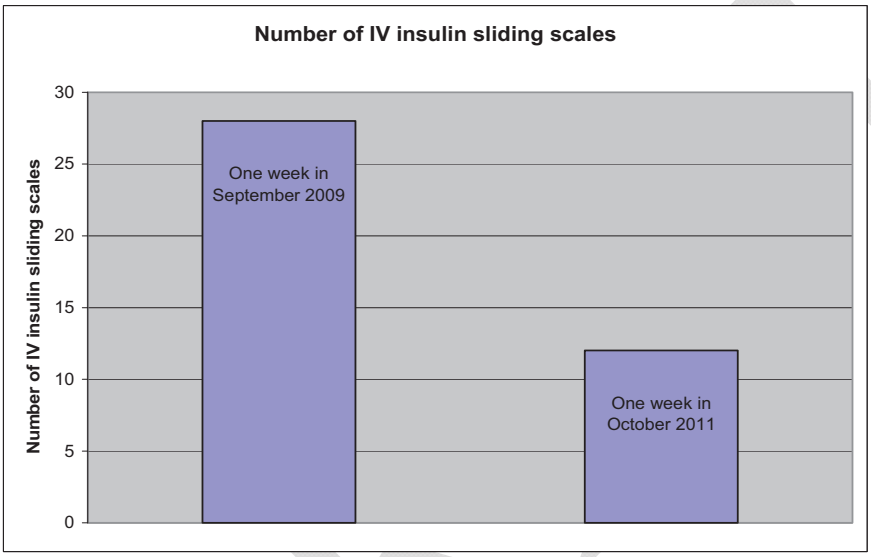
These have all had a positive impact on patient care. Data from the national in-patient audit has found that while the prevalence of in-patients with diabetes at the Royal Free increased by 17% from 2009-2011, rates of hypoglycaemia fell by 70%.

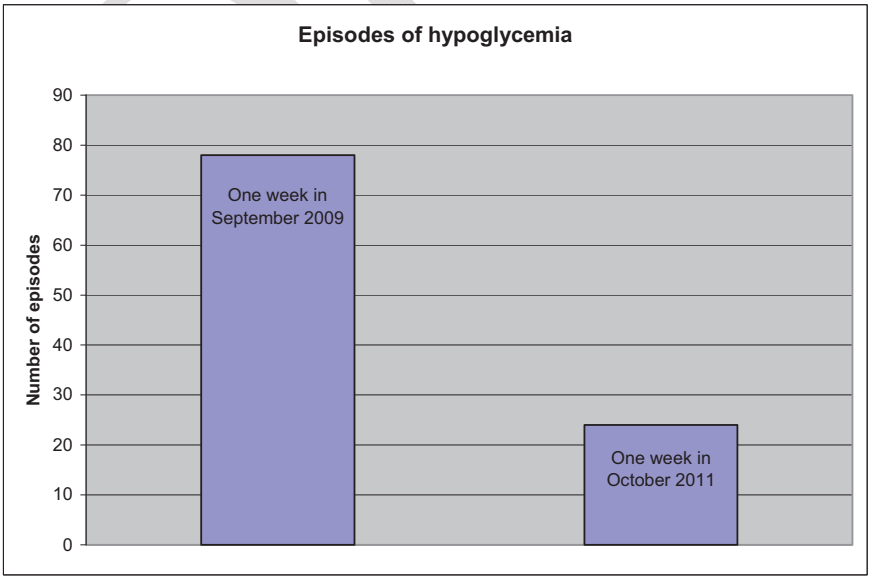
Meanwhile, trust-wide use of intravenous insulin fell by 58% during the same period, suggesting that clinicians are using the tools and are more questioning of its necessity, resulting in more appropriate prescribing.

The initiative’s success earned it an ‘improving services through training and development’ award at the Lean Healthcare Academy Awards in January, 2012. The initiative was also a finalist in the ‘best emergency/in-patient care initiative’ category in the Quality in Care Awards 2011.

The following graphs show the results of the national diabetes in-patient audit in 2011, compared with the results in 2009. The 2011 audit was conducted in October and the 2009 audit was conducted in September.


Number of in-patients with diabetes
Number of in-patients with diabetes
140
120
100
80
60
40
20
0
22 September, 2009
4 October, 2011


Number of IV insulin sliding scales
Number of IV insulin sliding scales
30
25
20
15
10
5
0
One week in September 2009
One week in October 2011


Episodes of hypoglycemia
Number of episodes
90
80
70
60
50
40
30
20
10
0
One week in September 2009
One week in October 2011

Ground-breaking haemophilia research

In 2011, the Royal Free and University College London (UCL) broke new ground with the trial of a new gene therapy for patients with haemophilia B.

Haemophilia B is bleeding disorder caused by a mutation in the gene which makes a protein called factor IX (9), which is essential for normal blood clotting. Patients with haemophilia B therefore bleed for a longer time than usual and may suffer from internal bleeding, usually around the joints and muscles, which can cause pain and stiffness and damage the joints over time.

There is no cure for haemophilia. However, treatment is available which involves injecting a genetically engineered clotting factor into the veins two to four times a week. In recent years, researchers have been investigating the concept of replacing the missing IX gene (gene therapy) as the ultimate treatment of patients

Over the past two years, researchers have been trialling a new gene therapy at the Royal Free's Katharine Dormandy Haemophilia Centre, with very promising results.

In the trial, six patients with severe Haemophilia B were given varying doses of a gene therapy designed to deliver a normal factor IX gene to their livers. Previous attempts to achieve this in the past 10 years failed but the latest attempt was the first successful trial, with all of the patients who volunteered for the study seeing benefits. At every dose level of treatment the blood level of factor IX rose from undetectable (which is associated with a severe bleeding tendency) to a level from 2% to 8% of normal. This converted the patients' condition from a severe to a moderate or mild bleeding tendency. In some instances, patients have had a sustained response for more than a year.

The trial is continuing with the aim of establishing a safe and effective dose to develop a gene therapy drug.

World class care - improving the patient experience

Compliments show that the Royal Free provides good quality care to its patients much of the time, and this is supported by its excellent clinical care and reputation for safety. Yet other patients' feedback, complaints and results from the national patient survey, show that there is still a significant opportunity to improve the quality of care for the people we serve.

During 2011- 2012 we embarked upon our world class care programme, which is designed to support our staff to provide a consistent culture of compassion, quality and personal responsibility and to deliver world class care to our patients every day.

As part of the programme, we have held "in your shoes" events to engage staff and patients and listen to their ideas. At the events, staff listened to patients' experiences and identified best practice and priorities for improvement. They used this knowledge and experience to formulate their own vision and their own standards of care to work alongside local service standards. The overall objective is to give every team the shared direction, energy, skills and support they need to deliver the consistently high-quality experience that they want for their patients.

The standards developed to deliver world class care consistently are:

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

The trust will provide the support needed to make our patients and staff's vision of world class care a reality.

Deborah Sanders, director of nursing, said: "We will integrate these standards of care at every stage, from recruitment and induction to appraisal and performance management, so that everyone has a shared direction.

"We are committed to continually building on these standards and have developed a cascade approach so that all staff can set their own local standards and expectations from listening to what their patients want and need."

Patients who attended sessions to help develop our standards said:

"I felt like the hospital was really taking me seriously by inviting me today"

"I felt relieved to be able to talk about my experience at the hospital, I didn't want to complain but I did want someone to know how I felt"

"Staff were so welcoming; it felt very easy to talk about my care"

"I didn't want to offend anyone, but found it easy to talk frankly about the things that had worried me"

Staff engaged in the sessions said:

"*I think attitude and cultural challenges (empathy, communication, safety) could be improved if there was a trust vision to 'be the best''*

"I found it hard to listen to bad stories; I want to be proud of where I work"

"I was amazed by how different two people's journeys had been"

"I hadn't thought about what patients felt about their care, just about whether they got better, that nothing bad happened"

"It was good to hear so much positive stuff from patients. I was worried this would all be about what we do wrong"

Quality, innovation, productivity, prevention (QIPP)

We aim to provide high quality healthcare that provides value for taxpayers' money.

One of the ways we achieve this is through the quality, innovation, productivity, prevention (QIPP) programme. The programme enables us to:

- increase quality of clinical outcomes, patient safety and patient experience
- improve services by encouraging people to think creatively and work differently
- emphasise the need to make the most of the resources we have in terms of time, people and money

- keep people as healthy and well as possible to avoid unplanned admissions.

As part of our QIPP programme, in 2011/12 we implemented a new fast-track pathway for patients with hip fractures. The new protocol means that the radiology and trauma wards are contacted as soon as a patient with a suspected hip fracture arrives in A&E so that they know a patient is on the way and they can make the necessary preparations. After a hip fracture is confirmed by an initial assessment in A&E and X-ray, patients who are medically stable are then fast-tracked to the trauma ward for an orthopaedic or orthogeriatric assessment, instead of remaining in A&E.

The initiative reduced the length of time patients with hip fractures are in the A&E department and speeded up their transfer to the trauma ward. The ward is a much more suitable environment for patients with hip fractures who are medically stable as it allows them to spend less time on a trolley and be transferred to a bed fitted with a pressure-relieving mattress.

The PACE service and TREAT, described in more detail below, are also part of the QIPP programme and are having a positive impact on patients' length of stay in hospital.

With all our QIPP initiatives we ensure quality is maintained by conducting a full impact, risk and quality assessment, which are signed off by the medical director and director of nursing. A series of quality metrics are monitored each month and assurance is sought from the clinical performance committee.

Right care, right place, right time

We have been working hard to ensure that we deliver the right care at the right place and at the right time.

An example of how we are delivering this is through our post acute care enablement (PACE) service and triage rapid elderly assessment team (TREAT).

The PACE service, run in partnership with NHS community services and social care in Camden and Barnet, helps patients who are well enough to

receive the care they need at home rather than in hospital by ensuring that the right support is in place.

Specialist “case finders” work with consultants to identify in-patients who no longer need round-the-clock medical care. They then design a bespoke package of care to be provided in the community so the patients can continue their recovery at home, while still being under the supervision of a hospital consultant.

Fran Gertler, integrated care lead, explained: “Patients benefit from being able to receive care at home, once their medical condition has been stabilised. Patients tend to recover better when they’re in their own familiar environment. Over the past 12 months, over 1,100 patients have been able to benefit from the PACE service which has reduced length of stay across care of the elderly patients by an average of 1.9 days.”

In a similar vein, TREAT aims to help elderly people avoid a hospital stay by providing specialist assessments in the A&E department. The team, who are specialists in elderly care medicine, thoroughly assess elderly patients who have come to A&E, identifying those who are well enough to be discharged and ensuring that support is put in place so that they can receive the care they require at home.

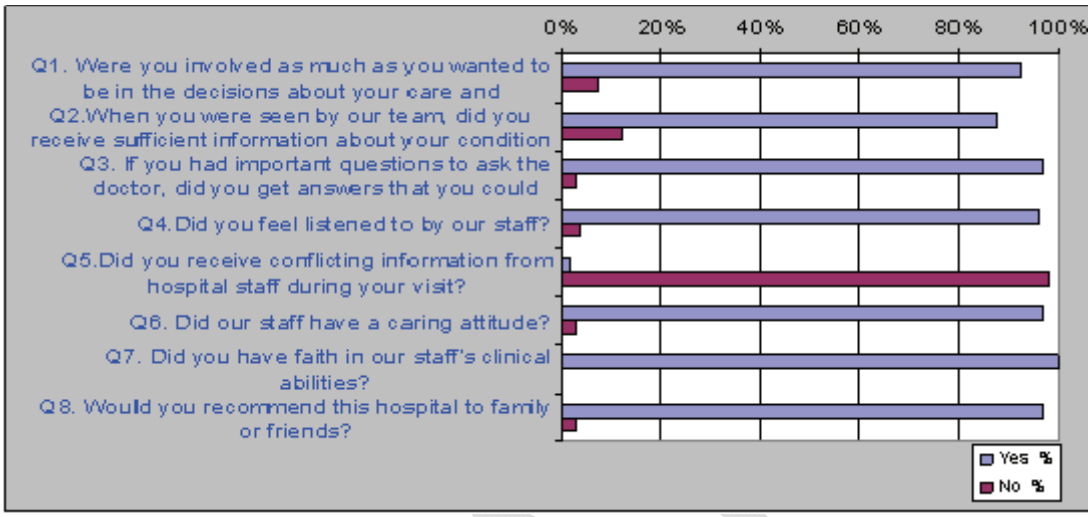
After assessing the patient, TREAT can organise investigations and support on the same day, such as X-rays, CT scans and occupational therapy, and put in place the relevant community healthcare and social services support if required. A “hot clinic” is also available post discharge for patients who need further assessment.

Over the past year, TREAT has undertaken nearly 2,000 consultations either in A&E or via the hot clinics. TREAT accepted 36% of the patients they triaged in A&E and as a result, 82% of these patients were discharged. Before the introduction of the team, almost all of these patients would have been admitted to hospital. The service has also reduced readmissions to hospital.

TREAT has now expanded its hours of operation to ensure that there is consultant cover seven days a week. Community nurses work with care homes to provide training and support for staff to help reduce hospital

attendances and a hot clinic is available for GPs to refer frail patients who are at risk of an imminent hospital attendance.

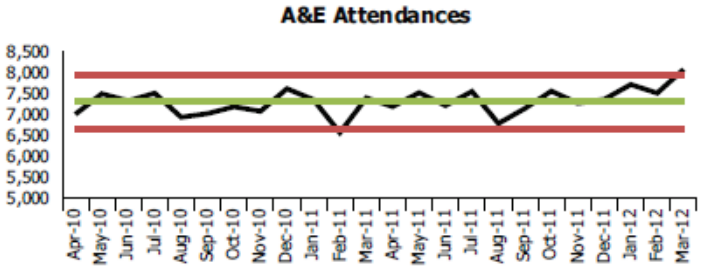
Between April 2011 and March 2012, patients who were successfully discharged from the Royal Free without being admitted were asked to take part in a phone questionnaire to find out what they thought of the TREAT service. The response was extremely positive, as shown in the graph below.



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 performance 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. Performance against each indicator is generally shown as a Statistical Process Control (SPC) chart, please see example below:

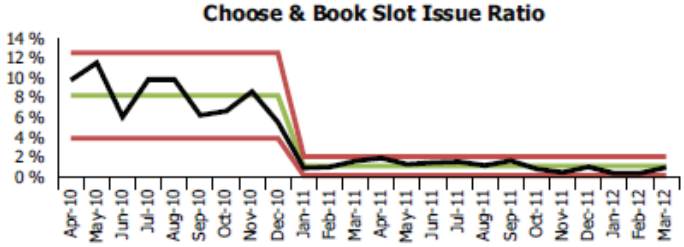


The purpose of these charts is to provide a simple view of performance over time, as well as an indication of whether any variation in performance is statistically important or not.

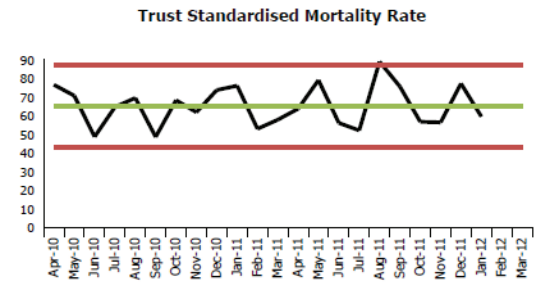
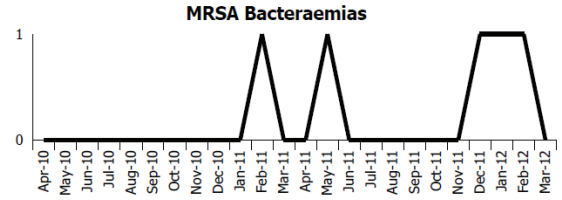
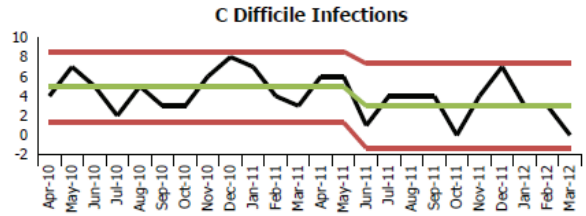
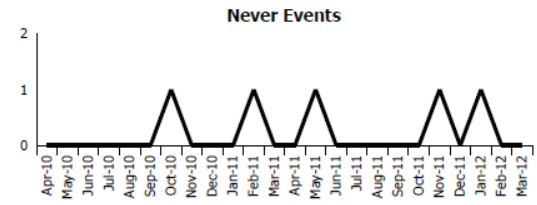
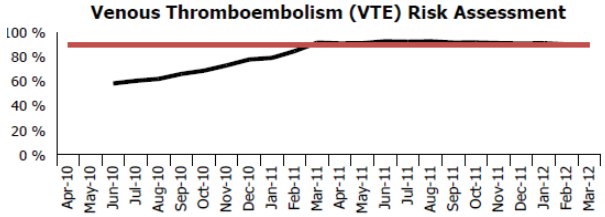
Each chart consists of four elements:

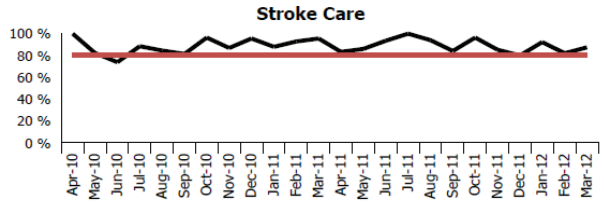
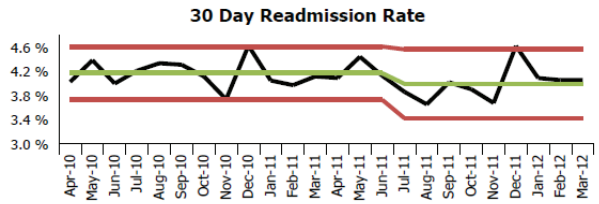
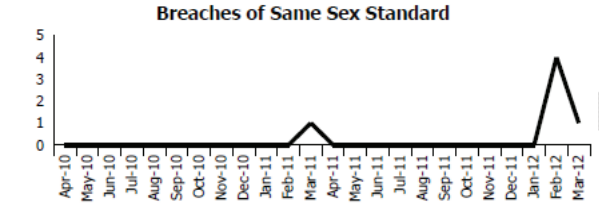
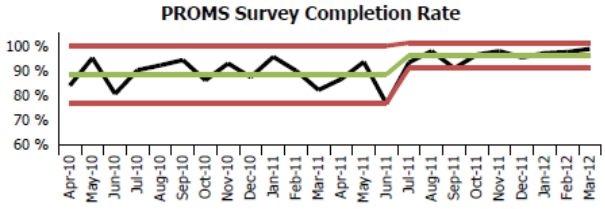
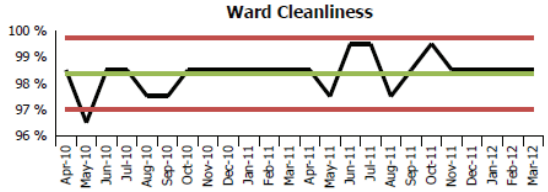
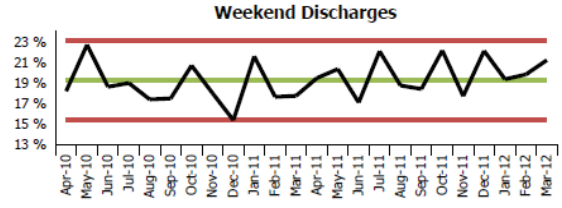
- the run chart for the indicator, showing performance by month over the last 24 months (Black Line)
- average (mean) performance during the period (Green Line)
- Upper and Lower Control Limits (UCL and LCL), which set out the expected range of variation for performance (2 standard deviations either side of the mean). Performance beyond these limits suggests a level of variation that has a probability of less than 2.5%.

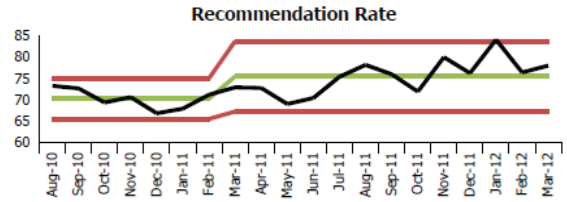
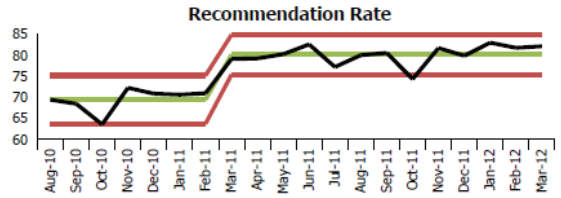
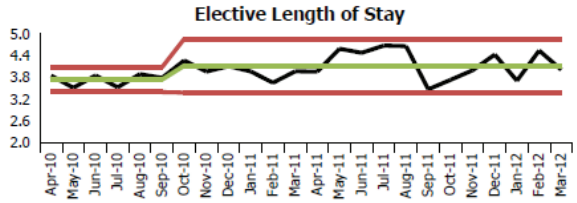
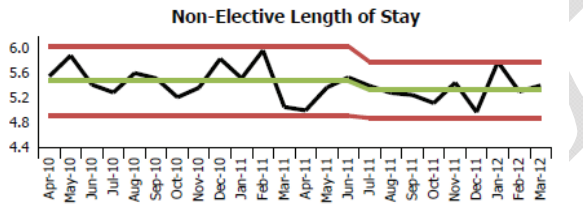
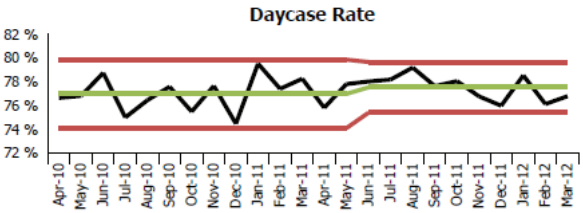
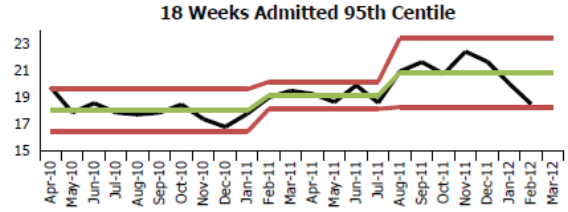
We also produce step change charts, a step change has been defined as 5 or more data points above or below the mean, or in the same direction (up or down), please see an example of the type of chart below:

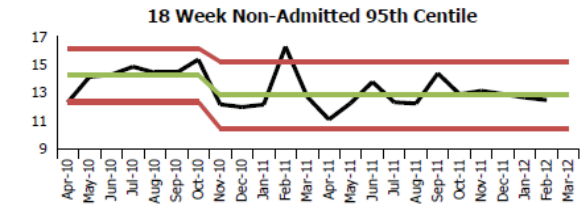
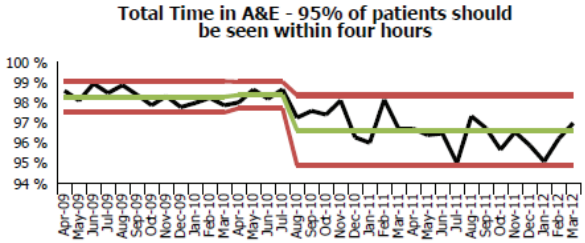
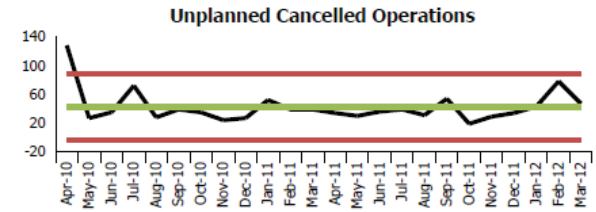
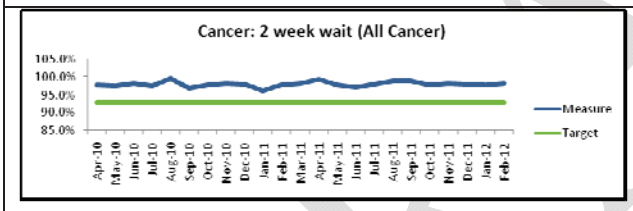
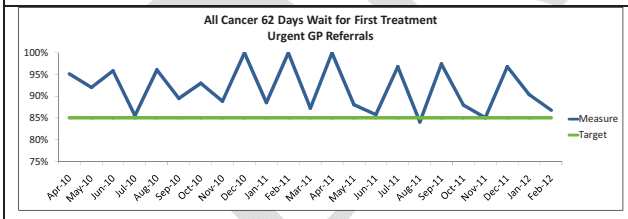


The data included is the most current available to March 31st 2012 apart from 18-weeks referral to treatment and cancer targets which is up to 29 February 2012.

Indicator	Commentary
	The hospital standardised mortality rate is a widely used measure which compares the expected death rate in hospitals with the observed rate. A lower rate is better. Over the course of the last 10 years the Royal Free is the best performing trust in England with a relative risk of in-hospital mortality 25% below that expected. Between April to December 2011 the mortality risk at the Royal Free was 74.6 (25% below expected); resulting in the trust having the 4th lowest relative risk of mortality out of 147 acute trusts.
	Low rates of acquired MRSA bacteraemias reflect good infection control. The trust recorded 4 cases in 2011/12. Whilst this was three more than last year and 1 more than our annual trajectory we did end the year by recording zero infections in March 2012.
	Low rates of C difficile infection also reflect good infection control. The Trust was set a maximum ceiling of 42 infections for the year which we achieved, ending the year with exactly 42 attributable infections, a reduction of 14 compared to the previous year. We ended the year recording zero infections in March 2012.
	Never events are a category of serious incident which the National Patient Safety Agency is particular focussed on preventing. 3 never events occurred within the Trust in 2011/12: ▪ Inappropriate administration of Methotrexate. ▪ Retained silicone template following cochlear implant. ▪ Retained naso-gastric tube.
	Venous thromboembolism (VTE) is when blood clots develop in the veins of the leg. In some cases this can result in a clot becoming lodged in the lung (pulmonary embolus) that can be fatal. VTE is associated with particular risk factors and, along with all Trusts, we now routinely assess the risk of VTE in

Indicator	Commentary
	individual patients when they are admitted to hospital. The Department of Health has set a standard requiring 90% of patients to be VTE assessed. The trust has maintained compliance with the 90% standard throughout the year.
	Evidence suggests that clinical outcomes are better, and the length of stay in hospital reduced, when stroke patients spend the majority of their stay in a dedicated stroke unit. The Department of Health requires 80% of patients to spend 90% of their stay on a stroke unit. The trust performed better than the national standard with a full year performance of 89%.
	A high emergency re-admission rate may suggest that patients have been discharged too early or have not received the quality of care required; the trust therefore monitors the rate with the expectation that over time it will reduce. For the full year 2011/12 the trust recorded a rate of 4%. As the step change chart suggests a reducing trend was observed last year.
	In order to maintain privacy and dignity hospitals are required to provide single sex patient accommodation. The trust recorded 5 breaches of the mixed sex accommodation standard this year. All occurred in February and March 2012 and were caused by ward beds not being available for patients requiring discharge from ITU.
	Since April 2009 the Trust is required to record patient reported outcome measures in 4 clinical procedures, Inguinal Hernia, Varicose veins, Knee and Hip replacement. The trust has remained consistently above the 80% target for the year.
	Target compliance achieved.
	Increasing the proportion of patients discharged at the weekends is considered to be indicative of good quality and robust clinical systems operating outside traditional working hours. For 2011/12 19.9% of discharges were

Indicator	Commentary
	recorded at the weekend, comfortably outperforming the target of 12.8% set by Commissioners.
Inpatient  **Outpatient**  	The trust records patient feedback in relation to the quality of their experience in both inpatient and outpatient settings. This indicator looks at the extent to which patients would recommend the trust to other people. Both charts record high recommendation rates and as the step change charts suggest the trend is improving.
 	A reducing length of stay is indicative of effective and efficient healthcare. For 2011/12 the trust recorded an Elective length of stay of 4.2 days compared to the target of 3.7. This indicator is monitored monthly as part of performance and quality reporting.
 	A reducing length of stay is indicative of effective and efficient healthcare. For 2011/12 the trust achieved the non-elective length of stay target of 5.3 days. This indicator is monitored monthly as part of performance and quality reporting.
 	Most patients prefer to be treated as daycases and with advances in medical knowledge and technology this provides a safe and cost-effective alternative to inpatient admission. For the year the rate of elective day case spells against all elective spells only just missed the target of 77.8% with a rate of 77.4%.
 	The Department of Health has a set a maximum wait time of 23 weeks for those patients waiting the longest for admission, measured at the 95th centile. Between April 2011 and February 2012 the trust recorded a wait time of 20 weeks against the 23 week standard with over 90% of patients admitted within 18-weeks.

Indicator	Commentary
	The Department of Health has a set a maximum wait time of 18.3 weeks for those patients waiting the longest for outpatient treatment, measured at the 95th centile. Between April 2011 and February 2012 the trust recorded a wait time of 12.8 weeks against the 18.3 week standard with over 95% of patients treated within 18-weeks.
	Waiting times of 4-hours or less are required for patients attending A&E departments. The trust's performance in March 2012 was 97% and for the full year performance was 96.3%, comfortably above the national standard of 95%.
	Operations cancelled on the day of, or following admission for non-clinical reasons, are extremely disruptive and upsetting for patients and indicative of poor patient experience. Compared to 2009/10 the trust has reduced the volume of operations cancelled by 40% from 799 to 477.
	The Department of Health as set a standard requiring 93% of patients referred urgently by their GP with suspected cancer to be seen in outpatients within 2-weeks. The trust has comfortably outperformed the standard throughout the course of the year.
	The Department of Health requires 85% of patients to receive their first cancer treatment within 62 days of referral. The trust achieved this standard in every month of the year apart from August 2011 and is forecasting compliance for March 12.

PART 4

THE VIEWS OF OUR STAKEHOLDERS

This section to be completed upon receiving responses from our stakeholders.

APPENDIX 1

CLINICAL OUTCOME METRICS

Nine metrics relate to performance across the whole trust. These are:

CLINICAL SERVICES:

- hospital mortality
- MRSA infection
- clostridium difficile infection.

RESEARCH AND INNOVATION:

- speed of research study approval
- staff publications
- recruitment into research studies.

EDUCATION AND TRAINING:

- General Medical Council (GMC) postgraduate doctors national training survey
- medical student teaching
- mandatory training.

All other metrics relate to the performance of individual specialties. They are listed below, grouped by specialty within our four clinical divisions.

URGENT CARE DIVISION

A&E and acute medicine:

- early warning score
- assessment of venous thromboembolism risk
- time spent in A&E.

Cardiology:

- door to balloon and call to balloon time for primary angioplasty
- echocardiograms performed to diagnose heart failure
- secondary prevention drugs prescribed following heart attack.

Respiratory medicine:

- percentage of patients with respiratory disease under the care of respiratory physicians
- readmission rates of patients with chronic obstructive pulmonary disease (COPD)
- treatment of patients with active TB.

Obstetrics and gynaecology:

- caesarian section rate
- consultant review within 12 hours of unplanned admission
- readmission rate in gynaecology.

Critical care services:

- catheter-related blood stream infections
- readmission to intensive care
- excessive time in the intensive recovery unit

Paediatrics:

- asthma plans for children
- children managed without a referral to tier four services
- median HbA1c in diabetic children

Health services for elderly patients:

- dementia care satisfaction
- pressure sore rate
- avoidable readmission rates.

SPECIALIST SERVICES DIVISION

Haematology:

- survival following an allogeneic stem cell transplant
- availability of laboratory results
- recruitment into clinical trials

Haemophilia:

- musculoskeletal assessment for patients with severe haemophilia
- recruitment into clinical trials
- efficiency of warfarin monitoring clinics.

Infectious diseases:

- reduction of HIV viral load
- effectiveness of HIV treatment
- communication with primary care.

Rheumatology:

- speed of assessing patients with connective tissue disorders
- treatment of patients with inflammatory arthritis
- speed of assessing pulmonary hypertension.

National amyloidosis service:

- rapid clinical review of new patients
- treatment of patients with CAPS
- follow up of patients with AL amyloidosis

Oncology:

- speed of cellular pathology reporting
- survival rates for breast cancer patients
- place of death for patients known to the community palliative care service.

TRANSPLANT & IMMUNOLOGY DIVISION

Ear Nose and Throat (ENT) and audiological medicine services:

- patient reported outcome measures after endoscopic sinus surgery for chronic rhinosinusitis
- Bamford-Kowal-Benc sentence scores following adult cochlear implantation
- hearing aid usage in children.

Gastroenterology:

- colonoscopy completion rate

- thromboprophylaxis in hospitalised patients with active inflammatory bowel disease
- management of carcinoid syndrome during hepatic embolisation.

Endocrinology:

- antenatal diabetes management
- diabetic foot management
- euthyroidismone year post radioiodine for thyrotoxicosis.

Liver services:

- graft survival following liver transplantation
- survival following pancreatic cancer surgery
- hepatitis C treatment success.

Renal services:

- patient survival on dialysis
- one year creatinine following kidney transplantation
- urinary infections following urological procedures.

Immunology:

- immunoglobulin levels in patients with antibody deficiency
- infections in patients with antibody deficiency
- number of days off work taken by patients with antibody deficiency.

TRAUMA & MANAGED NETWORKS DIVISION

General surgery:

- mortality following elective aortic aneurysm repair
- patient reported outcome measures following hernia repair
- 30 day post-operative mortality following colorectal cancer.

Trauma and orthopaedics:

- compliance with best practice for fractured neck of femur patients
- infection rate for post elective arthroplasty
- compliance with guidelines for open fracture of the tibia.

Eye services:

- timeliness of investigation in glaucoma
- outcome following cataract surgery
- timeliness of managing patients referred through diabetic retinopathy screening.

Neurosciences:

- response to rehabilitation referrals
- rehabilitation outcome following in-patient admission (NRC)
- rehabilitation outcome following in-patient admission (SAM)
- community neurological conditions management team multidisciplinary assessment within the last 12 months
- national sentinel stroke audit.

Pain management:

- reduction in pain intensity one month after pulsed radio frequency nerve treatment
- improvement in patient satisfaction scores after audit of patients' views
- improvements in self-efficacy, catastrophisation, depression and anxiety.

Plastic surgery:

- clinical infection rate: general, implants, hand trauma
- 30 day emergency readmission rate
- skin cancer complete excision rate.

Dermatology:

- dermatology life quality index (DLQI) in the inflammatory dermatoses
- psoriasis area and severity index (PASI) 75
- eczema area and severity index (EASI).

APPENDIX 2

A GUIDE TO QUALITY WITHIN THE TRUST

INTRODUCTION

This guide describes how the Royal Free Hampstead NHS Trust ensures the provision of high quality services for our patients. It sets out to describe what quality means for us and how we set a culture of quality and high standards throughout the organisation.

The guide has been adapted from the quality governance memorandum prepared for the trust board as part our foundation trust application. It is based on the quality governance framework used by Monitor, the independent regulator of foundation trusts. This subdivides quality governance into four main domains: strategy, cultures and capabilities, processes and structures and metrics.

What is quality?

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

At the Royal Free, our focus is on excellence and we therefore aim to provide services of the highest possible quality. This is reflected in the trust's logo – world class care and expertise. It is also embedded in our corporate objectives, which reflect our governing aims:

- To deliver excellent patient outcomes, teaching and research. Our aim is to be in the top 10% of our relevant peers. This means maintaining our excellent infection control and patient safety record, continuing to develop and invest in our research and research capacity and developing outcomes measures at clinical service line level.

- To offer excellent patient and staff experience. Our aim is again to be in the top 10% of our relevant peers. The main challenge here is addressing the variability of the patient experience and ensure we engage all staff in the running and development of the trust and give our staff the skills, resources and support they need to perform to the optimum of their ability.

- To deliver excellent financial performance and value for taxpayers money. Once again, we want to be in the top 10% of our relevant peers. We must have a major focus on productivity and service transformation as we meet the financial challenges ahead.

- To be strongly compliant with the law and the standards and targets set by our regulators and other relevant bodies. This includes health and safety legislation, the CQC regulatory standards and the standards and targets within the NHS operating framework

- To build a strong organisation fit for the future. We must ensure that we have the infrastructure, processes and people in place to enable us to deliver the four objectives described above.

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

- The trust consistently has one of the lowest hospital standardised mortality rates (HSMR) in England.

- During 2010/11 only one acquired MRSA (methicillin resistant staphylococcus aureus} bacteraemia occurred within the trust.

- The Royal Free stroke service was ranked in the top 25th percentile by the Royal College of Physicians in the latest round of the national sentinel audit 2010. We achieved 92% compliance overall, scoring 100 % in nine of the 12 areas.

- The trust has the second highest number of highly cited research publications of English NHS trusts.

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

- the administrative processes which support patients and staff, such as our out-patient appointment system
- our phlebotomy (blood taking) service
- overall patient experience.

What is quality governance?

Monitor defines quality governance as the combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- ensuring required standards are achieved
- investigating and taking action on substandard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best practice
- identifying and managing risks to quality of care.

Monitor requires that the board of directors of an applicant trust confirms, through a board statement and memorandum, that it is satisfied that:

- The trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare delivered to its patients.
- Due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans).

In preparation for its foundation trust application, the trust has undertaken a review of quality governance led by the medical director and director of nursing. The board has approved the recommendations from this review and implementation has commenced.

The trust also commissioned KPMG to undertake an independent review of quality governance. Their report assessed the trust as amber/green against the Monitor quality governance framework and concluded that "there is sufficient evidence that the appropriate quality governance arrangements are in place to enable the board of directors to confirm, by way of a board statement and detailed board memorandum, they are satisfied that the trust has effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare delivered to its patients."

The following sections describe our approach to quality in each domain of Monitor's quality governance framework.

STRATEGY

How quality drives the trust's strategy

Each year the board approves three high-level quality improvement objectives that are published in our annual "quality accounts. These are agreed following extensive consultation with external stakeholders. In order to develop our 2011/12 quality objectives, a series of discussions were held with the trust's shadow governors, Barnet and Camden Local Involvement Networks (LINKs), Barnet and Camden health scrutiny committees, North London Acute Commissioning Agency and NHS London. In addition, more than 300 of our trust members completed an online survey. Internally, discussions were held at board level and with staff groups.

Our 2011/12 quality improvement objectives are:

- In the area of patient experience, to improve our out-patient phlebotomy service. Our target is by April 2012 to ensure that 50% of patients are seen within 10 minutes, 80% within 30 minutes and 100% within an hour; and 100% of our staff working within the phlebotomy

service have undergone customer care training. The executive lead for this improvement priority is the director of operations.

- In the area of clinical effectiveness, to complete the development of our clinical specialty-based clinical outcome metrics and publish these in full by April 2012. The executive lead for this improvement priority is the medical director.

- In the area of patient safety, to reduce patient falls. Our target is to have achieved a 50% reduction in both the overall number of falls and falls that result in harm by April 2012. The executive lead for this improvement priority is the director of nursing.

The trust executive committee and the trust board receive quarterly updates on progress against these objectives.

The trust also drives quality improvement through its quality, innovation, productivity and prevention (QIPP) programme, led by the director of integrated care; and the commissioning for quality and innovation (CQUIN) scheme, led by the medical director. The QIPP programme incorporates transformational and transactional aspects of clinical management to support the delivery of quality services while at the same time reducing costs over the next five years. The programme responds both to financial pressures, resulting from flat income and expected increase in demand, and our commitment to delivering high quality services. There are currently more than 70 active QIPP projects. The CQUIN programme is agreed each year with our local acute commissioners following extensive discussion at a joint monthly clinical quality review group that now also includes input from local general practitioners.

In addition to our annual high-level quality objectives, QIPP and CQUIN programmes, the trust has demonstrated innovation in its approach to quality improvement. This includes development of adult and paediatric early warning systems, the first introduction in the UK of Schwartz rounding, introduction of the productive ward and participation in the Institute of Health Improvement's safer patient initiative. A selection of other quality improvement initiatives is described within our annual quality accounts. In the latest quality accounts, published in June 2011, we reported on projects to:

- improve care and safety for sick children through effective communication

- introduce a paediatric early warning system for children whose clinical condition is deteriorating

- improve the speed with which patients with heart attacks receive treatment

- improve the vaccination rates of children in our local communities

- introduce nurse rounding, a process by which nurses attend each patient on an hourly basis – research has shown this significantly improves patient safety and experience

- introduce ‘go see’ visits during which board members are teamed up with designated clinical areas that they visit regularly.

The board is particularly concerned that improvements occur with respect to patient and staff experience. For 2011/12 the patient experience improvement plan is focused on three areas of improvement:

- privacy and dignity

- reducing waiting

- developing leadership.

The trust communicates and discusses quality initiatives with staff, patients and other external stakeholders in a variety of ways. These include the annual quality accounts, which this year were published with our financial accounts in a single document, regular electronic briefings by the chief executive, meetings of governors, and staff QIPP engagement sessions. Nevertheless, the recent quality governance review recognised that communication could be further improved and as a result, a monthly electronic quality bulletin was introduced in autumn 2011.

How the board is aware of potential risks to quality

Our risk management strategy outlines the trust's approach to risk and details the processes in place to manage risk. The trust maintains a risk register and a board assurance framework, both of which are reviewed and revised on a regular basis. The risk, governance and regulation committee leads this process, but additional review is also undertaken at the trust executive committee, the audit committee and the board. The risk register is populated from a variety of sources including risk registers maintained within each clinical division, incident forms, audits, benchmarking and external reviews. The risk register and board assurance framework both contain actions to mitigate risk: these are also regularly reviewed.

The board also uses a variety of other mechanisms to assess potential risks to quality. These include, for example, our programme of 'go see' visits, in which directors are paired with clinical areas that they visit on a regular basis; regular reports to the board from the director of infection prevention and control (DIPC); a range of inspections by external regulators that are monitored by the risk, governance and regulation committee; our quality road map self-assessment process for CQC outcomes; and a wide range of metrics used to monitor performance (see section five). The trust participates in national in-patient and out-patient surveys, and uses patient experience trackers throughout the organisation to collect real-time feedback from patients and other users of our services. The trust encourages external stakeholders to identify risks to quality through a variety of formal and informal means. These include the patient advice and liaison service (PALS), patient representative groups, LINks forums, public board meetings, local commissioners, shadow governors and the local health scrutiny committees. The board's user experience committee has the key responsibility for monitoring and improving the quality of user and staff experience.

The QIPP programme, described in section two, is a key component of the trust's quality improvement process. However, we recognise that there is also a potential for some QIPP projects which primarily focus on cost reduction to have an adverse effect on quality. To avoid this all QIPP projects are assessed for their potential impact on quality before and after implementation, including a detailed quality impact assessment. Senior clinicians are included within the membership of both the QIPP steering group and the QIPP board,

and QIPP projects are separately reviewed by the medical director and the director of nursing for any potential negative impact on quality. In addition the board monitors a set of specific trust wide metrics that may be adversely affected by cost improvement projects.

CAPABILITIES AND CULTURE

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

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

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

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

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

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

The board has promoted a number of quality strategies and initiatives that have been developed and implemented with extensive staff engagement. As already described, these include the development of the quality accounts, the drive to improve infection control, the QIPP programme, the safer patient initiative and the development of clinical outcome metrics for each clinical business unit. These and other quality-focused programmes have helped promote a quality-focused culture throughout the organisation. Senior executives are directly involved in quality improvement initiatives: for example the director of nursing is responsible for the current falls reduction programme; the medical director is responsible for the development of clinical outcome metrics and the CQUIN programme; the deputy chief executive is responsible for the QIPP programme; and a divisional director, acting with the DIPC (director of nursing), leads our infection control programme.

The board actively encourages staff to participate in quality initiatives. The recent EUREKA scheme encouraged staff to suggest quality schemes as part of the QIPP programme. Annual staff achievement awards recognise those individuals and teams that have made a significant contribution to high quality within the trust. Using our clinical incident reporting system, we encourage staff to report errors and adverse events that have, or could have, an adverse impact on quality. Staff receive training and experience in service improvement methodology through direct participation in quality improvement projects, such as our theatre improvement project. Quality improvement projects are reported and communicated by a number of means, including the annual quality accounts, Freemail (our regular staff news update) and the chief executive bulletin.

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

PROCESSES AND STRUCTURES

Roles and accountabilities in relation to quality governance

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

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

Board committees are aligned with the governing objectives and have a key role in quality governance (annex four).

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

- The user experience committee meets bi-monthly and is responsible for seeking and securing assurance that the trust's services are

delivered to its customers (GPs and patients) so as to achieve the high levels of performance expected of them by the board, namely "recommendation rates consistently in the top 10% in the UK versus relevant peers".

- The risk, governance and regulation committee meets monthly and is responsible for ensuring that the trust is fully compliant with all its regulatory duties and for ensuring that all material risks to trust objectives are understood and appropriately addressed.

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

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

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

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

Beneath the level of board committees, other committees and working groups also play an important role in quality governance. These include groups that have a focus on a specific issue, such as the committee that ensures the trust is compliant with the Human Tissue Act, to those with a broader remit such as the education committee. The recent review of quality governance recommended that the majority of these groups should report directly to the trust executive committee, as this is the board committee that meets most

regularly and is able to address operational issues most rapidly. It also provides a key link to the trust's clinical divisions. Reports from these groups are also made available to other board committees, on a regular or ad hoc basis as appropriate.

The trust's clinical services operate within four divisions: specialised services, urgent care, transplant & immunology and trauma & managed networks. Each division contains a number of clinical business units. Divisions focus on quality within a variety of forums, but the recent quality governance review recommended the establishment of divisional safety and quality assurance boards to provide a specific divisional focus to quality governance. Chaired by the relevant divisional director, these boards will meet monthly from autumn 2011.

Processes for escalating and resolving issues and managing performance

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

The recent quality governance review also sought to strengthen the process of escalation by assigning trust executive sponsors to each committee and working group, and developing a standardised escalation policy.

How the board actively engages patients, staff and stakeholders

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

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

- The extensive engagement that was undertaken for our quality accounts.

- Patient focus groups that have been established in a number of specific areas eg phlebotomy.

- The trust's shadow council of governors and membership which have been in place since 2008. The board regularly consults the council and members concerning quality and responds to quality issues raised by the governors. Governors sit on the clinical performance committee and the user experience committee.

- The clinical performance committee has involved governors in the development of specialty clinical outcome metrics.

- Board members regularly undertake 'go see' visits to clinical areas, which involves speaking with patients.

- The user experience committee regularly reviews the results of patient and staff feedback.

- The board regularly engages with local LINKs and health scrutiny committees.

- The trust meets commissioners, including GP representatives, in a monthly clinical quality group, attended by the trust medical director.

- The trust has appointed a director of integrated care, who is responsible for working with commissioners and GPs to develop high quality community-based services.

- We are one of the few acute trusts to have appointed a public health lead who works within the trust and with our local community to promote screening and other preventive measures to improve the health of our patients and the wider population.

The trust is committed to making its quality performance outcomes as accessible as possible. For example, our comprehensive board performance

dashboard is included within the published papers of our quarterly public board meetings. Our quality accounts include a comprehensive set of quality data together with easily understandable descriptions of each metric. Performance metrics are also discussed with commissioners at regular monthly quality review meetings. We have recently begun placing performance metrics on our external internet site.

MEASUREMENT

How appropriate quality information is analysed and challenged

The trust already generates a large volume of metrics relating to the quality of operational performance, patient safety, patient experience and clinical outcomes. The trust metrics library currently consists of more than 200 measurements. This is supplemented by metrics provided by external agencies such as Dr Foster. Additional metrics are also under development; for example the clinical performance committee is developing 81 clinical outcome metrics at clinical business unit level and six education and research metrics at organisational level.

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

- metrics related to national priorities and regulatory requirements, eg A&E metrics
- metrics specifically related to safety, clinical effectiveness and patient experience, eg standardised hospital mortality; rapid access chest pain; net promoter score
- metrics specifically related to early warning of quality deterioration, eg patient falls, average length of stay
- metrics related to adverse events and harm, eg never events, MRSA rates

- risk ratings

- RAG rating and an overall commentary on performance.

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

The trust is currently implementing service line reporting within its clinical business units. This will facilitate better analysis of metrics at specialty and consultant level. Consultant level review will also be incorporated into our revalidation processes for medical practitioners.

The recent quality governance review recommended that a defined process should be introduced for future metric development and that each metric should be owned by the board committee; these recommendations are currently being implemented.

How the board assures the robustness of quality information

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

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

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

The trust actively encourages participation in national clinical audits and confidential enquiries. In 2010/11 we participated in 87% of the 49 national clinical audits for which we were eligible and in all of the four confidential enquiries for which we were eligible. The trust reviews the outcome from these audits and when concerns arise will undertake specific reviews.

How quality information is used effectively

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

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

- improvement in MRSA rates
- improvement in the number of cancelled operations
- most recently, reduction in patient falls.

All metrics are now presented in a consistent format within the board dashboard. Furthermore, descriptors are being developed that provide an easily understandable guide to the purpose and source for each metric: the 2010/11 quality accounts provide an example of this approach.

CONCLUSION

This guide describes how the Royal Free Hampstead NHS Trust approaches quality. It complements the trust's annual quality accounts, which report on the quality of our services over a specific 12-month period. The latest quality accounts are available on our website. In future, our intention is to revise this guide on a regular basis and also to include it as part of our quality accounts.

NORTH·LONDON
HOSPICE

Quality Account

2011-2012

The care that our father receives from the Specialist Palliative Care Team has been excellent. We have been very happy with the friendliness and professional expertise. We have felt entirely confident with their advice and nursing skills. They have been most understanding and spent time to explain the process and help us to come to terms with what is going to happen. We have also felt able to ask questions and have been given helpful advice. Thanks for all the care received.

Community team patient's relative, October 2011

North London Hospice in Finchley
47 Woodside Avenue N12 8TT

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110 Barrowell Green N21 3AY

020 8343 8841

www.northlondonhospice.org **Regd Char No: 285300**

Part 1
Chief Executive's Statement: Statement of Quality

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, due to the generous support of our local community.

The charity makes no charge to its patients or their families or carers. It costs 7 million per annum to provide this service for which NHS contributes 23% of this funding.

Our Vision is that everyone living with terminal illness in Barnet, Enfield and Haringey should receive the specialist palliative care (including practical, spiritual and emotional support) that they require to minimize their symptoms, maximize their quality of life and allow them to live and die with dignity in the surroundings of their choice.

Our Vision includes their friends, family and carers and to ensure that they have the support they need to cope with any difficulties arising from their illness and to recover and rebuild their lives afterwards.

We acknowledge that as we are serving a population approaching a million people, we will not always be able to be the direct provider of care and that to achieve this Vision, we will need to build partnerships with the NHS, social services, voluntary, religious and cultural organisations to assist them to provide the best possible end of life care.

This is the first Quality Account that North London Hospice has produced. In May 2011, North London Hospice decided to move from producing an internal Annual Quality Report to complete annual Quality Accounts. It is not mandatory this year for us produce a Quality Account as a voluntary hospice without a community contract with the NHS. However, the Trustees supported the proposal from the quality team to create Quality Accounts. It was felt to be good practice to make the Hospice's quality reporting systems more transparent to external agencies and the public and reflects our ongoing commitment to public involvement and feedback on the future development of our services.

Central to our focus on providing quality care is that we are aware that we care for patients and their families at a very critical time in their lives. We want to get things right as we do not get a second chance.

NLH Board of Trustees reviewed and approved this Quality Account at a meeting on 14th May 2012. tbc

To the best of my knowledge the information reported in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by North London Hospice.

Douglas Bennett
Chief Executive
May 2012

Introduction
This is the first Quality Account that North London Hospice has produced. It covers the time period April 2011-March 2012 and demonstrates the following:

- our continuous commitment to evidence based quality improvement
- how we receive challenge and support from local scrutinisers on what we are trying to achieve
- how we are held to account by the public and local stakeholders for delivering quality improvements

North London Hospice has decided to focus on service activity data relating to Barnet and Enfield for this first Quality Account.

The Quality Account replaces North London Hospice's Annual Quality Report, which was scrutinised in previous years by NLH's Clinical Governance Team, Management Team and Trustees.

This is the first time that NLH's quality agenda has been made available to the public and reflects our openness to external scrutiny, ongoing commitment to public involvement and provides feedback for the future development of our services.

Our services are provided free of charge by specially trained multi-professional teams, which include doctors, nurses, physiotherapists, social workers, counsellors, chaplains and volunteers.

North London Hospice offers the following services:

1. **Community Specialist Palliative Care Teams**

"All members of the Team are very supportive and professional."

Two teams of nurses, doctors, physiotherapists and social workersworking in the community, provide expert support and advice. One team is based in Finchley and provides care to Barnet and Haringey patients, another is based in Enfield and provides care to Enfield patients. Their work complements that of 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

"I may not have been able to cope without all their help."

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 during 0900-1700 hours.

3. Day Services
Our Day Services which included a Day Centre and outpatient facilitiesare currently under review. Later this year we plan to open a new Day Services centre in Enfield. All existing Day Centre patients will continue to receive a service in the meantime. The purpose of the transition is to provide a more bespoke service to a greater number of patients and to be more inclusive of carers - offering pre and post bereavement support. Eventually we are aim to provide more choice to three times the amount of patients. The service will be opening early summer 2012.

4. Inpatient unit

"Thank you for the care, it cannot be faulted."

We have 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. Unfortunately the unit is unable to provide long-term care.

5. Palliative Care Support Service (PCSS) (Hospice at Home)
Most people would like to be cared for and finally to die in their own homes, in familiar surroundings with the people they love.
Our 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. Bereavement service
This service is offered to families, - including children - friends and carers of all our patients, up to 14 months after the patient has died. Specially trained counsellors are available offering support and help as needed.

Part 2

2.1 Priorities for improvement 2012-2013

The following priorities for improvement for 2012-2013were identified after initial consultation by NLH service management teams with their clinical team members. These service management teams made proposals to NLH's Management Group and Executive Team in February 2012.

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

1. Patient experience: Share your experience
   For many years NLH has been listening to service users through focused projects, complaints analysis and the introduction of user surveys in 2011. In 2011 our complaints form and training encouraged all types of feedback to be received, both good and bad, as a way of reviewing the quality and service responsiveness to user needs. In 2012-2013 NLH plans to collate the rich text of users' narrative to elicit individual experience and key themes of user feedback and experience. We must continue to listen to users to help improve our services and explain in our service information and fundraising communications the care that NLH provides. We hope it will make user feedback more accessible to those whose first language is not English or those whose literacy levels make it difficult for them to use our survey form. This work correlates with NLH's User Involvement Strategy and future plans of creating service users forums, developing NLH's website for users and user involvement literature.

2. Patient safety: Care planning and how it ensures patient risk is minimised.
   The Inpatient Unit team plan to critically review its wound care plans. Patients on the unit 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 than the healing of wounds.The quality of wound care appears to be achieving this aim but it has not been audited for some time. The team plan to audit their wound care plans, implementing any learning and recommendations.

   The Community teams plan to review the process of risk assessment for Community patients. The plan is for the project group to work with the local Community Nursing Services, which will involve process mapping on how risks are identified, how the

risks are documented, recorded, stored and communicated. It is hoped that best practice will be agreed and joint action plans created, appropriate policies amended and the information cascaded to the relevant services.

3. Clinical effectiveness: Advanced Care Planning(ACP)
   NLH has carried out some internal training and developed a policy to support:
   - more systematic communication with patients
   - recording of patients' preferred place of care (PPC)
   - statements of wishes and preferences
   - advanced directives of refusal of treatment in end of life care.

   The project group plan to develop a user information leaflet on ACP, audit documentation of PPC and roll out internal training to all clinicians.

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 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 2011-2012, NLH provided and/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 NLH has reviewed all the data available to them on the quality of care in these NHS services.
TheNHS grant income received for these services reviewed in 2011-2012 represents 25per cent of the total operationalincome generatedby the North London Hospice for the reporting period 2011-2012.

Participation in clinical audits
During 2011-2012, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that North London Hospice provides.
During that period NLH did not participated 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 2011-2012 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 2011-2012, 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 2011-2012 and North London Hospice intends to take the following actions to improve the quality of healthcare provided (nil).

To ensure that we are providing a consistently high quality service, we take part in our own clinical audits, using national audit tools developed specifically for hospices where available e.g. Help the Hospices' Controlled Drugs Audit Tool and Infection Control and Prevention Tool. This allows us to monitor the quality of care being provided in a systematic way and through use of the audit cycle there is a framework where we can review this information and make improvements where needed.

North London Hospice identifies priority areas to audit formally, according to which areas have impact on patient care, health outcomes, issues arising from complaints or incidents, interests of staff and users, as well as any national, regional or local requirements. Each year, an annual audit plan is created which North London Hospice's Clinical Governance Committee recommends to the Trustees Board to approve. North London Hospice's Audit Steering Group meets monthly and is made up of clinicians and non-clinicians, and includes a volunteer. It receives audit results and ensures learning is shared. If areas of risk are identified, then a plan to minimise risk is actioned. It reports quarterly to North London Hospice's Clinical Governance Committee.

Through the Clinical Governance report, the Board of Trustees is kept fully informed about the audit results and any identified shortfalls. Through this process, the Board has received an assurance of the quality of the services provided.

The reports of 13 local clinical audits were reviewed by the provider in 2011-12 and North London Hospice undertook the following actions to improve the quality of healthcare provided.

Antiemetic/Opioid documentation in the Community
Action was required to improve standard of medication record keeping.In their corporate plans for 2011-2012, the Service Management Teams identified the need to improve documentation and held three training sessions to address this with practitioners.

A new Community Team Audit Group was also created to enhance the integration of clinical audit in the team's practice. Re-audit is planned for 2012-2013.

Daycare and volunteer private transport
Improved service delivery noted with new private ambulance contractor so contract maintained.

Audit of Information Pack and Bereavement Pack documentation on IPU
The documentation of patient information pack giving was good. Tracking of patient notes was identified and raised as a clinical risk and incident management process commenced.As a result there is a new administrative system in place for tracking the movement of patient notes. This is being added to the Health Records policy.
Ongoing feedback about IPU patient information is being captured through the annual user survey.

Audit of documentation of falls in the IPU
Audit identified a lack of proactive management of falls on the Inpatient Unit. An action plan incorporated this area as a Priority for Improvement for 2011-12 and as detailed in Part 3, resulted in development of a falls risk assessment tool, guidelines, core care plan and Prevention of Falls Policy. A re-audit is planned for 2012-2013.

Drug errors re-audit
A high proportion of mechanical errors were noted with syringe drivers. As a result, a log has been created to monitor syringe driver history and maintenance. The incident form was revised to incorporate learning from the audit where drug error management and documentation needed improving.

First visit documentation audit – allergies
In the Community Service, action was required to improve the standard of record keeping of allergies. Following the audit, the cause of poor documentation was identified as a technical error when saving electronic records data. All community staff have been informedof how to save an allergy record effectively. A re-audit this year has showed significant improvement, averaging 93%.

Complementary therapies compliance audit against the new Network Criteria
An action plan was created to ensure compliance. A register of therapists is now in place and also a new process for seeking updates on indemnity insurance details. A complementary therapy patient information leaflet has been produced.

A consent form has been added to the complementary Therapy Policy and therapists are to be trained in using the multi-professional electronic patient record system.

Hand-washing audit
This audit revealed 96% compliance with hand hygiene technique. The mandatory training and annual update in hand hygienenow includes monitoring the effectiveness of hand hygiene, using a light box. To increase the return of data tools, improved monitoring will be put in place. A re-audit is planned for 2012-2013.

Infection control audit
An extensive internal and external audit against the standards of the Health and Social Care Act 2008 was undertaken and an action plan created. Significant action has occurred during this year. A training programme is currently being commissioned relating to practical assessments of aseptic technique competencies for all clinical staff. The Job Description of the Nursing Director requires updating to include Infection Control requirements that are now reflected in the role. A re-audit is planned.

Care Quality Commission standards compliance audit for all clinical services
As part of our ongoing commitment to continuing quality, we audit our services annually against CQC Essential Standards of Quality and Safety. An action plan has been created for all services. It has been incorporated into the individual services corporate objectives and is monitored by Clinical Quality Group. As this is an annual audit, re-audit is planned for September 2012.

Oxygen cylinders audit
Good compliance against Oxygen Procedure was noted. Our Policy and Procedure is due for renewal and will be actioned. It was noted that the 87% compliance of the daily checking of the Inpatient Unit emergency equipment, falls short of the 100% standard. The inpatient team have been reminded that a 100% standard must be achieved and any deviation from this standard will be followed up with individual staff.

Inpatient workforce review
A high quality of care was noted. Workforce issues are to be discussed with the inpatient team and an action plan to be created.

Controlled drugs audit
Good results (above 80%) in adequacy of premises/security, procurement, examination of stock held, CD register and records review, CD prescribing/administration and destruction were recorded. An action plan is in progress.

Research

The number of patients receiving NHS services, provided or sub-contracted by North London Hospice in 2011/2012, 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 we were contracted to participate in.

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2011/2012 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. Improvement goals were discussed with the Barnet commissioner of services. No one was in post for the discussion to take place with Enfield at the time.

What others say about us

North London Hospice is required to register with the Care Quality Commission and its current registration status is unconditional. Registration was conditional on the appointment of a Registered Manager which was completed on 7th July 2011. NLH has the following conditions on registration - none.

The Care Quality Commission has not taken any enforcement action against North London Hospice during 2011-2012

North London Hospice is subject to periodic reviews by the Care Quality Commission (CQC) and its last review was in May 2010. The last on-site inspection took place in March 2006.

In their assessment, CQC raised that NLH did not have a Health and Safety competent person. This has been actioned and one has now been appointed (1/12/11).

The Hospice was fully compliant and rated as low risk.

NLH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data quality

In consultation with user groups, a review of the structure of the data recorded is in progress with a view to:

- standardise information and statistics reported
- enable a consistent approach throughout the organisation
- avoid misinterpretation
- improve understanding of the data by the various user groups

This in turn will lead to the production of better quality information.

North London Hospice did not submit records during 2011-2012 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.

Statistics relating to activity for the various services

North London Hospice Information Governance assessment report score overall score for 2011-2012 was 0% and was not graded. North London Hospice score for 2011-2012 for Information Quality and Records Management was not assessed during 2011-2012 as not mandatory for independent hospices.In 2012-2013, North London Hospice will be producing an Information Governance Toolkit (IG Toolkit) application, to establish an NHS N3 connection for the Hospice. An N3 connection will enable the Hospice to acquire services available on the NHS network and to link with hospitals, medical centres and GPs in England and Scotland via this network.

The IG Toolkit involves extensive analysis of our core policies which relate to information security, data protection, data handling and retention, review of staff training and reviewing information and communications technology.

Infrastructure: work has begun on this and will continue during 2012-2013.

North London Hospice was not subject to the payments by results clinical coding audit during 2011-2012 by the Audit Commission. This is not applicable to independent hospices.

Part 3
Quality overview

"Our Vision is that everyone living with a terminal illness in Barnet, Enfield and Haringey should receive the specialist palliative care (including practical, spiritual and emotional support) that they require to minimise their symptoms, maximise their quality of life and allow them to live and die with dignity in the surroundings of their choice.

Our Vision includes their friends, family and carers and to ensure that they have the support they need to cope with any difficulties arising from the illness and to recover and rebuild their lives afterwards.
We acknowledge that as we are serving a population approaching a million people, we will not always be able to be the direct provider of care and that to achieve this Vision, we will need to build partnerships with the NHS, social services, voluntary, religious and cultural organisations to assist them to provide the best possible end-of-life care."

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 in December 2011. It has four main groups that oversee quality review and development within the organisation. The Clinical Quality Group meets every three weeks and has an overview of both strategic and operational quality issues in relation to clinical services. The Clinical Governance Committee meets quarterly and provides a framework for continuous improvement of the quality of its services for patients and those who care for them.
The Risk Committee meets monthly and is responsible for the management of non-clinical risk.

The Audit Group meets monthly and ensures that there is a robust process for audit within North London Hospice that facilitates learning and change in practice. Quality issues are cascaded to front line staff through clinical and non-clinical team meetings.

NLH is fully compliant with "Essential Standards of Quality and Safety" (Care Quality Commission, 2010). It self assesses itself against these standards annually (last Audit June 2012) and action plans are put in place where needed. These are added into individual service's corporate objectives plan and reviewed quarterly by the Clinical Quality Group.

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

Fixtures and fittings are regularly checked to ensure they are fit for purpose and meet the needs of our patients.
While a patient is with us their room and bathroom are cleaned daily by members of our housekeeping team who follow a cleaning schedule. In common areas we have a quarterly high-level cleaning regime in place. All areas of the Hospice are on a rolling programme of re-decoration to ensure the Hospice looks clean and fresh and well cared for at all times. We have an annual infection control audit carried out by an external auditor. Our overall score in 2011 was 91% with Clinical Environment scoring 100%. Our facilities team take pride in their work and gain satisfaction from providing our patients with a facility we can all be proud of.

"Pleasantly surprised by the friendly atmosphere."

Central to achieving NLH's vision, NLH works in partnership with voluntary and statutory agencies within the locality.

NLH is actively involved in local End of Life Boards whichwork in partnership to achieve local end of life strategies and share best practice. Our clinicians attend General Practice Gold Standard Framework meetings which review the care of end of life patients being cared for by individual practice teams.

Our Finchley Community Team has been working collaboratively with the Barnet Disability Team to improve end of life care for people with learning disabilities in Barnet.

NLH delivers a bi-annual "Foundations in Palliative Care" four day course, open to all trained nurses and allied health professionals. We deliver 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.

We provide a variety of training placements:

- for student nurses with the University of Hertfordshire
- for social work students' placements with London South Bank University
- chaplaincy placements
- work experience for those wishing to apply for nurse, medical, allied health professional training
- half-1 day hospice placements for final year medical students
- 6 month placements for junior trainee doctors (recognised training unit with Barnet GP Vocational Training Scheme) and for Specialist Registrars on annual placements from London Postgraduate Deanery.

We are currently providing a commissioned End of Life training programme in care homes in Enfield.

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 2012, it is planned to build up NLH's external course provision for clinicians.

1.1 Service Activity Data

INPATIENT UNIT

Highlight Information

In 2011-2012, the inpatient unit cared for a total of 316 patients, involving a total of 325 admissions.

71% bed occupancy rate.
15% of patients admitted had been cared for on the unit before.
A patient's average length of stay was 14 days.
1% of cases admitted as day cases.
232 of the patients admitted to the unit died.
71% patients died on the unit.
22% were discharged home.
3% were discharged to a care home.
4% were admitted to hospital for acute care management.

New patients

Data Item	Definition	Analysis	NLH
No. of patients	No. of new patients	No. of new patients	300
		New patients as % of all patients	92%
Total admissions			325
Age of patients-female		Under 25 25- 64 65 to 74 75 to 84 Over 84	0 55 42 50 28
Age of patients-male		Under 25 25- 64 65 to 74 75 to 84 Over 84	0 48 36 39 16
Number of unrecorded genders			2

Analysis of admissions and outcomes

Data Item	Definition	Analysis	NLH
Day cases		Day cases as % of admissions	1% (n=4)
Admission type		Re-admissions as % of all admissions	15% (Admissions=325 Readmissions=50)
Average length of stay		Average	14 days
Ratio of deaths to deaths and discharges -total -home/hospital/ care home/ elsewhere (define)	No. of deaths to no. of discharges (completed episodes)		2.49 (Deaths=232, discharges=93)
Total percentage of deaths	Patients admitted 325	Deaths 232	71%
Total % of discharges to home		Patients 72	22%
Total % of discharges to care homes		Patients 9	3%
Total % of discharges to acute hospital		Patients 12	4%

Bed Usage

Data Item	Definition	Analysis	NLH
% Bed occupancy	Available beds 6222 Occupied beds 4412	Average per unit	71%
Throughput (admissions per bed per year)	Admissions/17 beds (325/17)	Average per unit	19.12 admissions per bed

DAY CARE SERVICES

As explained in the introduction, our Day Service model is currently under review. As we plan to open new Day Services in Enfield, the current Day Service and outpatient services at the Finchley site ceased to accept new referrals from July 2011. The day service at the Finchley site operated 8 sessions a week until November 2011. As patient activity has decreased, the number of sessions has also decreased. It was considered not to be useful to report on service activity here.

Community Teams Highlight information

NLH has two specialist community multidisciplinary teams, one supporting Barnet patients and another supporting Enfield patients.
In 2011-2012, a total of 1255 patients were seen by the two specialist community teams.
924 of these patients (Barnet=466, Enfield=458) were new patients.
79% had a cancer diagnosis.
17% had a non-cancer diagnosis.
4% diagnosis not recorded.

Each patient had an average of:
5 visits.
16 phone calls to patient and family.
11.5 phone calls to other professionals from the specialist community teams.

58% of the total patients seen by the two specialist community teams died during their care period. Of these:
46% died in their own home.
10% died in a care home.
24% died in a hospice.
19% died in hospital.
1% died in other places.

Data Item	Definition	Analysis	Enfield	Barnet	NLH
No. of patients	No. of**NEW** patients seen for the first time per service	Average no. of**NEW** patients per service	458	466	Total: 924 Ave: 462
	No. of re-referrals	No. of re-referrals	29	23	52
	No. of continuing patients	No. of continuing patients	158	121	279
Total no. of Patients			645	610	1255
Diagnosis		Cancer Non-cancer Not recorded	497 106 42	488 112 10	985 (79%) 218 (17%) 52 (4%)
Total Visits	Face to Face visits		3444	3039	Total: 6483
Average no. of visits per patient			5.33	4.98	5.16
Total phone calls to patient and family			9880	10434	20314
Average no. of phone calls to			15.31	17.10	Avg: 6.19

patient and family					
Total phone calls to professionals			5990	8485	Total: 14475
Average no. of phone calls to professionals per patient			9.28	13.90	11.59
Caseload	Average per CNS	Enfield 6.8 Staff Barnet 9.9 Staff	95	61	Avg: 78
No. of Deaths during the year			351	377	728
Ratio of deaths to deaths and discharges -total -home/ hospital/ care home/ elsewhere (define)	No. of deaths to no. of discharges (completed episodes)	Enfield: Deaths 351 Discharges 201 Barnet: Deaths 377 Discharges 132	1.75	2.86	2.19
Total % of deaths			54% 351 Death 645 Patients	60% 377 Deaths 610 Patients	58% 728 Deaths 1255 Patients
Patients who died analysis		Patient Home inc. Care Home residents	52% 181	59% 224	56% 405
		Hospice/Specialist Palliative Care Unit	26% 90	22% 82	24% 172
		Hospital (Acute)	22% 79	17% 64	19% 136
		Hospital (Community)	0	0	0
		Other	0% 1	2% 7	1% 8
Age of patients-	Male	Under 25	3	0	3
		Under 65	87	77	164
		65 to 74	77	78	155
		75 to 84	95	91	186
		Over 84	45	44	89
		Not recorded	0	1	1
Age of patients-	Female	Under 25	0	3	3
		25- 64	91	103	194
		65 to 74	76	58	134
		75 to 84	103	86	189
		Over 84	64	62	126

		Not recorded	2	2	4
		Number unknown gender	2	5	7

Palliative Care Support Service

Palliative Care Support Service (PCSS) was launched as a new service in Barnet on 1st April 2011.
It has cared for 188 patients in its first year and provided a total of 8339 hours of direct care to patients in their own homes.
This is an average of 39.9% hours of care per patient.

Data Item	Definition	Analysis	NLH
No. of patients	No. of patients seen for the first time		188
	No. of re-referrals		0
	No. of continuing patients		12
Age of patients-male		Under 25 25-60 61-70 71-80 Over 81	0 15 19 29 34
Age of patients-female		Under 25 25-60 61-70 71-80 Over 81	0 17 17 21 36
No. of total hours per patient		average no. of total hours per patient per episode	8339 total hours 44 hours average

2.1 Service Quality Data

Indicator	Threshold	Outcome
Percentage of audits completed on schedule	80%	85%

Eleven of thirteen audits have been carried out and findings presented to the Audit Steering Group and Clinical Quality Group and were reported on

earlier in this document. Two further audits are due to be presented in April 2012.

2.2 Patient Experience

Quality and Performance Indicators	Quality and Performance Indicator(s)	Threshold	Outcome
Service User Experience	% of patient/carers satisfied with the service	80% of patients/carers satisfied with the service	99% rated care as satisfactory and above
Relatives Experience	% of patient/carers satisfied with the service	80% of patients/carers satisfied with the service	95% rated care as satisfactory and above
Number of Complaints			31
Of complaint investigations completed (n=24), the number of complaints that were founded			20
Of complaint investigations completed (n=24),the number of complaints which were unfounded			4
The number of complaints action plans completed		100%	*18 (78%) completed* *5 (22%) Action Plans being completed*

Complaints are an important source of information which tell us about the experiences of service users. They are a crucial way of enabling the Hospice to evaluate if they are being successful in meeting the needs and expectations of both patients who use our services, as well as their carers and relatives.

"More information about the Hospice, general information and about the services and things on offer would be good."

North London Hospice 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 us improve our services, feedback of any problems or concerns people may have are encouraged. Any feedback received, however minor, is actioned as a complaint to ensure that it is fully investigated and that learnings are identified and acted upon.

A leaflet is available which explains how to lodge a complaint, either formally or informally. Complaints can be made to any member of staff, either verbally or in writing. The leaflet also explains how the Hospice will respond to any complaints received and how to proceed if not satisfied with the response that the Hospice provides.

"I would prefer the same person to come and see me."

During the period April 2012 to March 2012 we received 31 complaints. Full responses have been completed for 24 with seven investigations ongoing.

Category of Complaint	
Admission	3
Communication	12
Other	7
Staff Member	5
Treatment	3
Violence and Aggression	1

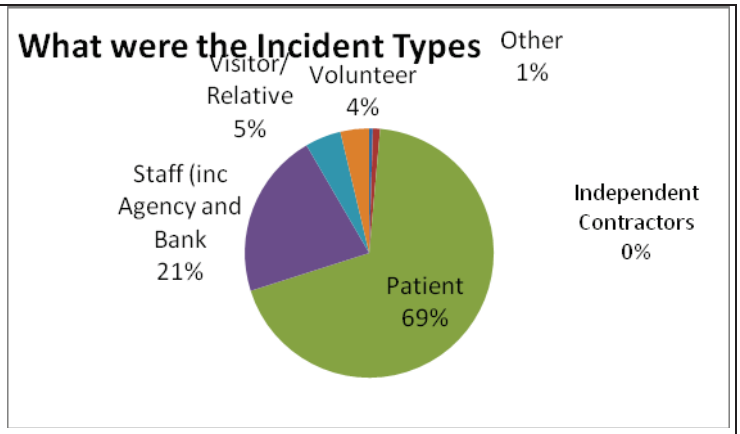
No complainants expressed any dissatisfaction with the responses made and none have asked for an independent review through the services available, including the Health Service Ombudsman or the Care Quality Commission.

2.4 Patient Safety

Quality and Performance Indicator(s)	**Threshold**	
Number of Incidents	Total Patient Only	214 148
The number of patients who experience a fracture or other serious injury as a result of a fall		1
Number of patients admitted to the IPU with pressure sores graded 3 or 4		9
Number of patients who developed pressure sores grade 3 or 4 within 72 hours of admission whilst on the IPU		1
Number of patients who developed pressure sores grade 3 or 4 after 72 hours of admission on IPU		1

During the period 1 April 2011 and 31 March 2012, we received 214 Incident Reports. This report is based upon these. It is expected that we will receive a number of other forms during the next few days which also relate to this period which will increase the actual number received for the year. The breakdown of the forms received to date is as follows:

Independent Contractors	1	0%
Other	2	1%
Patient	147	69%
Staff (inc Agency and Bank	46	21%
Visitor/ Relative	10	5%
Volunteer	8	4%



Pressure sore monitoring and reporting

When patients are admitted to the Inpatient Unit with pressures sores or risk factors associated with their development, our focus is to support healing where possible or minimise progression and provide comfort and relief from pressure sores. All patients are assessed within 24 hours of admission using the Waterlow Score (Pressure Ulcer Risk Assessment Tool) and again as change of condition indicates or weekly. All beds have air layer pressure relieving mattresses. Motorised air mattresses and 2-4 hourly change of patient's position are employed where indicated.Due to the advanced stage of illness and the debilitated condition of many of our patients on admission to the Inpatient Unit it is not unusual to find that we care for patients with pressure sores on admission or they develop or worsen whilst on the Inpatient unit. Grade 3 or above pressure sores are reported using our Serious Incident Procedure. If the pressure sore was identified as grade 3 or above within 72 hours of admission NLH ensures that the previous service provider that cared for the patient is aware and reports this to the local NHS Trust Quality Department. Where the pressure sore develops after 72 hours an internal investigation is carried out to identify why this occurred so that we can minimise their reoccurrence. NLH also reports these to Care Quality Commission and local NHS Quality Department.

One such incident occurred where a patient was reported on admission to have a sacral pressure sore grade 1. It was assessed and four days later was noted to be grade 3. The patient who was receiving end of life care and was breathless, could not tolerate being off her back as this position helped to ease her breathing.

Despite being cared for on a pressure relieving mattress, receiving wound care and regular repositioning, the patient experienced deterioration in her pressure sore.This was regrettable but unavoidable.

Following procedure, CQC and local NHS were notified and an investigation carried out to understand why this had happened and what steps could be taken to improve care. The presence and grading of pressure sores is now documented at the point of referral by the Triage Nurse and the IPU nurse re-grades the sore within 24 hours of admission.

The case where the grade 3 or above pressure sore developed within 72 hours of admission, was reported to the previous care provider and local NHS quality department.

Patient Related Incidents

The services that North London Hospice providesare not just for the patient who is being cared for. The service extends togivingsupport and advice to members of their families, to help them care for the patient.

A patient safety incident is any unintended or unexpected incident which could have, or did lead to harm for patients receiving care from North London Hospice. The purpose of reporting incidents is to learn from them in order to reduce the likelihood of the event occurring again.

Why is reporting important?

- Isolated incidents may seem trivial or of little consequence. However, the aggregated data may show certain trends which are impacting on the Hospice's ability to provide a safe environment in which to care for our patients.

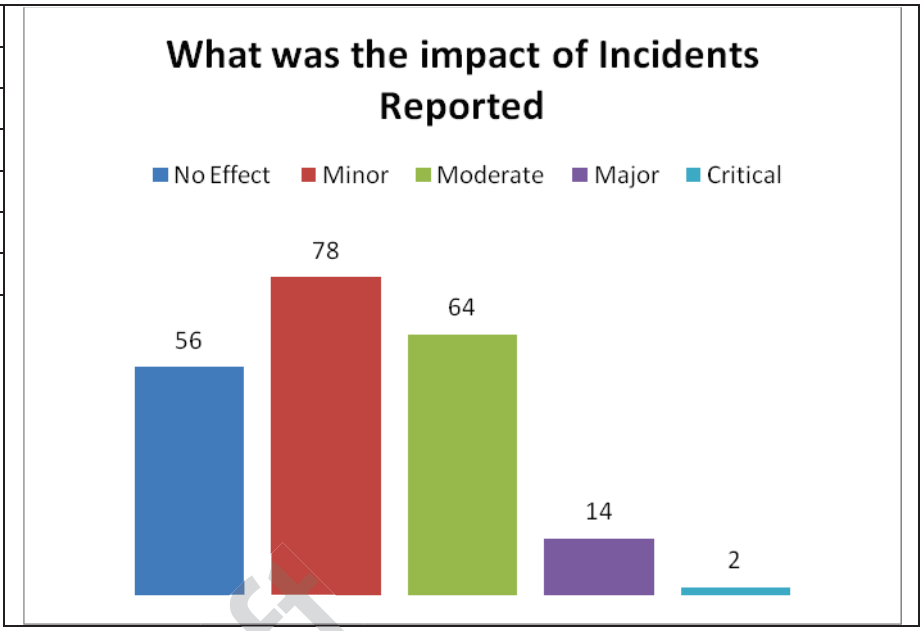
- Reporting incidents promotes learning. Sharing the experience enables us to look at the systems in which we work and the contributory factors which may have increased the likelihood of the event occurring.

- The sign of a good reporting system is one where the number of incidents reported increases, but their severity falls. This is an indicator that staff are identifying risks earlier, before they become more serious. It also indicates that they feel able to report incidents without the fear of being criticised by other staff. This helps to build an open and fair culture.

Of the 214 incidents reported within North London Hospice during the year April 2011 and March 2012, 147 (69%) related to incidents which affected a patient.

Every incident is graded into one of five categories to ascertain the likely impact it had on the patient or the Hospice in being able to provide care. The chart below shows how the patient only incidents reported have been graded.

		Total
No Effect	26%	56
Minor	36%	78
Moderate	30%	64
Major	7%	14
Critical	1%	2
Total		214



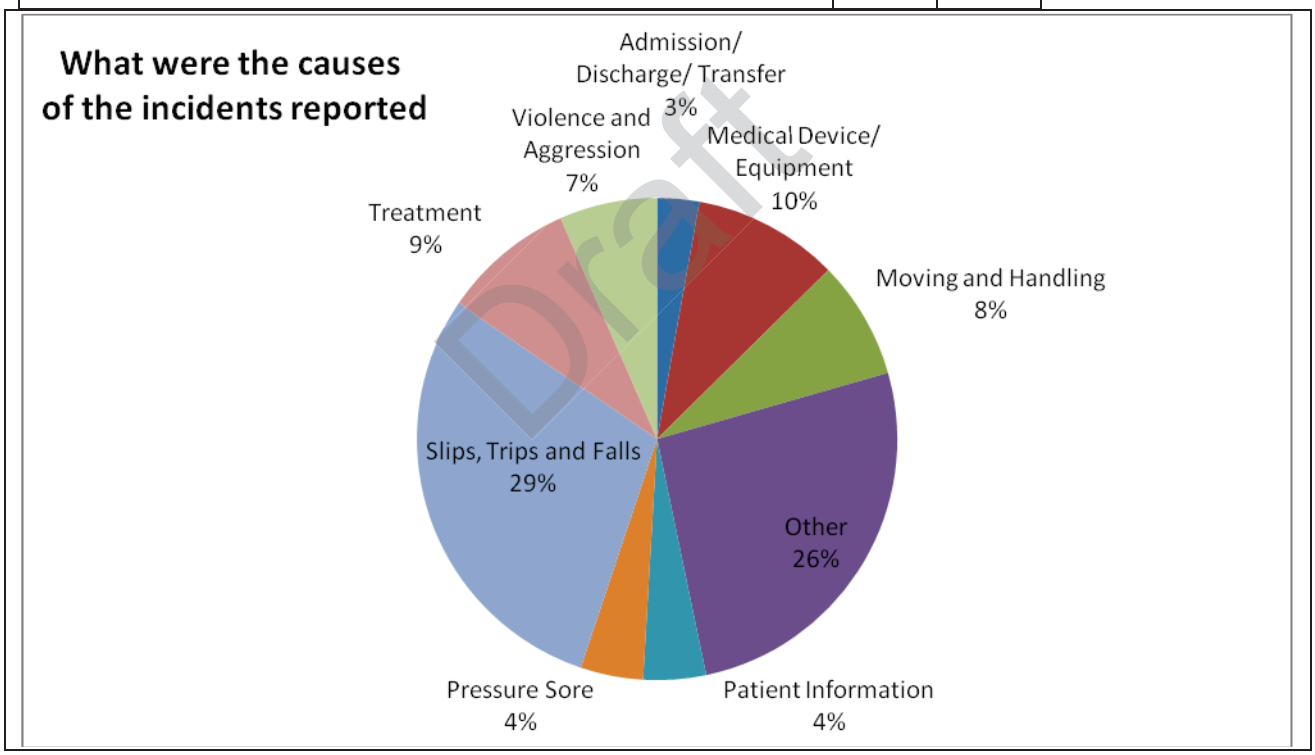
Incidents that came within the major and critical categories combined (total 16 (7%) of 214 incidents) included

- A patient who was in last few days of life died following her own removal of medical equipment
- Unable to provide home carer due to threats made to staff
- Unable to provide home care because staff were already allocated
- Family returned controlled drugs to the Hospice rather than a Pharmacist, which meant staff had to contravene policy (x2)
- Patient sustained a pathological fracture following a fall
- Patient who had died was found by a visitor
- Patient was found unresponsive in Day Centre by staff but they were subsequently assessed and made a recovery

What were the causes of the incidents reported?

When we look at the causes of the incidents reported the reasons are very varied, as shown in the chart below.

What were the causes of the incidents reported?		
Admission, discharge and transfer	3%	6
Medical device/equipment	10%	21
Moving and handling	8%	17
Patient information	4%	9
Pressure Sores	4%	9
Slips, trips and falls	29%	63
Treatment	9%	19
Violence and aggression (Patient on staff)	7%	14
Other	26%	56
		214



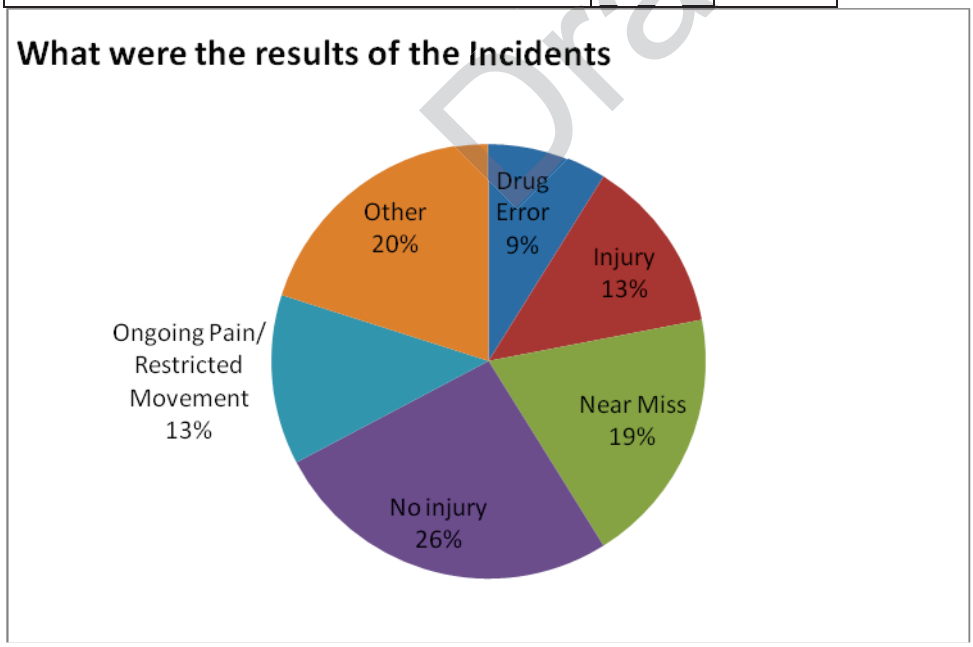
Falls by Hospice patients are seen as the biggest reason for incidents occurring. During the twelve months period April 2011 to March 2012 they accounted for 57 incidents which equates to 27% of all incidents. We have begun work to manage the number of falls but because of the deteriorating medical condition of the majority of patients, we cannot eliminate them. During the past year this work includes the introduction of a Prevention of Falls Policy, which includes a Falls Risk Assessment to be completed for all patients, a Use of Bedrails Policy and a Room Environment Assessment.

To ensure the wellbeing and safety of the patient following a fall, if it can be seen that they have suffered any injury, or if they say they have, they will always be seen by a doctor to ensure they have suffered no ill effects. They will then be monitored to make sure that there are no after effects from the fall and any contributory factors are reduced where possible.

What were the results of the incident?

The result of any incident will always be assessed according to the impact it had on the person affected. The following chart shows that 52% of reported incidents resulted in no injury, including where it was categorised as a near miss. In the case of patient falls, the result is often bruising, a laceration or a minor injury. In all cases where there has been an effect on the patient, they will be monitored to ensure there are no adverse effects on them.

What were the Results of the Incident?		
Drug error	9%	19
Injury	13%	28
Near miss	19%	41
No injury	26%	56
Ongoing pain/ Restricted movement	13%	27
Other	20%	43
Total	100%	214



What about the future?

During the forthcoming year North London Hospice will aim to build on the progress that has been made during the present year to improve the safety of all persons who use the services provided.

Over the past year, a number of initiatives and actions have been completed which are intended to improve the level of incident reporting and provide support to staff undertaking incident investigations.

A new incident reporting Policy and Procedure, including a new Incident Reporting Form, was approved by the Board in May. The need for, and the benefits of, incident reporting are included in the Hospice Induction Training, together with guidance for staff on undertaking an incident investigation. In addition, specific training on incident reporting has been provided to some teams within the Hospice. The result of this has been to increase staff awareness of incident reporting. There was a 62% increase in the number reported during the year April 2011 to March 2012 - against the same period in 2010/11.

In addition to the Incident Policy, the Hospice has also approved and introduced a Serious Incident Policy. This details a number of specific incidents that would need to be reported immediately to the Service Director or On Call Director and a formal investigation undertaken. During the period there were no serious incidents.

The majority of incident investigations are straightforward and do not require a full investigation. During the year there was one incident which required a formal investigation which was undertaken by a member of the nursing team with support and guidance provided.

Details of all incidents are reported to and reviewed by the Risk Committee (non clinical incidents) and the Clinical Quality Group (clinical incidents). Feedback is available for all teams so that staff are able to learn from incidents that occur.

To support these policies and to reduce the occurrence of the number of incidents, the Hospice introduced a Risk Assessment Process. This enables the staff to take proactive action to identify and manage risks in different areas, thus potentially enabling them to reduce the number of incidents reported.

Infection control

Quality and Performance Indicator(s)	**Threshold**	
The number of patients known to be infected with MRSA on admission to the IPU		2
The number of patients known to be infected with Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission to the IPU		0
Patients who contracted these infections whilst on the IPU		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.

Priorities for Improvement:
Following consultation with Hospice managers, clinical governance group, trustees and local palliative care commissioners, the following three priorities for improvement were agreed for 2011-2012:

Priority 1 Patient Experience: User involvement survey and development of user forums

Priority 2 Patient Safety-Development of Falls toolkit and Falls Risk Management Policy

Priority 3 Clinical effectiveness - Enhancing nutritional care of patients

Priority 1 - Patient Experience

User Involvement

In order for NLH to meet the needs of the local population in the boroughs we serve, the patients, their carers and community members need to be consulted in all aspects of service delivery, development and redesign.

NLH has spent many years working on user involvement feedback. We know from experience that the people who use our services need to be given a 'voice' to share their views on our services and how they should be developed and delivered.

Over the past seven years patients and their families have fed back to our team of volunteer researchers. During this period each project captured a small sample of in-depth views and experiences of service users.

NLH is hoping to see User Involvement embedded into the everyday core business and practice of all our services. We want to ensure that we take into account the views and experience of all service users (patients, carers, families and referrers to the services) in order to improve the user experience in a seamless delivery of all services throughout the Hospice.

In 2011 NLH User Involvement Strategy was developed. Its aims are:

- To develop an organisational culture that value the views of service users and remains consistently receptive to their views
- To have evidence of high quality services tailored to the needs of service users.
- To develop services and facilities through proactive involvement of service users, representing the diverse range of people in our care.
- To implement a practical structure that encourages and enables the involvement of service users at all levels of the organisation.
- To introduce service user forums and ensure that they have a clear purpose.
- To ensure that the whole community is represented.
- To ensure an approach to service user involvement that is consistent with recognised best practice.
- To ensure that all staff and service users understand the principles behind service user involvement and the process by which to involve or be involved.
- To ensure that all services users feel valued and supported.

In 2011 it was agreed to distribute a patient survey and develop user forums as one of NLH's three priorities for improvement.

Patient and relative/carers surveys

Surveys were sent to all patients and relative / carers who are receiving or have received a service from the Hospice during the period 1st June 2011 to 23rd December 2011.

	No Issued	Responses	%
Inpatient Unit. Relatives (Sent to relatives/ carers 3 months after patient death)	39	19	49
Inpatient Unit Patients (Given or posted to patient on the day of their discharge)	24	7	29
Community Services Relatives (Sent to relative/carer 3 months after patient death)	91	30	33
Community Services Finchley (After direct face to face contact with the Service)	154	61	40
Community Services Enfield (After direct face to face contact with the Service)	181	67	37
Day Care Centre (To each patient after six weeks using the Service)	50	28	56

A total of 539 surveys were sent to patients and carers and recorded on ICare (Patient information system).
212 surveys were returned with a response rate of 38%.

These figures include surveys sent to Day Centre patients which was still fully operational at the commencement of the survey initiative, although not accepting new referrals.

Palliative Care Support Services (PCSS)

A survey was sent to patients' families three months after the death of the patient. The surveys were sent to families who received the PCSS service only.
28 surveys dispatched by post but only three returned therefore, for this year they do not provide any meaningful data.

Survey 2011 results

The highlights of the survey are:

Did the care you received meet your expectations	94%
Did the service meet your needs and priorities	96%
Were you treated with respect and dignity	94%
Would you recommend the service to friends and family	92%

"I felt you gave the right amount of support to patient and wife."

Inpatient Unit

- The survey forms for the patients were either handed to or posted to them on the day of their discharge
- The survey forms for relatives and carers were posted to them 3 months after the patients death

Comparing the Inpatient Unit patients and relatives responses to the service provided.
(Question 4 N/A)

Comparing the IPU patients and relatives responses to the staff provided.
(Question 2 N/A)

The results of the Inpatient surveys are extremely encouraging with all questions showing positive results and none below 60%. From these we have identified 3 areas to concentrate on to bring them up to the levels of the other responses:

- Increasing the involvement that patients feel about their care
- Increasing accessibility to ask questions
- Reviewing how we respond to patients and relatives' questions

"Use this opportunity to express deep appreciation and thanks for the support and help offered with such care and sensitivity."

Community Nursing Teams

- Survey forms were sent to the patients after the 1st or 2nd meeting
- Where the patient had not responded the relative/carer was sent a form 3 months after the patients death

Comparing the Enfield and Finchley Community Teams Services and the relatives

"I cannot thank you enough for making my mothers last days pain free."

Comparing the Enfield and Finchley Community Teams staff

Again some excellent results, all 80% or more positive. We have identified two areas to bring up to the levels of the majority of responses:

- Increasing the awareness of the religious, cultural and spiritual needs
- Increasing the awareness of meeting the needs of close family and friends

"I have every confidence in the members of the Community Team."

Comparing the results of theInpatient Unit and Community relatives responses regarding staff

There are two issues that may have affected these survey results:

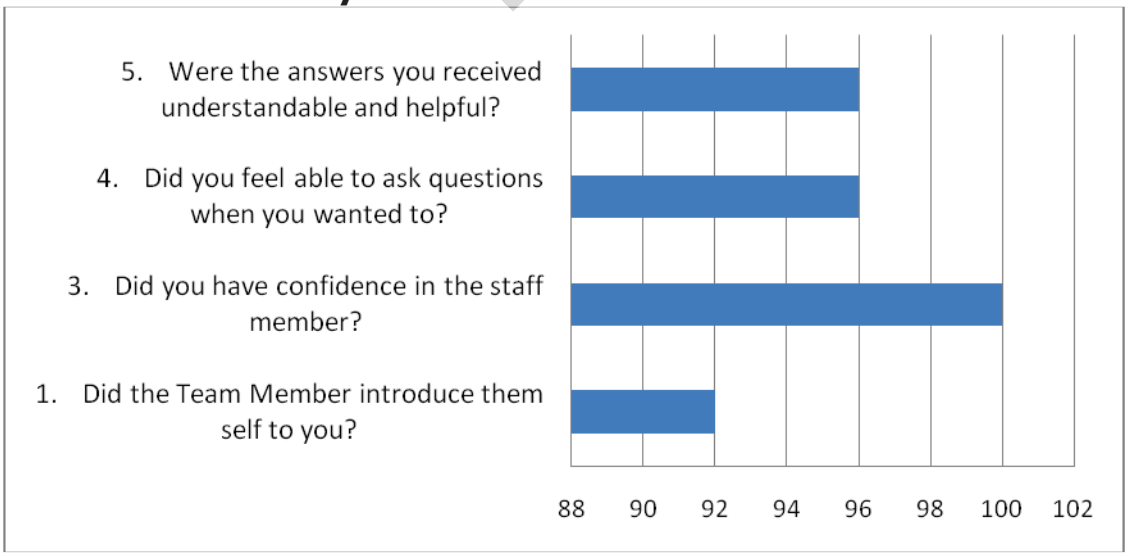
- The Inpatient Unit relatives come into the Hospice and see first-hand the care that is provided
- The relatives of community team patients are more likely to not have been present when a member of the Community Team is visiting and may therefore be responding to comments relayed to them

The services offered to Day Centre patients:

Survey forms were sent to Day Centre patients 6 weeks after they used the service. Half the forms were sent out before the announcement was made about the changes to the service.

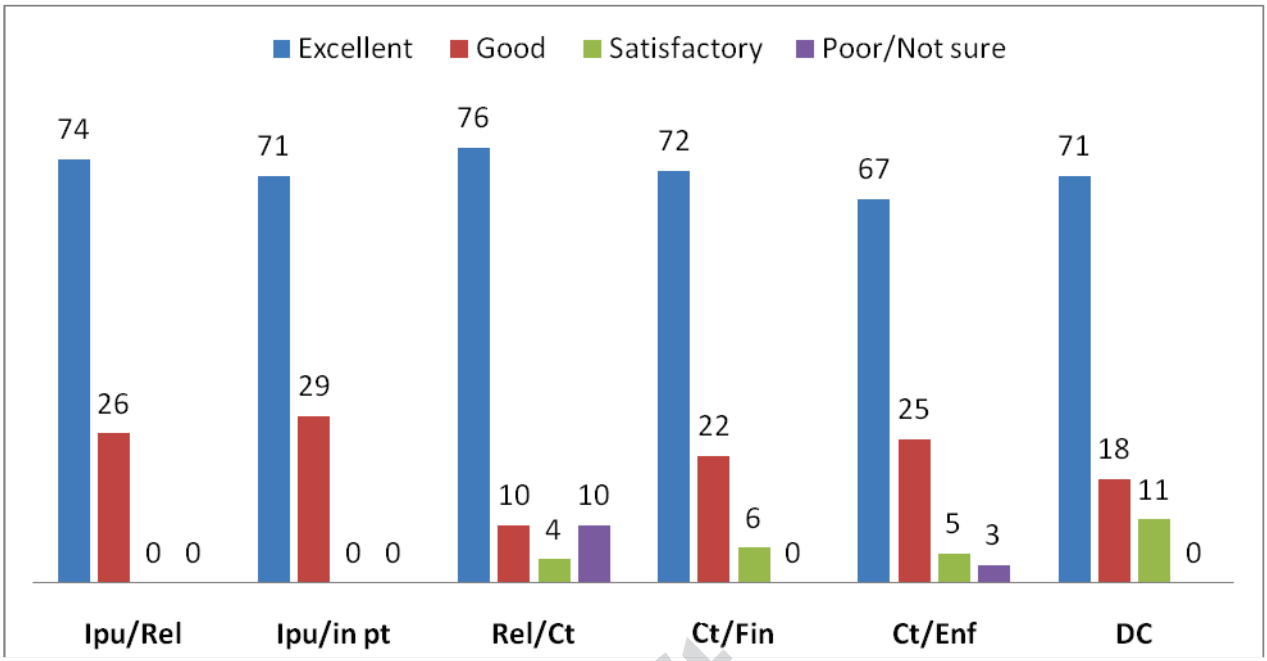
These results show that Day Centre patients were extremely happy with the service they received. We will ensure that these needs are similarly met when we open the new Day Services at Enfield. We will also concentrate on the needs of close family and friends in order to improve their experiences.

The staff at the Day Centre:



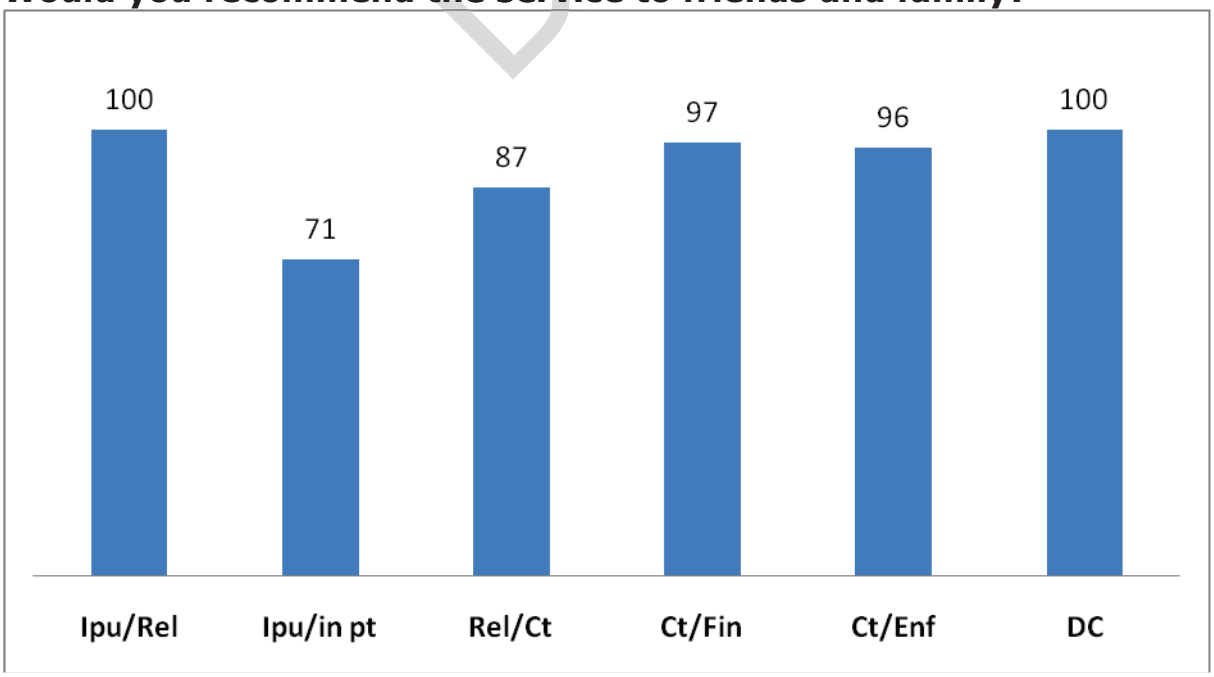
These results show that Day Centre staff were well received by the patients. The issues that have been identified will be reviewed and monitored as the new services on the Enfield site are developed and introduced.

Rate the care and treatment that you have received from North London Hospice.



It is interesting that in their responses to the individual questions, the relatives of the Community patients have scored consistently lower than otherareas but they are the ones who gave the service the highest excellent score.

Would you recommend the service to friends and family?



Overall 95% of patients and carers who responded to the survey would recommend the service to family and friends.

Performance measures

	Ipu/Rel	Ipu/inpt	Rel/Ct	Ct/Fin	Ct/Enf	DC	PCSS	Total	
1.Patients referred to the service at the right time for them.	89%	86%	56%	90%	87%	85%	0	0	
	N=19	N=7	N=27	N=61	N=67	N=27		208	83%
2.Staff always introducing themselves	79%	71%	90%	95%	93%	77%	100%		
	N=19	N=7	N=30	N=61	N=67	N=26	N=3	213	89%
3.Patients feeling confident in the staff caring for them.	79%	57%	55%	86%	91%	82%	100%		
	N=19	N=7	N=29	N=61	N=67	N=28	N=3	214	82%
4.Patients q's answered in a way they could understand	53%	57%	50%	84%	83%	74%	100%		
	N=19	N=7	N=28	N=61	N=66	N=27	N=3	212	74%
5.Pts having the opportunity to ask Q's when they wanted	0	57%	50%	95%	95%	67%	0		
	0	N=7	N=28	N=61	N=66	N=24	0	186	83%
6.Pts reporting that their privacy is respected when being examined or during discussions with staff	88%	71%	0	0	0	81%	0		
	N=17	N=7	0	0	0	N=27	0	51	82%
7.Patients being involved as much as they want to in decisions about their care	63%	57%	61%	83%	85%	56%	100%		
	N=19	N=7	N=28	N=59	N=67	N=27	N=3	210	75%
8.Pts feeling that they are being treated with respect & dignity	94%	71%	0	90%	91%	93%	100%		
	N=18	N=7	0	N=61	N=66	N=28	N=3	183	91%
9.Pts religious, cultural & spiritual needs are always acknowledged and respected	100%	86%	73%	78%	78%	58%	0		
	N=15	N=7	N=30	N=60	N=65	N=26	0	203	77%
10.Pts would recommend the service to friends/family	100%	71%	87%	97%	96%	100%	0		
	N=19	N=7	N=30	N=61	N=67	N=28	0	212	95%

In February 2012 the results were forwarded to the Executive and Management teams of the NLH. The teams have an opportunity to review the results and identify any improvements required to be put in place.

The timeframe and targets for changes will be set by March 2012 to be contained within their service plans for the year.

Conclusion
A number of areas have been identified for actions or reflection about the way that the services are provided and these results establisha benchmark against which the Hospice can be measured in the future.

Teams will work towards taking forward the actions and reflections and aim to ensure that they are implemented before the 2012 survey is sent out.

A final report with the findings of the research will be produced by April 2012, for distribution to patients and family/carers and referral agencies.

Volunteer Involvement

Three new volunteers were recruited and have been trained to help those users who requested assistance in completing the survey.

Service User Forums

A request was made to the Enfield team to provide a list of patients and carers who we could invite to join the Enfield forum to discuss current provision and services within the new building. A Hospice volunteer was identified, whose wife was cared for by the Hospice. He now sits on the Enfield Site Development Steering Group.

A meeting was held in October with current Day Centre volunteers and drivers to introduce the proposed new services that would run from the new Enfield building.

During October volunteers were recruited and trained in how to interview patients about the new Enfield development and to find out any issues or ideas they may have regarding the Enfield site and the services. 24 patients and 4 family members/carers were interviewed. Patients rated the importance of the current Day Centre service and fed back on what they enjoyed about it and what they would like to see in the new Enfield site.

A stakeholders' consultation meeting with voluntary providers and faith groups was held on 2nd November to gauge their views on the services to be run from the Enfield site. There was support for the proposed new services and support offered to the team.

Future plans
Future plans for user involvement are:

- Creation of Service User Forums across all services.
- Web page to be developed for User Involvement.
- Gathering case studies from users wishing to tell their story.
- Designing of user involvement literature.

Further surveys will be sent from June to December 2012.

Priority 2-Patient safety

Falls

Falls are known to be the most reported safety incident countrywide. Whilst many falls do not result in harm to the person receiving care, in some cases injury occurs with the potential for serious injury, resulting in distress to the person receiving care and possible admission to hospital. North London Hospice incident figures indicated that the risk of falls was and is a key area of risk within the organisation. We recognise that given the nature of the people we care for, there will always be a risk of falls within health and social care services. There is much that can be done to reduce the risk of falls and to minimise harm, whilst at the same time enabling service users to be independent and as mobile as possible.

Plan for 2011

1. Falls Audit - this was presented in April 2011 to the Audit Steering Group and in June to the Clinical Quality Group.
2. Prevention of Falls Policy - this was approved by the Clinical Governance Committee in October 2011 and a pilot commenced on the inpatient unit in November 2011.
3. Development of a 'Falls Toolkit' including:

    - Validated Falls Risk Assessment tool - in pilot November 2011
    - Falls Risk Assessment Guidelines - in pilot November 2011
    - Falls Care Plan and Guidance - in pilot November 2011
    - Generic Risk Assessment for use of lap belts with wheelchairs - in place August 2011
    - Safe Use of Bedrails Policy approved by Clinical Governance Committee October 2011
    - Bed Rails Risk Assessment and Decision making tool - introduced October 2011

4. Inpatient unit room environment assessment tools - commenced November 2011.
5. Training - initial training to support the introduction of the policy happened locally.

Plan for 2012-13

1. Falls Risk Management training to be incorporated into mandatory training programmes, at induction and annually.
2. Audit of compliance with policy to be carried out in April 2012.

Sustaining Change

With the introduction of the policy, risk assessments, care plans and guidance we have set standards which include:

- Falls assessment screening tool to be completed on all patients within 24 hours of admission
- Full falls assessment to be completed within 24 hours of need being identified from screening tool
- A falls care plan to be completed for every patient for whom a full assessment is required
- IPU room environment risk assessments completed annually
- Bed maintenance checks completed twice yearly
- Risk Committee to undertake quarterly review of falls incident data

Priority 3 -Clinical effectiveness

Enhanced nutritional patient care

Nutritional care is an essential aspect of palliative care having physical, social, cultural, spiritual and emotional aspects. The nutritional needs of people with specialist palliative care needs differ according to the patients' disease and the stage they are at in their illness. Thus nutritional care needs to be individualised.

The following targets were set to address enhancing nutritional patient care at NLH:

- 100% of patients are cared for according to NLH nutritional policy
- 100% patients nutritional care is individualised and care plans reflect this

The following action plan was agreed and progress to date is detailed below:

1. **Development of a nutritional policy**
   - Policy ratified by Clinical Quality Group March 12.
   - NLH Consensus Statement on Nutritional Care available to all staff.

2. **Review of nutritional assessment tools and the value of introducing to NLH services**
   - Nutritional Assessment Tool for IPU ratified by Clinical Quality Group March 2012

3. **Development of core care plan on nutrition and hydration**
   - Core care plan ratified by CQG March 2012.

4. **Provision of training on nutritional needs, assessment and care**
   - Planned to commence March 2012

5. **Staff involved in food handling to receive annual food handling awareness training**
   - 81% of staff (n=78) and 75% volunteers (n=230) have completed training.

6. **Catering staff have minimum of level 2 food handling qualifications**
   - 100% achieved

In addition to the above objectives, the following initiatives have been implemented or are being planned, to improve the whole nutritional care experience for patients and staff:

- Patient menu folder in all patient rooms listing: menu, alternatives meals, breakfast menu, snacks, condiments and the availability of pre-ordered cakes for special occasions
- Increased availability of water for visitors
- New patient jugs with indicators for where patient needs assistance
- Trained volunteers feeding and serving patients where indicated
- Pre meals drinks trolley
- Tea at 3pm initiative
- Protected meal times
- Catering staff visits to inpatient unit patients to seek feedback

What our staff say about the organisation
We employ 137 staff, have 450 volunteers and bank staff are used as required in clinical and non clinical roles.
During 2011-2012, 17 staff joined NLH and 21 staff left.
Staff have the following opportunities to air their views:

- 1:1 meetings with line manager
- Annual appraisals
- Staff meetings
- Management Development Programme
- Employee Assistance Programme (this is an anonymous and confidential forum for obtaining assistance. Statistics only are provided on the issues discussed).
- Consultation groups e.g. Workforce Review Group
- HR surgery held twice a week for all staff to discuss any issues regarding terms and conditions (started March 12)
- Voluntary exit interviews for staff leavers with HR

NLH is currently reviewing hospice wide staff sickness. It has been noted that there is significant short term sickness in some areas. To address this, new absence management training is being rolled out to the organisation by the HR Manager and the "Bradford Score" is being piloted in one service. It is hoped that the reasons behind such absences will be better understood and help to reduce sickness absence.

Volunteers survey

The survey was sent out 6 weeks after major changes were announced in the Hospice. The purpose of the survey was twofold –

1) To find out how well volunteers felt supported and part of the Hospice

2) To find out the reaction to proposed changes in volunteering practices and roles.

50% of volunteers responded. All volunteer groups responded so there was a good representation across the board.

Volunteers wanted

- More training and ongoing training
- To develop sustained relationships with patients/carers
- More clarity about roles & more utilisation
- More ongoing support
- More positive feedback about how a volunteer role makes a difference
- More sense of being a core part of a team with staff
- A chance to meet with other volunteers/work as volunteer team/feedback to each other
- More effective pro-active communication and consultation
- More ongoing information about developments – Enfield development particularly

We feel that many volunteers see the NLH as the Finchley site only. We need to improve communication about the wider picture in the community – (ambassadors).

What our regulators say about the organisation

North London Hospice is regulated by the Care Quality Commission (CQC) formally the Health Care Commission. The CQC may request evidence that we are meeting the 16 Essential Standards of Quality and Safety at any time, either at an unannounced inspection visit or by producing Provider Compliance Assessmentdocuments which contain detailed evidence about each outcome area. At the point of registration with the CQC we were issued with a Quality Risk Profile which showed us as low risk but highlighted 2 risk areas, no permanent Accountable Officer- now resolved, and the need to have a permanent Registered Manager- this too is now resolved.

Statements from PCT, LINks, OSCs

….. To be inserted

How to provide feedback on the account

North London Hospice welcomes feedback, good or bad, on this Quality Account. If you have comments contact:
Pam McClinton
Director of Nursing
North London Hospice
47 Woodside Avenue
London N12 8TF

The Board of Trustees' commitment to quality

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Central London Community Healthcare NHS
NHS Trust

Barnet ▮ Hammersmith and Fulham ▮ Kensington and Chelsea ▮ Westminster

CLCH Quality Account 2011/12

Contents

Section One - Overview

Case Study: Looked after Children Nursing Service "It's all about our patients - where the patients go, we follow."

About the service
The Looked After Children (LAC) Nursing service, provided by CLCH across all of our boroughs, is a service aimed at improving the health outcomes of looked after children – some of the most vulnerable in our community. In Barnet the service is called 'Children in Care'. With a range of profiles including safeguarding backgrounds, mental health and behavioural issues, sexual exploitation, and drugs and substance misuse, the children that the service works with have associated health needs.

Engaging people
Due to their specific needs, this group of service users is particularly challenging and can be very hard-to-reach and resistant to care. However, the LAC service truly puts the service user at the heart of everything they do, embedding engagement within their everyday practice in innovative and creative ways to ensure that the service is completely shaped by service users. Some examples of how the LAC service engages with their users include:

- **Putting the individual at the centre of everything they do, for example:**
  - meeting for health assessments at times and sites chosen by the service users
  - communicating with the service user by their chosen method (eg email or text)
  - communicate with service users in ways that are flexible/accessible, ie make changes to language used and references specific to the user group
  - limiting note-taking during health assessment discussions to retain personal connection; assessments written up directly after meeting

- **Happy hands:** use of creative arts to elicit feedback from children using the service; children are asked to draw around their hand and then on the handprint write their feedback about their nurse. This feedback informs ongoing service delivery. Specific changes have been made in response to feedback; for example, staff now wear jeans and more casual clothing to be more approachable.

- **Patient stories:** use of written patient stories about their experience of the service; highlight the things that are important to the service users

About our Quality Account 2011/12

What is a Quality Account?

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

Why has CLCH produced a Quality Account?

CLCH is a community healthcare provider. We provide healthcare to people in their homes and the local community. Therefore we must publish a Quality Account. This is the second year, from April 2011 to March 2012 that we have published a Quality Account.

What does the CLCH Quality Account include?

Over the last year we have collected a lot of information on the quality of all of our services within the three areas of quality defined by the Department of Health: safety, clinical effectiveness and patient experience.

We have used the information to look at how well we have performed over the past year and to identify where we could improve over the next year, and we have defined three main priorities for improvement which we set out later in our Quality Account.

This Quality Account covers the four boroughs in which we were working during 2011/12: Hammersmith and Fulham (H&F), Kensington and Chelsea (K&C), Westminster, and Barnet.

You can find this in the Publications section of our website www.clch.nhs.uk

How did we produce this Quality Account?

To make sure that our priorities also reflect the priorities of our patients, the wider public and the people we work with, we involved different groups to help us put the report together: patient and community representatives, our commissioners and our staff.

We have a dedicated Quality Accounts Stakeholder Reference Group to provide comments and feedback right from the start of the drafting process in February this year.

The membership of this group includes representatives from Local Involvement Networks (LINks), local council Overview and Scrutiny Committees (OSCs),

commissioners and GP consortia, as well as clinical and managerial members of our own staff.

We hope that this group will continue throughout the year to provide assurance and feedback as we implement the plans laid out in this report. You will find more about the involvement of different groups in their own statements (to be inserted).

How can I get involved now and in future?

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

How do I request a hard copy of the CLCH Quality Account?

To request a hard copy of the CLCH Quality Account, contact the CLCH communications team by phone on 020 7798 1420 or by email to communications@clch.nhs.uk.

What if I want to know about the quality of a specific service that I use or am interested in?

This Quality Account covers the quality of services as a whole across CLCH. However, we understand that you may be interested in a specific service or services that you have used, for example foot care or health visiting.

To find out how a specific service of interest to you performed during 2011/12, please go to the Publications section of our website, www.clch.nhs.uk, where information on individual services and service areas can be found in a series of service-level Quality Reports for 2011, produced in February 2012.

What if I want to talk to someone about CLCH's services or my experiences?

If you would like to talk to someone about your experiences of CLCH services or need to know how to find a service, you can contact our patient advice and liaison service (PALS) in confidence on 0800 368 0412 or email to clchpals@nhs.net You will also find these and other contact details in our 'Useful contact details' section on page 45.

Case Study: Soho Walk in Centre

As a result of the feedback received from our patients using the Walk in Centre in Soho, the service has taken action to reduce the waiting times experienced by service users by increasing capacity. A new clinic room is now operational and as a result patient throughput is improving.

About CLCH

In February 2012 we officially launched our refreshed vision and mission statements:

Our vision is to lead out of hospital community healthcare

Our mission is to give children a better start and adults greater independence

We want to continue to deliver the very best healthcare and treatment to people in the community and closer to home. We recognise how important it is for us to strengthen our partnerships with hospitals, GPs, social care, the voluntary sector and our communities in order to make a real difference to people's lives.

We are the largest community healthcare organisation in London and we were the first in London to be awarded NHS Trust status. As such we are at the forefront of changing the way community healthcare services areprovided to achieve the best possible results for our patients.

We employ more than 2,600 community healthcare professionals who provide out-of-hospital, community-based healthcare services for nearly one million people who live and work in the London boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

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

The full range of CLCH services includes:

- Adult community nursing services – including 24 hour district nursing, community matrons and case management
- Child and family services -including health visiting, school nursing, children's community nursing teams, speech and language therapy, blood disorders, and children's occupational therapy
- Rehabilitation and therapies - including physiotherapy, occupational therapy, foot care, speech and language therapy, osteopathy
- End of life care – for people with complex, substantial, ongoing needs caused by disability or chronic illness.
- Offender health services – at HMP Wormwood Scrubs
- Continuing care – services for older people who can no longer live independently due to a disability or chronic illness, or following hospital treatment
- Specialist services – including elements of long term condition management

- Walk-in and urgent care centres – providing care for people with minor illnesses, minor injuries and providing a range of health promotion activities and advice.

For further information about our services in each area, please visit our website www.clch.nhs.uk

Our journey to becoming an NHS Foundation Trust

We were formed in 2008 from the three healthcare organisations which were formerly part of the primary care trusts in Hammersmith and Fulham, Kensington and Chelsea, and Westminster. We became a standalone NHS Trust in November 2010. In April 2011 Barnet Community services also joined us to become part of our single organisation now spanning all 4 boroughs.

We are one of only two NHS Trusts in London that exclusively deliver out-of-hospital, community-based NHS healthcare services, and one of just18 across England. Most community healthcare services in England have been merged into either hospital trusts or mental health trusts.

We aim to become a Foundation Trust during the summer of 2013 and as part of this we look forward to building a membership, made up of local people, patients and employees. We believe that as a Foundation Trust we can continue to provide patients with the very best care and treatment, by really focusing on community-based services. We would be even more responsive to people's healthcare needs, because they would be part of the organisation helping to shape local community services. We would also have the additional advantage of having the freedom to invest in state-of-the-art care and treatment for patients.

CLCH works with partners, such as GPs, acute and mental health trusts and other providers, local councils and primary care trusts (PCTs), across our local boroughs, aiming to provide joined-up and seamless care pathways for our patients. The main hospital trusts that we work with are Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust, The Royal Free NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust.

The communities across H&F, K&C, Westminster and Barnet share some common characteristics. For example, the people in all three inner boroughs are on average younger and more mobile than the London-wide average. Communities tend to be densely populated and ethnically diverse, with a high proportion of people born outside the UK. Health inequalities are evident between people living in the most affluent and the most deprived areas. Overall, the main causes of illness and premature mortality are circulatory diseases and cancer, and there are also high rates of mental ill-health. However, there are also some differences between boroughs:

Hammersmith and Fulham has relatively poor health and deprivation indicators. The borough also includes Wormwood Scrubs prison and the healthcare of

offenders placed there is the responsibility of the NHS.

In **Kensington and Chelsea** the health divide appears to be widening as people become healthier in line with London as a whole, but health in the more affluent areas is improving more rapidly and therefore widening the divide.

Westminster has high numbers of homeless people and those living in temporary accommodation, with the associated adverse impact on health. There are high numbers of older people living alone and the daily influx of commuters and tourists swell the population considerably.

Barnet has a diverse community that includes both disadvantaged and affluentareas. There are high levels of health inequalitieswhich include high rates of heart diseaseand cancer. Smoking remains a substantialcause of lower life expectancy and highdisease rates along with relatively high incidence of obesity.

Case Study: Continence Service

Incontinence, both urinary and bowels, is a very embarrassing condition that is underreported therefore it is very difficult for patients to speak with anyone about it. The perception is that the condition is inevitably age related. It is therefore important that the clinicians are very empathetic and to involve patients in the clinical decisions taken regarding their care.

There have been big improvements in the last year to make the service more accessible to patients. The service now runs 13 clinics weekly across Kensington and Chelsea and Westminster. This has been increased from 9 clinics per week last year meaning that patients can now be given clinic appointments closer to where they live in order to make travelling easier. There are also afternoon clinics so patients now have more choice in their appointment times. In addition to having more clinics open for longer we now provide every new patient with a one hour face-to-face assessment, up from 45 minutes last year. Every patient also receives a telephone call the day before their appointment to remind them.

There is seamless referral between the physiotherapist and the nurses for patients in Kensington and Chelsea PCT and Westminster according to clinical needs and with the full agreement of the patient. The service collaborates with the Urogynaecology nurse specialist, the urology nurse specialist at St Mary's Hospital and the Women's Health physiotherapists at the Imperial College. We also refer patients to the acute sector for further investigations and management of both bladder and bowel symptoms if the need arises.

The majority of our patients have reported that the service we offer is good and that they are treated with respect and dignity.

Executive Summary

Statement from our Chief Executive

James Reilly
Chief Executive

Our Board is committed to providing quality healthcare for our patients and their families.

Central London Community Healthcare NHS Trust has made a firm commitment through our Quality Strategy and Patient and Public Engagement Strategy to keep patients at the heart of everything we do.

We are there to respond promptly and to help people get back on their feet as quickly as possible. We also provide support for the long term -to help people to live with any conditions as actively as possible with our help.

In this Quality Account, we reaffirm the importance CLCH places on the three pillars of quality: **Safety, Clinical Effectiveness and Patient Experience**. We have reviewed the detailed data available to us on our performance in each of these areas over the last yearand aspire to build on some of the positive findings to maintain our focus on quality improvement. This Quality Account openly describes what we do well and also where we need to make improvements. It focuses on the reasons why I and thousands of other staff have chosen to work in the NHS –to strive for safe, effective care of which patients and staff can ultimately beproud. Our job is to understand what our patients want from us, to truly listen to what they tell us about their care, their experiences about what worked well and what could be better.

We continue to remind ourselves that the quality of patient care is our highest priority but this needs to be evident in the everyday experiences of people accessing our services. Much of what is written in this account reminds us of why so many people are quite rightly proud of the NHS but also that staff need help and support to change things for the better. For example, whilst we have seen progress in how patients rate our services through the collation of patient experience measures, there is more work for us to do to prevent pressure ulcers which can be a significant cause of sickness and discomfort and lead toa reduced quality of life for patients. This Quality Account also sets out other issues and risks we must address and identities the five priorityquality areas we are committed to improving over the next year.

I wish to take this opportunity to thank our staff who continuously strive to improve the care they deliver, ourpatients for taking their time to tell us when we got it right but also where we could do better and ourcolleagues across the local health and social careeconomy for working with us to provide a comprehensive local service.

Patient comment– district nursing

'Excellent service; mum has had a district nurse for many years with ulcers and oedema. Legs clear due to very good attention. All very kind and attentive.'

Our view of the quality of services provided during 2011/12

Safety: We made good progress towards building a culture of openness and learning from experience. The most significant safety concerns are associated with the development and deterioration of pressure ulcers whilst under our care and standards of clinical record keeping. During 2011/12 the Trust has undergone a number of external assessments, which have provided the Trust Board with a level of assurance that effective patient safety systems are in place. We know the Trust still has work to do to ensure that we remain compliant and that we continue to improve yet further. Key to improving within these areas will be enhanced clinical supervision by colleagues and service heads.

Clinical effectiveness: In line with the Government's principle of "no decision about me without me", we worked hard last year to develop and implement ways of measuring the effectiveness of the care weprovidefrom the patients' point of view. Specifically, we conducted Patient Reported Outcome Measures (PROMs) surveys in 96% of our service areas. This year we are very eager to continue tobuild on this work to collect better evidence of the effectiveness of our care, and to use that evidence to improve the outcomes that our patients achieve. We will do this in a variety of ways including: improving the quality of our clinical audit programme, conducting more PROMs surveys in more areas, and developing new ways to organise our services so that they take greater account of the overall needs of each patient.

Patient experience: We focused a great deal on developing our understanding of patient experience through the systematic collection of patient feedback surveys known as Patient Recorded Experience Measures (PREMS). Overall, indicative results from these surveys were positive – 89% of the 12,657 patients surveyed rated overall experience of their care as "good" or "excellent". Next year we want to build an even richer, more robust understanding of the experience of our patients by using electronic devices wherever possible and reaching those groups who are seldom heard. We are also increasingly using patient stories as a method to hear the patient's voice and see quality through their eyes.

Summary of our five main improvement areas for 2012/13

Having reviewed the data available to us during 2011/12 and looking across the whole Trust, we have identified five main areas for improvement for 2012/13. These priorities have been determined through consultation with our staff, key stakeholders such as the Local Involvement Networks, as well as our own patients. We will monitor and report on progress against each of these areas over the course of the year:

Safety: Supported by enhanced clinical supervision from fellow colleagues and service heads

1. **Reduce the number of preventable pressure ulcers in the community**

2. **Strengthen clinical record keeping practice to support patient care pathways**

Effectiveness:

3. **Demonstrate service improvements as a result of clinical and patient reported outcomes**

4. **Implement comprehensive Patient Reported Outcome Measures (PROMs) and outcome measures along all clinically agreed pathways of care**

Patient Experience:

5. **Continue to develop a more detailed understanding of patient experience applied consistently across all services– particularly the increased use of patients stories as a way of gaining feedback**

This Quality Account has been developed in consultation with our patients, staff, Local Involvement Networks (LINks), commissioners and Board members, based on evidence of how we performed in 2011/12 and what our patients have told us. We would like to express our sincere thanks to all involved in supporting us with the production of this account.

To the best of my knowledge, the information contained in this document is an accurate reflection of our performance for the period covered by the report.

James A. Reilly
Chief Executive Central London Community Healthcare NHS Trust

Statement from the Chair of the Patient Safety and Quality Committee

Julia Bond
Non-Executive Director

During 2011/12 the Trust has made significant progress in measuring and benchmarking the quality of the services we provide. We have developed measures which have enabled patients and families to access detailed information about the effectiveness of the care they receive. We have presented some of these measures in this Quality Account.

This year we have been proactive in developing better processes and systems that enable us to capture at an early stage any issues affecting the quality of our care and the experiences of our patients, so that we can take immediate and appropriate action. Along with many quality improvement initiatives throughout the Trust, we can build on our current position and provide increasingassurance to service users and carers, staff and stakeholders.

The dedication and continual commitment from our staff is fundamental to improving the quality of the services we provide and we are proud of them. I acknowledge that there is room for improvement and with this in mind much attention this coming year will be centred on building the capability and capacity of our workforce to put robust systems in place and supporting them to build a culture of quality across the organisation.

Julia Bond
Non-Executive Director and Chair of the Patient Safety and Quality Committee

Case Study: Involving service users in service delivery at Alison House Learning Disabilities Service

Alison House provides men and women with learning disabilities aged 18 to 65 with a short respite break away from home. The service has a strong focus on service user engagement and empowerment.

Working with a challenging group of service users, it would be very easy for staff to allow them to be passive recipients of care. This is especially true of service users who are non-verbal. However, at Alison House they are actively engaged in all aspects of their individual care and of shaping service delivery and the strategic direction of the service. The types of engagement activity have been modified specifically for individuals and for this group.Examples include a PREMs programme using photo symbols on electronic devices, participation in a choosing staff panel and regular coffee mornings for service users and carers.

Statements from our stakeholders

Please note that the following statements have been reproduced exactly as they were provided by these groups and have not been amended for consistency in form or style in line with the CLCH style guide. (Statements to be included)

Statements from our Local Involvement Networks (LINks)

Hammersmith and Fulham LINk statement
Kensington and Chelsea LINk statement
Westminster LINk statement
Barnet LINk statement

Statements from our local Overview and Scrutiny Committees (OSCs)

Royal Borough of Kensington and Chelsea Overview and Scrutiny Committee statement
Westminster Overview and Scrutiny Committee
Barnet Overview and Scrutiny Committee

Statement from our commissioners

Statement from Inner North West London PCTs re: Central London Community Healthcare Quality Accounts 2011-12
Statement from North Central London Commissioners re: Central London Community Healthcare Quality Accounts 2011-12

Patient comment

'Friendly, knowledgeable nurses, being looked after in my own environment a definite bonus'

Patient story – children's community nursing
"The children's community nurses come to see me at home to give me an injection. If they did not give me the injection my eye could get worse and I could go blind.

The thing I like least about them coming is the injection. The cold spray helps with the pain. I know that I have to have the injection.

Sometimes I have to have an injection at the hospital V (Play Specialist) comes with me and takes my mind off that injection (which is very painful) by doing Arts and Crafts. I don't mind if I have the injection at home or at the hospital. It is fine in both places.

I like it when C (Children's Community Nurse) comes to see me. She takes my mind of the injection. She asks me about school and things. It is nice to have the chance to share it with someone.

I don't like it when nurses leave when I have got to know them, like J and H. C has been coming to see me for a long time now.

The Community Nurses come to see me after school so that I don't miss any of my schooling.

Sometimes the nurses arrange for me to go to concerts and things through charities. I really like that. Last year I went to see JLS"

Section Two–Our priorities for providing high quality services

PATIENT STORY: Stoma Care

'Prior to the operation I had an appointment with one of the specialist stoma nurses, who gave me all the practical information I needed in dealing with a stoma and how to manage after the operation. I did find the realisation that I would probably have to live with a stoma a bit of a shock as the surgeon had said I had only had a 50/50 chance of needing to have one. The meeting was, however, extremely useful as I was then able to come to terms with it prior to surgery and I was also able to practice empting the bag.

On the day after my operation a specialist stoma nurse came to see me and to help me prepare and empty the bags and then visited me daily. Their kindness, extraordinary patience and support were invaluable and I returned home confident that I could cope with my ileostomy.

The week after I got home a specialist stoma nurse contacted me every day to ensure I was OK. They also visited me on two occasions to check I was managing the stoma care until I was well enough to attend their clinic.

In hospital I developed an infection in my operation scar which continued after I arrived home. I needed to have the wound dressed every day and this was done firstly by the district nurses and then by the practice nurses at the surgery. After a few weeks I think that the wound dressings might have interfered with the ileostomy bag as the bags began to leak at the top which was rather alarming. This made me feel very insecure so I contacted the stoma nurses, who saw me the next day and suggested a different type of bag, which was fine and I didn't experience any more problems. I then continued to visit the stoma nurses regularly at the hospital, who made sure that my stoma template was regularly corrected and that everything else was OK. They were also extremely helpful regarding diet and other general lifestyle advice. It was so reassuring to be able to talk to them regularly and their help and advice was invaluable.

I found that I experienced few problems in dealing with the bag, except the leakage, during the first few weeks as I was pretty much housebound and only went out for short periods. As I got back to normal life and started going out more, e.g. going to the office, visiting friends and the theatre etc., I did find I was constantly anxious about emptying the bag as however prepared you are, you worry about finding a toilet and also about the smell which isn't very pleasant but the odour elimination sprays did help quash some of my anxieties. I found that I needed to empty the bag 6 – 10 times in a 24 hour period which was quite restrictive and I was constantly checking to see if it needed empting.

I was very lucky, as after only 3 months I was able to have the reversal operation but the stoma nurses were still there to pack and dress my wound every few days. I am now completely healed and back to normal. During this whole process I felt fully supported by the stoma care nurses and think that the fact that they knew me throughout the process, from before the first operation into my home and afterwards, made such a difference to my recovery process, both physically and psychologically.

I can't thank the specialist stoma nurses enough for their tremendous support and care. I really don't know how I would have coped without them.'

Safety

What do we mean when we talk about safety?

"Treating and caring for people in a safe environment and protecting them from avoidable harm"– for example, by ensuring that patients are protected from community acquired infections.

We treat safety as an absolute priority at all times. We ensure safety is on the agenda of every CLCH Board meeting. Our approach is to learn from our experiences and to improve patient safety and the safety of our staff wherever possible. We take the safety of our patients and staff very seriously and work closely with our partners and statutory agencies to reduce our risks. There is a positive safety culture of risk management in the Trust. We encourage staff to report incidents and near misses as we feel that this is the only way to learn lessons and stop mistakes happening again. We also encourage patients to be involved inthe risk assessment process and encourage patients to report incidents.

For further information related to the safety of our individual services, please see the service-level Quality Reports for 2011, in the Publications section of our website www.clch.nhs.uk.

Looking back: What have we done over the past year to improve safety?

1	Improved discharge processes from hospitals to the community
	This was a priority for us last year and so we carried out a pilot to test ways to improve processes of getting patients out of hospital when they were ready in a safe and co-ordinated way. We placed community liaison nurses in St. Mary's and Chelsea and Westminster hospitals for three months, to work in partnership with hospital and social care staff in improving patient discharges into our community nursing services. Some of the aims of the pilot were to reduce the number of safety incidents related to discharge planning, improve information on community nursing referrals and increase the amount of time community nurses spent with their patients by reducing time spent on poor referrals. We saw some very positive results: • A 40% reduction in safety incidents relating to poor dischargeat Chelsea and Westminster and 15% at St Mary's hospital in the pilot

	period compared to the same period last year • Around 71 hours of district nursing time was saved as a result of the community liaison nurse informing community nurses that their patients had been admitted to hospital, increasing time with their otherpatients by 8% compared to the same months in the previous year • The majority of the patients were satisfied with their discharge experience whilst the community liaison nurse was involved in their care. Overall, the pilot demonstrated that the community liaison role had made a significant difference to the quality of discharge, but also highlighted the gaps in providing seamless care. It therefore helped us formulate a number of recommendations and a framework for further improvement, some of which are listed below: • To adapt the community liaison nurse role into a more integral role of a health and social care coordinator who will be based within the hospitals, to assist in the planning of future care specific to patients' existing needs. • For the local hospitals and CLCH to quarterly review all safety incidents reported about poor hospital discharges, particularly around medicines management. • To develop a CLCH single point of access that will help easy access into our services • To develop an electronic referral form that contains mandatory information sections, thus improving the quality of referral information for our staff. • To provide a CLCH community nursing leaflet for patientscontaining the relevant contact details of teams and the service we provide.
2	Strengthened results of clinical and patient reported outcomes (PROMs)
	To tackle this issue we have: • Provided central support to ensure that each of our services can carry out the improvement actions that they have identified in their area • Improved the quality of clinical audits so that we can identify further ways to improve clinical effectiveness • Implemented guidance from the National High Impact Actions for Nursing and Midwifery. As a result of this 96% of our services have articulated the numbers and types of patient reported outcomes (PROMs) within their service level Quality Reports but developments have been uneven in terms of how data is being used as clear evidence of the outcomes delivered. Further work will need to be undertaken to understand the extent to which outcomes are dependent on a range of services working together, and in many cases also working with other organisations.

	An information technology solution has been developed to support the delivery and analysis of PROMs. All of our services have developed detailed clinical audit forward plans and are routinely using clinical audit as a tool to measure effectiveness. A new clinical audit strategy has also been launched. We therefore intend to continue the development of clinical effectiveness systems in the coming months, and in particular to: • Complete a gap analysis of existing outcome measurement tools developed • Identify potential for sharing of approaches between services • Identify priority services for refinement and development of outcome measures • Undertake development work and training with staff teams.

Looking ahead: What are our priorities over the coming year?

1	Reduce the number of preventable pressure ulcers in the community
	***Pressure ulcers**, also known as bed sores or pressure sores, is damage that occurs on the skin and underlying tissue and can be caused by three main things:* • *Pressure – the weight of the body pressing down on the skin* • *Shear – the layers of skin are forced to slide over one another, for example when you slide down or are pulled up* • *Friction – rubbing the skin.* We have identified that pressure ulcers are one of the most common healthquality issues across all our services and so we need to be more proactive in tackling this. We have established a pressure ulcer working group to take this forward. We have already implemented a common care plan to help us to assess patients using the right sort of tools and have developed patient information for patients and carers to help themselves better manage the condition if it occurs. Staff have received targeted training and it is becoming more custom and practice to routinely take photographs of wounds to help us to track the healing of wounds. In addition to this, over the next year we will: • Review trends in ulcer development, identification and management in different parts of the organisation. • Review clinical guidelines for the prevention and treatment of ulcers, and recommend changes in practice where this is necessary • Develop better information for patients and carers • Review how we can best supportpatients who do not follow our advice.

	• Develop more robust systems for enhanced clinical supervision.
2	Strengthen clinical record keeping practice to support patient care pathways
	Clinical records *are the documents which relate to a patient's medical history, diagnoses and therapies and provide a record of the care that has been delivered.* ***Care pathways*** *are multidisciplinary plans of care, which outline timings and treatments for patients with a particular condition. They are based on best practice and standard policies to improve the quality of care for patients.* Themes identified from incident reporting and a subsequent clinical recording keeping audit has highlighted poor standards in clinical record keeping practice. Record keeping forms a vital and integral part of clinical care and professionalpractice and protects the welfare of patients by promoting continuity of care with the patient and also across multi-disciplinary teams. We are going to ensure that all services using paper-based records should be working to the same core record keeping standardcriteria. Training is being implemented into both paper-based and electronic records. A review of patients'records will be built into staff appraisal and clinical supervision processes. We will strengthen the clinical supervision process to ensure that staff are adequately supported and monitored in clinical practice.

A more detailed breakdown of our safety performance can be found in the BackgroundInformation section on page tbc.

Case Study: Tackling specific issues within individual service areas:
Communication from hospitals discharging children to the community - appropriate hospital staff informed of the lack of information

Communication from hospitals discharging children to the community - An "in-reach" service pilot started at the end of October 2011. A named children's community nurse visits St Marys Hospital and Chelsea and Westminster paediatric units on a weekly basis in order to improve communication and feedback prior to discharge into the community.

In Barnet, there have been similar issues to Inner CLCH – lack of notification of children being discharged into the community. There are two hospital-based community children nursing teams (Barnet & Chase Farm and Royal Free Hospitals); improving communication with the borough based complex care nursing team by hospital visits to raise the service profile and caseload reviews.

Patient story

'Now that I am better I miss those two nurses who used to come and visit me, they were the ones who helped wash my hair, watched me till I fell asleep. They also told me never to give up when things were getting tough.'

What do we mean when we talk about clinical effectiveness?

"Clinical effectiveness is about whether or not a patient's care or treatment was successful. In other words, did it have the impact that it was supposed to have? And did it achieve the best possible result or outcome for the patient?

This may include improvement in specific medical or health conditions, but in the community we also have a strong focus on improving quality of life, for example: independence, mobility, activities of daily living and social participation."

Providing effective healthcare is at the heart of our vision and mission; it is the guiding principle behind everything that we do. Our aim is to make sure that the care we provide to our patients and their families achieves the best possible impact on their health, wellbeing and quality of life.

One of the key tools we use to measure how successful treatments are is to collect data on patient reported outcomes (PROMs).

A Patient Reported Outcome Measure (PROM) is essentially a questionnaire that the patient will fill in once at the start of their treatment, and then once more at the end of their treatment. The questions can be general – about basic aspects of quality of life, such as how anxious the patient is feeling, or about mobility. They can also be more specific to the patient's particular condition – these PROMs focus on particular sorts of limitations or problems that people can experience as a result of a very specific condition (for example, the restless Leg Syndrome, or ask questions relevant to a wider set of conditions that affect a body part. By measuring the difference between the patient's answers at the start and at the end of their treatment, we can see whether the treatment was effective. This helps the NHS measure and improve the quality of its care.

For more information related to the clinical effectiveness on our individual services, please see the service level Quality Reports for 2011 in the Publications section of our website www.clch.nhs.uk

Looking back: What have we done over the past year to improve clinical effectiveness?

3	Involved patients more in designing and managing their own care – "No decision about me without me"
	To increase the involvement of patients in managing their own care we have: • Improved support for patients with long term conditions (specifically respiratory) to manage their own conditions where appropriate • Implemented Patient Reported Outcome Measures (PROMs) more broadly across the Trust so that more patients are involved in joint goal setting and measurement. From this work we have identified further areas for improvement including: • Defining clearly the patient population that requires a management plan provided as part of their care • Standardising the content and format of the management plan • Delivering a written self-management plan, irrelevant of the barriers encountered.
4	Improved service models and developing 'integrated pathways' of care
	*A **clinical pathway of care** is a multidisciplinary plan of care, which outlines timings and treatments for patients with a particular condition. They are based on best practice and standard policies to improve the quality of care for patients.* To make improvements in this area we have: • Developed and testing patient pathways where care is structured around the patient. In September 2011 CLCH embarked on a transformation project to develop, design and implement high quality clinical care pathways across the services that CLCH delivered. 11 pathway leads were recruited and underwent a two week induction programme that familiarised them with the care pathway model. Ongoing transformational educational packages and individual support is being delivered from the Institute of Innovation and Improvement. There are 19 care pathways identified which are due for completion in September 2012. • Implemented the Liverpool Care Pathway (LCP), which is seen as best practice in end of life care, to improve this across relevant adult services. This has resulted in the improvement in the identification of "end of life" patients as well as improvement in the recording of patients' preferred place of care at the end of their life and achievement of those wishes. More than 190 staff were trained and

	positive feedback was received. We have developed supporting documentation and an IT portal for end of life care so that information can be stored and shared. We have developed an ongoing training programme to provide refresher training for staff and established a strong network of Link nurses to continue to support the use of the Liverpool Care Pathway.

Looking ahead: What are our priorities over the coming year?

3	Demonstrate service improvements as a result of clinical and patient reported outcomes (PROMs)
	This priority area is very simply about taking practical steps to improve outcomes for our patients. It is about the fundamental task of making sure that our patients get the best possible results in every single case. We chose this as a priority area in consultation with patient and public representatives from LINks groups. Together, we all agreed that although we already have mechanisms in place to review and improve outcomes on a routine basis, this area is so important that we should make it one of our top priorities in terms of further embedding into practice. We will provide training and support to services to help them map out processes for capturing patient reported outcomes (PROMs) and to enable them to use their data effectively. Our approach will also draw on best practice from research being carried out in Europe. This will help our patients by ensuring that we are equipped with the best tools and information to improve the quality of care given.
4	Implement comprehensive Patient Reported Outcome Measures (PROMs) and outcome measures along clinically agreed pathways
	Outcome measures *are agreed areas of performance that we look closely at. This enables us to gain an understanding of the effectiveness of treatment that is given.* Our integrated pathways of care are well under development but we need to do some further work to ensure that we are being effective in the care we are providing. Pathways rely on multiple services coming together and sometimes multiple organisations. We will be building on the existing PROM measurement tools and defining clear outcome measures for patients on integrated pathways of care.

A more detailed breakdown of our clinical effectiveness performance can be found in the BackgroundInformation section on page xxxx.

Patient story – pressure ulcers
'I lived with my sores for six years, I used to think about it every day; can I wear these trousers? How long could I stay in bed if I was tired? As soon as I did not do as I was told the sores would deteriorate. I finally got my double mattress so my partner could sleep next to me and she would help me to move during the night. The nurses would sometimes terrify me into compliance as I never wanted another sore or to go back into hospital - thank goodness they did.'

Patient experience

What do we mean when we talk about patient experience?

"Patient experience is about ensuring patients, relatives and carers have as positive experience as possible at every stage of the care or treatment that is being provided. Patient experience refers to the overall experience throughout the course of treatment, and not just the results that were achieved at the end. It is a fundamental part of how we think about the quality of healthcare.

For example, a patient's experience could be strongly influenced by whether they felt treated with dignity and respect, or whether they found it easy to access the service."

Last year we put a lot of work into surveying our patients about their experiences. In 2009/10 we conducted one simple survey across the whole of CLCH which only gave us a very limited view of how patients felt about our services. So last year we improved on this and carried out over fifty individual surveys, known as *Patient Reported Experience Measures (PREMs)*, covering every service area. The questions that were asked in each area were designed for the specific patient group using that service – which allowed us to get a more detailed understanding of what patients were telling us about their experiences of our care.

The results of these surveys indicate a very positive level of overall feedback from patients. Across CLCH an average of 89% of patients rated their overall experience as "good" or "excellent".

For further information related to patient experience of our individual services, please see the service-level Quality Reports for 2011, in the Publications section of our websitewww.clch.nhs.uk

Looking back: What have we done over the past year to improve patient experience?

5	Developed a more detailed understanding of patient experience in order to improve quality
	To achieve this aim we have refined our patient survey questions and methodology (PREMs) and piloted ways to collect experience data from harder to reach groups – including through patient stories and using technology to capture patient feedback. In particular we have achieved the following: • **Detailed feedback:** Collecting feedback from patients and service

	users about specific issues relating to each service. • **Trust wide core questions:** Collecting a core set of feedback across the Trust in relation to the main elements of patient experience, such as being treated with dignity and respect. By asking the same core set of questions across the whole Trust, we'll be able to get an overview of how we're doing and spot where there may be an opportunity for improvement. • **Showing real-time trends:** Starting to build a robust dataset that will show us trends in improvement over time: the data will be updated and available to view in real-time. • **Minimising administrative burden:** Gathering and analysing this data in a way that minimises the administrative burden on frontline staff and managers. • **Getting more representative feedback:** Testing different ways to collect feedback in order to get a really rich, representative picture of how different patients experience our services. The CLCH PREMs programme has now been widely used for approximately five months. We have successfully piloted an electronic PREMs in the dietetics service and the learning disabilities service. The development of the next phase of the PREMs programme will provide yetmore detailed reporting opportunities and the use of electronic devices and the many benefits associated with their deployment. There will also be several developments with the survey structure and there will be a single set of six core questions applicable across the Trust along with standard demographics. We will also include a "net promoter" survey question – asking patients if they would recommend the service to others who might need it. We have successfully implemented a framework for patient stories with over 50taken to dateacross a broad range of services. Each CLCHBoard now hears the voice of a patient through a patient story at the beginning of its business. .

Looking ahead: What are our priorities over the coming year?

5	Continue to develop a more detailed understanding of patient experience applied consistently across all services
	We have identified a series of actions to improve our understanding of patient experience, focusing on both breadth (ensuring representative data from all groups) and depth (rich, meaningful data). The main actions that we will take are: • Refine our PREM questionnaires so that we are asking questions that are simple to understand and focus on the issues that are most important for patients • Introduce a standard set of core questions that will be asked in every

	• Build on our collection of patient stories – this means providing training to our staff to be able to listen to an individual patient's story and record it in a way that helps to really communicate that patient's experience of our services. • Capturing the experience of patients for whom traditional methods of engagement have been challenging. Adjustments have been made to the organisational-wide programmes for capturing patient feedback to cater for groups with whom we know we would have difficulties engaging. For example, child-friendly PREMs are in development and a learning disability version of the PREMs has been very successfully piloted using hand held electronic devices. • Use more innovative methods of capturing views.

A more detailed breakdown of our clinical effectiveness performance can be found in the Background Information section on page tbc.

Patient story – homeless support
"I haven't been in care long. Don't know my mum and dad is dead. I came into care on what is called a Southward ruling and if you didn't know what that means if you're homeless – but the nurse had to explain it to me.

When you are faced with such a big thing that you don't know where to look or what to say it's a problem. I am staring down the barrel of the criminal court gun. There isn't a person in the world who is there for me apart from my nurse. I didn't think I would see anyone but into the cell she trots, not scared of anything or anyone, just wants to know how I am. I lie and say I am fine. She knows I am not! She doesn't judge – anyway there is a man upstairs wearing a wig that will do that! She doesn't make me feel awkward or embarrassed. Ten minutes passes – that is all she is allowed. I see her in court, a quite reassuring body. That's when I find out what nursing is and what nurses do best. My nurse was there. Really I just wanted to say thank you."

Section Three – Background information

Clinical effectiveness case study

Embedding patient reported outcome measurement into standard clinical practice within the Heart Nursing service

Our nursing service sought feedback from some of our patients to see if there was any significant improvement in their quality of life. A questionnaire was offered to 18 clients on two occasions; following their initial assessment and then at a minimum of two months later. There is a reasonable expectation that following a period of support with a clear management plan the client should in most instances feel physically and emotionally stable enough to cope with the associated long term symptoms of their condition.

The results show there is significant improvement in the outcome for most patients. However, in some cases this improvement in their quality of life is not always perceived as evidence of an improvement or positive change. This is often because the patient is either becoming unwell again at the time of the follow up assessment or the improvement is slower than they had expected. This is where encouraging them to participate in developing a care plan is vital.

For example, in one situation a client was able to note the physical improvements in her wellbeing, now being able to go for walks outdoors - however she felt emotionally she was still not coping. By showing her the response of her follow up assessment and comparing the pre/post data she was able to confirm the changes and in fact this spurred her on to adopt a positive outlook on her health.

Formal statements required by the Department of Health

Statement from the Care Quality Commission (CQC)

Central London Community Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is registered. In line with the requirements of registration, all service activities and localities were registered with the CQC without any conditions. The CQC have not taken any enforcement actions against the Trust between April 2011 and March 2012.

Use of the CQUIN payment framework

2011/12 framework:

A proportion of CLCH's budget 2011/12 was conditional on achieving quality improvement and innovation goals agreed between CLCH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available in the Publications section of our website **www.clch.nhs.uk**

Our CQUIN goals for 2011/12 were as follows for Inner North West London:

1. To develop an in-reach model for adult's and children's community services
2. To improve self-management for patients with Long Term Conditions
3. To develop and pilot electronic data exchange of Long Term Condition patient data
4. To improve end of life care for adults and children

All of the goals from 2011/12 were achieved for Inner North West London.

Our CQUIN goals for North Central London were as follows:

1. Pressure sore reduction
2. Falls reduction
3. Improving End of Life Care
4. Chronic Obstructive Airways disease
5. Collaborative working in Learning disabilities
6. Effective communication between community and primary care

We are still waiting for final confirmation regarding the goals achieved for North Central London.

The agreed goals for **2012-13** are as follows:

North Central London:

1. NHS Safety Thermometer-Improve collation of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and Venousthromboembolism
2. Improved outcomes for pressure ulcers
3. To reduce the number of patients on the district nursing case load who experience a fall
4. Innovative ways of capturing real-time patient stories through a range of multi-media options
5. Electronic Clinical Communications to GP's
6. Increasing the stop smoking offer in health services

Inner North West London

1. NHS Safety Thermometer-National Standard Template for Falls and Pressure Ulcers
2. NHS Safety Thermometer-Local stretch on pressure ulcers and falls
3. Electronic Clinical Communications to GP's
4. Innovative ways of capturing real-time patient stories through a range of multi-media options
5. Improve health outcomes for patients with autism and learning disabilities
6. Productive referral management-enabling the child health programme
7. Compliance with the Dressing formulary

Participation in clinical audit

Central London Community Healthcare NHS Trust was only eligible for one National audit during 2011-2012 (Parkinson's audit) for inclusion in the Quality Accounts, although due to Trust reconfiguration and the movement of staff, this audit was not undertaken. We have registered for the Parkinson's National audit for 2012-13.

Case Study
Falls: Patient and Public Involvement
CLCH took part in the post-falls patient and public involvement initiative, 'Older people's experience therapeutic exercise as part of falls prevention service', having previously participated in the 2010/11 National Falls Audit. While there were only a small number of responses (19 in total), quality was comparable or better than the National results where this could be determined. Fifteen of the 19 respondents reported being 'Very satisfied' with their exercise programme the other 4 being 'Satisfied' (overall 100% being 'Very satisfied' or 'Satisfied'). Recommendations and actions resulting from the work are currently in progress across the CLCH Falls Services.

Participation in research

During the last year CLCH has developed its research culture internally by appointing a Head of Research and Development, producing a Research Strategy, and also has incorporated a research component in the job description of all professional leads.

In addition externally CLCH has developed new partnerships and is one of 11 partners of the Academic Health Science Partnership (AHSP. The AHSP brings together providers of primary, secondary, tertiary, community and mental healthcare in North West London to work with Imperial College London to improve the health and care of the area's population of 1.9 million people.)

Currently CLCH has supported staff undertaking research as part of their PhD, and Masters level programmes and current research activity is in the region of 18 active studies: fiveNIHR portfolio studies, one commercially funded study, six student research studies and one study was given a prestigious Mary Seacole award. The studies cover a range of specialities, using qualitative, quantitative or mixed methods approaches. Staff have published papers and disseminated their findings, and will have an opportunity to present at our first research conference in July.

Knowledge Research and Information Services supports research through a trust library service and access to Imperial College Library facilities. Remote access to electronic journals means that staff can now access knowledge services from their place of work.

We have also invested in the library at Edgware Community Hospital to provide a quiet dedicated place to work with 14 library computers, allowing access to the national and local electronic journal subscriptions and access to a range of databases. Library staff are available to support research by providing sessions on literature searching, critical appraisal and also fulfil the following functions.

- Enquiry service for face to face and remote users,
- Information services and literature searches
- Alerting services
- Information literacy training & support
- Athens administration
- Obtaining documents from other libraries
- Photocopying/scanning

Future plans include the establishment of research peer support networks or journal clubs, procurement of electronic materials, training to develop research skills and knowledge.

Data quality

Our actions to improve data quality

CLCH will be taking the following actions to improve data quality:

- CLCH is committed to obtaining, holding and making use of high quality data in its clinical and corporate record-keeping systems.

- CLCH can demonstrate that it meets the national targets for collection of ethnicity data and validated NHS Number overall.

- We understand the significance of supporting and training staff to prioritise the collection of high quality data: CLCH has made good progress towards meeting the NHS London KPI around patient facing time within the Health Visiting and District Nursing services by working with staff to teach them the importance of full recording.

- We have undertaken an audit of paper-based record keeping standards twice a year. This has been expanded to cover electronic records. Following on from this audit a system of peer reviews of clinical records will be implemented.

- The Information team routinely monitors data quality. A range of standard reports are available to staff and team managers to identify missing data items.

- Business managers and the Head of Performance monitor data month on month to identify trends.

- The information team ensures outlying values are investigated and confirmed prior to the issuing of reports.

- The Trust Board has commissioned the Performance Framework project to ensure that we collect meaningful data that will improve services received by our patients, and which can be used by CLCH to manage its services, plan for the future and develop CLCH into the leading community service provider in London.

- We are working to define accurate service line financial reporting to ensure our services offer best value for money.

NHS Number and General Medical Practice Code Validity
CLCH did not submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Information Governance Toolkit (IGT) attainment levels
The CLCH Information Governance Toolkit submission scored 71 percent overall for 2011/12, for which the Trust achieved a green (satisfactory) rating. During this period, 98.2% of CLCH staff passed the mandatory training module which helped to achieve compliance against 1 of the 40 requirements.

Clinical coding error rate
CLCH was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

More detail on our patient safety performance

Looking back: What have we done over the past year to improve safety?

Developing a robust approach across the organisation
Over the past year we have focused on bringing together our Barnet services with our inner borough services so we have a common approach to managing safety across the whole of CLCH. We want to make sure that staff across the organisation feel supported to be open about reporting specific safety incidents, and that there is a free and honest approach to learning from every experience.

Developing a Culture of Openness, Learning from Experience and Fair Blame
This year CLCH has again placed a strong emphasis on embedding a culture of Being Open, Learning from Experience and Fair Blame.

Learning from Experience: we have continued to embed the robust approach and positive culture to support Learning from Experience throughout the organisation, ensuring that systems were brought together smoothly during the integration with Barnet Community Services.

Being Open:*This refers to communicating honestly and sympathetically with patients and their families when things go wrong.* We have further developed a safety culture that is: supportive of its service users and staff: open, transparent and fair; and is conducive to learning from errors when they occur. We take an open and honest approach to communication with service users and their carers, and between all healthcare professionals and healthcare managers within the Trust.

Fair Blame: we need to continue to ensure that staff are confident in the fairness of the system in order to further develop a culture whereby all incidents are routinely reported and investigated.

In this context we have focused on a number of targets that measure our success in continuing to develop and support such a culture. The key targets that we have tracked in this area are:

1. An increase in the overall number of incidents reported
2. An increase in the proportion of near misses reported
3. The continued development of a CLCH-wide Learning from Experience Group

4. To increase the use of the electronic incident reporting system to feed- back learning – by monitoring the proportion of electronic incident reports reviewed and updated by a manager within seven days.

Safety Targets

The following sub-sections provide detail on our level of progress, lessons learned and next steps in relation to each of these targets.

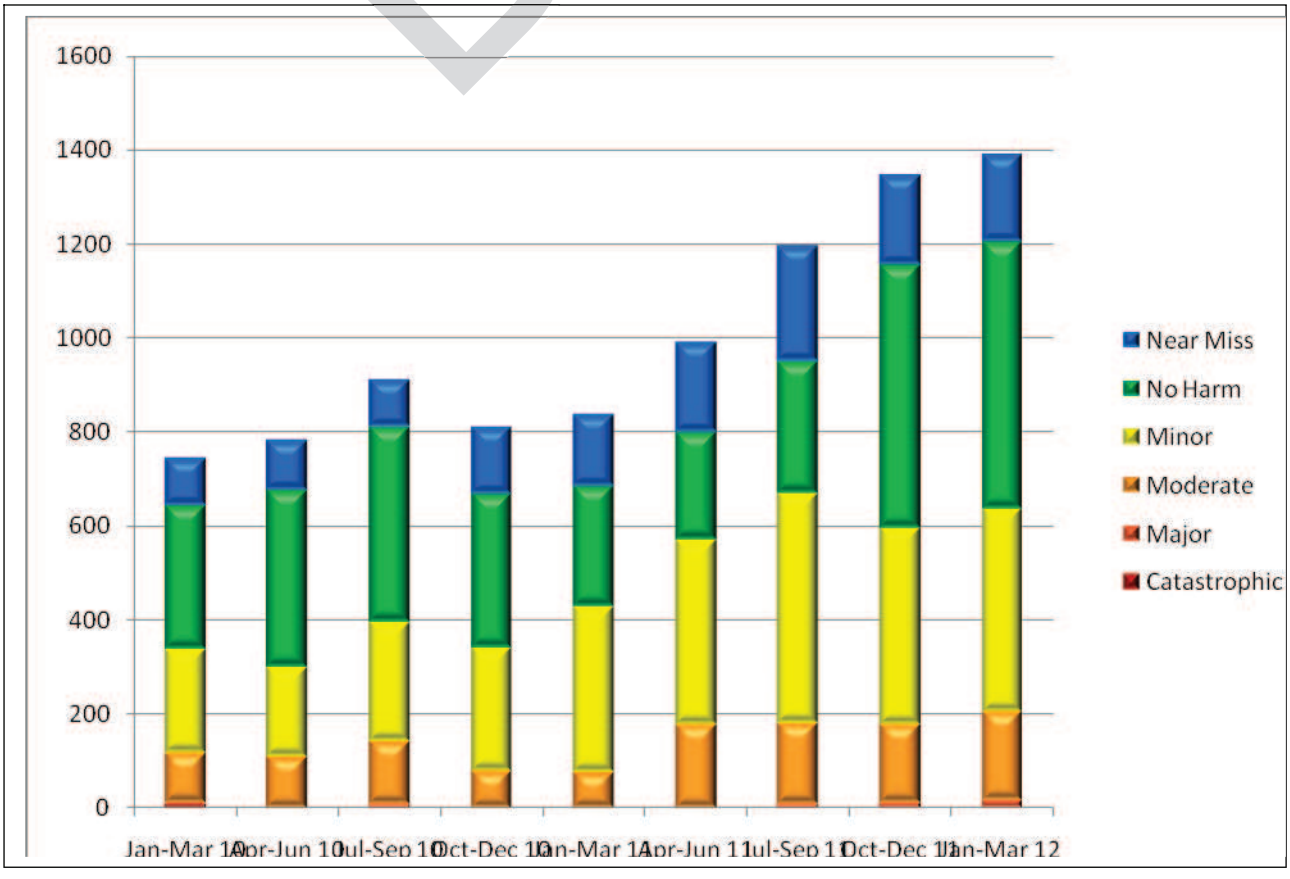
Target 1: An Increase in the Overall Number of Incidents Reported

We are pleased to again report a significant increase in the overall number of incidents reported over the past year. **The number of incidents reported during 2011/12 was 4,924, which is an increase of 47% from the 3,344 incidents that were reported during 2010/11.**

This increase follows a number of improvement actions that we have undertaken over the past year in this area, in particular:

- A continued effort to embed the online incident reporting system throughout CLCH, which included a programme of training to roll out the system throughout Barnet prior to integration in April 2011.
- An ongoing campaign by the Learning from Experience Team to support staff to use the electronic reporting form, and also liaise with managers to ensure that incidents are reviewed appropriately.
- Increased feedback to staff on the incidents that they report – bi-monthly newsletters containing information on incidents, trends and related learning are now produced by the Learning from Experience Team and distributed to all staff.

Total quarterly incidents April 2010/11 – March 2011/12 by severity



There continues to be relatively wide variation amongst service areas in terms of the level of reporting of incidents and near misses. This is heavily influenced by fundamental differences between service areas around the levels and types of safety issues faced as a result of their clinical setting and specific patient needs.

For example, district nursing, tissue viability and palliative care report a significant proportion of pressure ulcers – and to a large extent this is simply reflective of the fact that under NICE guidance they are required to report newly acquired or deteriorating pressure ulcers as incidents. In reality the vast majority of such incidents reported are in relation to pressure ulcers developed while the patient was in hospital or prior to receiving care from CLCH and were reported by the service following an initial assessment visit. The recording of such incidents does not necessarily reflect poor care, but notes that more intervention is needed and ensures that a manager is aware. It also helps us to map the prevalence of pressure ulcers across the organisation to ensure resources are appropriately targeted.

Next steps:Continue to share best practice, provide training, support staff and provide awareness raising campaigns. In particular targeting specific groups and services that are currently reporting lower numbers of incidents (and where it is expected that there may in fact be more incidents taking place within these settings).

Target 2: An Increase in the Proportion of Overall Incidents Reported as Near Misses

We are continuing to aim for a significant increase in the reporting of near misses as they are a key source of information to enable learning, whilst at the same time without harm occurring to patients or staff.

We are very happy to report a significant increase in the proportion of overall reported incidents during 2011/12 that were near misses rather than actual incidents. During 2011/12 17% of all incidents reported were near misses compared to 14% in 2010/12.This increase is even more marked if we consider that it sits in the context of an overall increase in incident reporting.

Our discussions with NHS London and the National Patient Safety Agency (NPSA) have indicated that a target of 75% of incidents being reported as near misses would be considered ideal practice; however it is acknowledged that this is a highly ambitious target at the present stage.

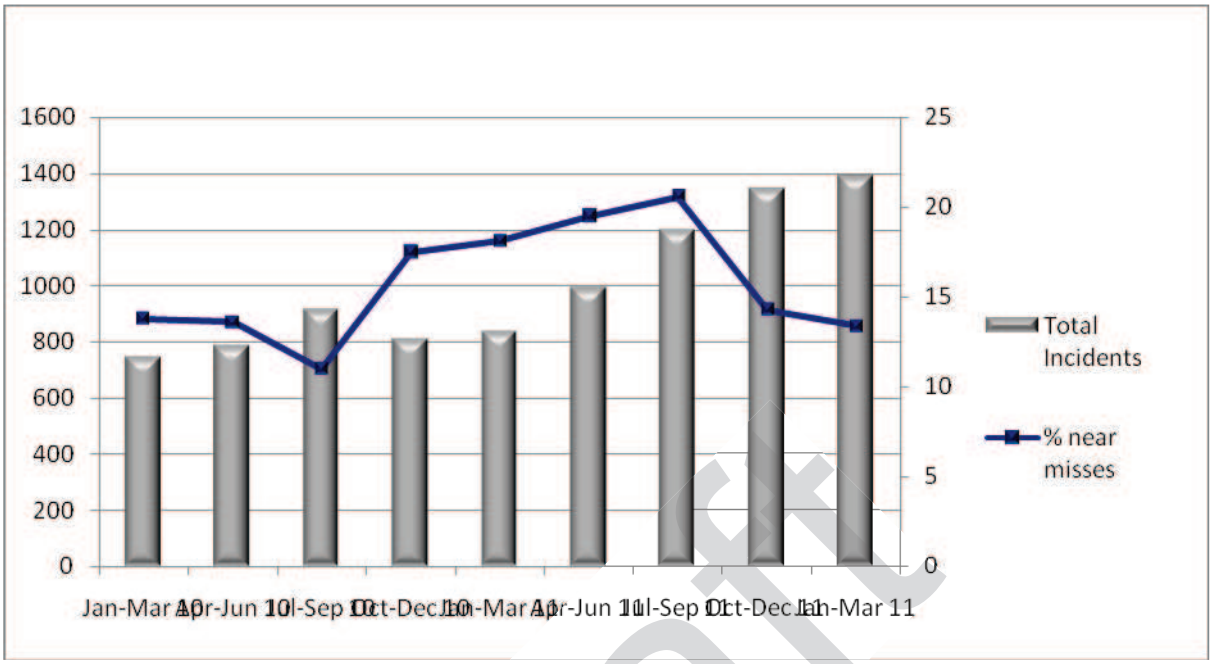
Case study: Early Supported Rehabilitation Team

This project set out to explore if the existing Early Supported Rehabilitation Team (ESRT) in Westminster Rehabilitation Service offers clinically effective rehabilitation for patients post fractured neck of femur (NOF). The project was designed to:

1. Improve discharge processes from hospital
2. Strengthening the results of clinical and patient reported outcomes
3. Develop a more detailed understanding of patient experience through patient stories

The project group can conclude that the ESRT does offer clinically effective care, as 80% of the patients' goals were achieved for patients and there may be opportunities for potential cost efficiencies in improving the hip fracture pathway of care.

Near misses as a % of total incidents reported, from April 2010/11 to March 2011/12



Next steps: the recent increase in near miss reporting can be attributed in part to our ongoing awareness-raising campaign in this area.However it is clear that we still have a very long way to go to achieve the target of 75%. We will continue to conduct awareness training and activities in order to ensure that all staff understand and support the importance of near miss reporting and that they have the appropriate skills and IT support in place.

Target 3:The Continuing Development of a CLCH-Wide Learning from Experience Group

A key aim over the last year has been to further develop the effectiveness of the Learning from Experience Group and ensure that systems for cascading recommendations and learning directly from the Group across the organisation were embedded.

We are happy to report that the Group has continued to meet throughout 2011, with membership evolving in line with the new clinical structure for inner CLCH and integration with Barnet. The Group continues to be chaired by the Director of Operations, with representatives at Associate Director level for all of the clinical areas, and Heads of Department for corporate services. Key functions of the group include:

- Bringing together information from incidents, complaints and PALS into one forum

- Identifying trends to be investigated and alerting Board sub-groups to areas which might require more specialist review
- Assessing all risks identified from investigations for transfer to the risk register

- Identifying key learning points to cascade across the organisation via the Learning from Experience newsletter and other means of communication

A separate monthly Serious Incident Review Group has now been established which reviews all completed Root Cause Analysis investigation reports and action plans. This is to enable the detail within them to be considered appropriately and the action plans properly assessed for robustness.

Next steps:to ensure that learning from incidents is formally discussed at service and team level and fed up to the Learning from Experience Group so that learning and good practice can be more effectively shared.

Target 4: An Increase in the Proportion of Incidents Reviewed/Updated Electronically by a Manager within Seven Days

A key performance indicator (KPI) was introduced in 2010 for 90% of all incidents to be reviewed/updated by a manager within seven days of the incident being reported onto the electronic system. **For 2011, an average of 89% of incidents were reviewed/updated electronically by a manager within seven days.** This is an improvement on the figure for 2010 of 85% but narrowly missing the target of 90%.

However, the KPI was monitored closely through 2011 and the improvement was demonstrated as the year progressed. **For the quarter Oct-Dec 2011, 98% of incidents were reviewed/updated electronically by a manager within seven days.** This figure is expected to also be achieved throughout 2012.

Next steps:To achieve a target of 90% of all incidents to be reviewed/updated by a manager within seven days of the incident being reported onto the electronic system. This will continue to be prioritised by Associate Directors at monthly Operations Directorate Performance Meetings and monitored by the Board.

The Learning from Experience Group now plays a central role in the regular monitoring of safety at CLCH. The data routinely reviewed by the Learning from Experience Group includes:

- Incidents – any unexpected incident that could have or did harm a patient.
- Any contacts received through the Patient Advice and Liaison Service (PALS), including formal complaints
- 'Root Cause Analysis' reports in relation to specific issues
- Serious incidents (SIs) – very serious incidents such as unexpected or avoidable death.

Where a particularly high risk is identified, it will be escalated to the Board for more detailed scrutiny and review, and an action plan will then be developed accordingly.

Tackling specific issues

Looking across the whole Trust, the most common types of incidents reported in 2011/12 were in relation to 'communications' and 'slips, trips and falls' and pressure ulcers. The graph below shows how many incidents of each type were reported across the whole Trust last year.

Pressure ulcers

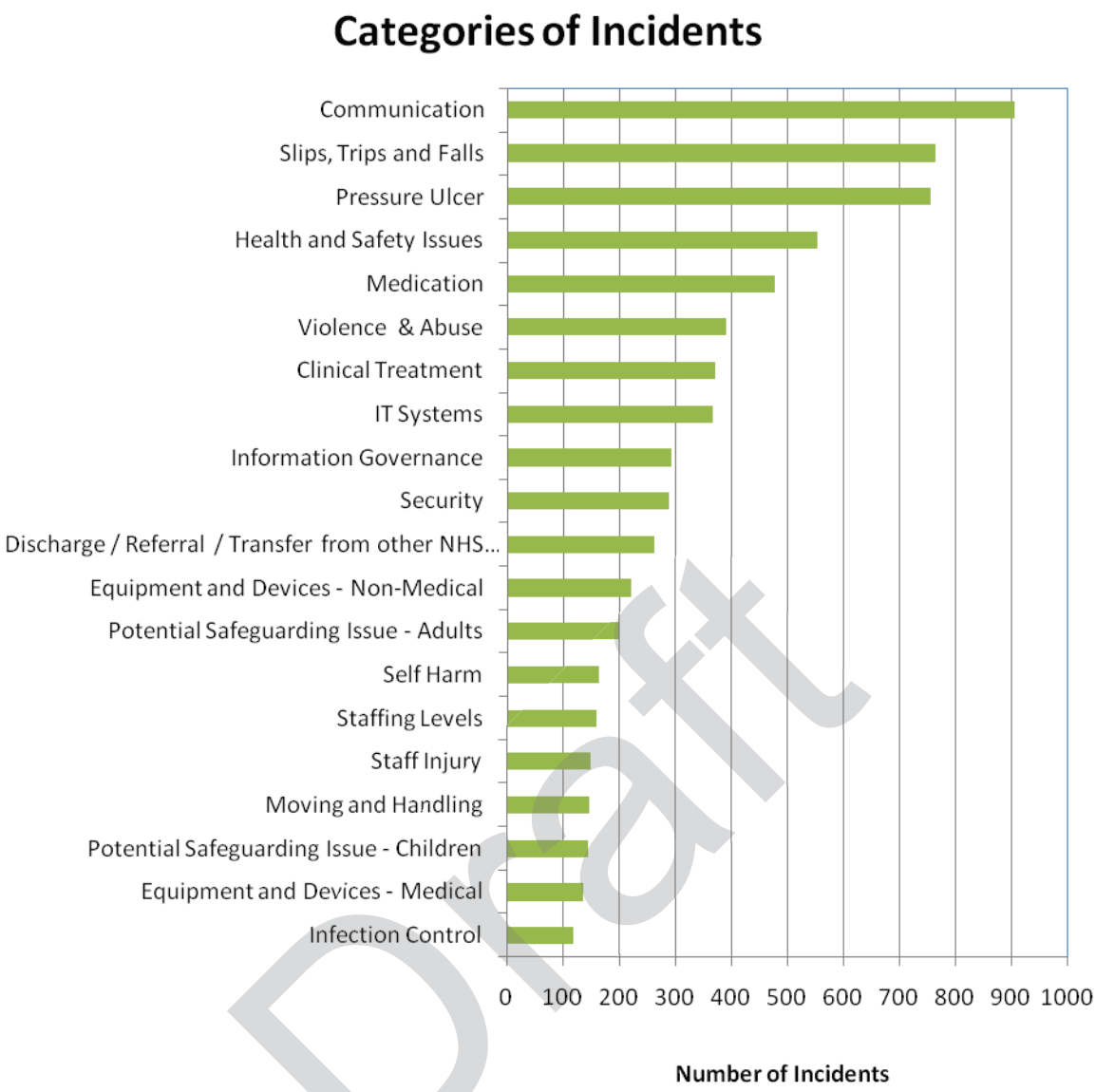
The Learning from Experience Group has acknowledged that the number of pressure ulcers reported by CLCH services is still increasing. There has also been a considerable increase in the number of grade 3 and 4 pressure ulcers reported that have developed while the patient is receiving CLCH services, and are therefore reportable as Serious Incidents. Root Cause Analysis investigations are carried out on all of these and the Board is notified of learning and recommendations. It is however still the case that the vast majority of pressure ulcers are developed outside of our care, for example in non-CLCH nursing homes or acute hospitals.

Slips, Trips and Falls

A CLCH wide Falls working group was established to look at falls prevalence and to develop a Trust wide Falls prevention policy which details various falls prevention strategies. Falls prevention services exist in each of the boroughs and a common risk assessment form has now been implemented.

Communication Incidents

The category of these incidents is really quite broad but may involve the way in which we manage our clinical records, systems of communication from one organisation to another, communication issues with patients themselves or between staff. Our learning from experience group will be looking at these in much more detail.


Categories of Incidents
Communication
Slips, Trips and Falls
Pressure Ulcer
Health and Safety Issues
Medication
Violence & Abuse
Clinical Treatment
IT Systems
Information Governance
Security
Discharge / Referral / Transfer from other NHS...
Equipment and Devices - Non-Medical
Potential Safeguarding Issue - Adults
Self Harm
Staffing Levels
Staff Injury
Moving and Handling
Potential Safeguarding Issue - Children
Equipment and Devices - Medical
Infection Control
0 100 200 300 400 500 600 700 800 900 1000
Number of Incidents

Summary of safety targets, achievement and next steps

Area	Target	Achievement	Next Steps
Encourage the reporting of incidents	Increase in overall number of incidents reported	• 34% increase (from 2010 to 2011)	✓ Continue to share best practice, provide training, support staff and provide awareness raising campaigns.
Increase the proportion of overall incidents reported as near misses	Increase in the proportion of overall incidents reported as near misses	• Increased from 14% to 18% (from 2010 to 2011)	✓ Continue to emphasise the importance of reporting near misses within a targeted training and awareness raising programme
Embed the appropriate systems and processes to support Learning from Experience	Develop systems for cascading recommendations and learning directly from the Group	• Membership of LfE Group evolved in line with new clinical structure • Serious Incident Review Group established • Bi-monthly newsletters distributed to all staff	✓ Ensure that learning from incidents is formally discussed at service and team level and fed up to the Learning from Experience Group
Embed protocols for feeding back review and analysis from minor incidents and near misses	Increase the proportion of electronic incident records reviewed and updated by a manager within 7 days	• Average of 89% of incidents reviewed and updated electronically by a manager within seven days.	✓ Achieve a target of 90% of all incidents to be reviewed and updated by a manager within seven days. ✓ Continue to prioritise target within individual services and directorates

More detail on our clinical effectiveness performance

This section summarises the main themes and next steps that we have identified across the whole of CLCH in relation to clinical effectiveness. Because the ways of measuring effectiveness are often so specific to a particular service, we have given a number of examples and summarised the general picture.

How do we know if we are achieving the best possible results for our patients?

Each of our services regularly monitors its own effectiveness in order to identify areas for possible improvement. Effectiveness can be monitored in different ways and the approach is often very specific to the particular service that is being provided.

The main ways that we monitor and measure effectiveness are:

- **Clinical Outcome Measures** – measuring a patient's progress or improvement in terms of basic clinical goals. For example, an improvement in a patient's mobility as a result of a successful rehabilitation programme following a stroke

- **Patient Reported Outcome Measures** (PROMs) – in this case, patients set their own goals for how they would like the treatment to affect their health and quality of life. The clinician then works with the patient to review progress against these goals. PROMs are a relatively new approach to measuring effectiveness within community healthcare and so the measurement tools are not yet fully embedded across all of our services.

- **Measuring compliance of our services with best practice guidance** – for example, guidance from the National Institute for Health & Clinical Excellence (NICE). NICE is an independent organisation that issues guidance based on evidence from medical research. NICE guidance provides a very robust standard for us to use when we are deciding how toprovide the most effective care to our patients.

- **Clinical audit** – a formal way of analysing a service against specific standards, and then identifying areas for improvement where necessary. The 'specific standards' could include any of the above measures.

Looking back: What have we done over the past year to improve safety?

Developing and implementing Patient Reported Outcome Measures (PROMs)
Using PROMs to measure effectiveness is a helpful way to make sure that the individual patient is at the very centre of the care and treatment that they are receiving. This is because PROMs measure improvements by the patient's own assessment of themselves, not just through the eyes of the clinician.

They are important because PROMs put people at the centre of our NHS by listening to their perceptions of their health status and health-related quality of life and it enables us to respond to it. It also helps us to make measurable improvement in the aspects of quality of healthcare which patients and their families see as really important. PROMs questionnaires do not ask about patients' satisfaction with or experience of healthcare services, or seek opinions about how successful their treatment was.

As a tool for measuring effectiveness, PROMs are now fairly at a widespread stage of development. We strongly support this approach and we have focused our efforts over the past year to ensure all services have developed PROMs. During 2010/11 we started to use PROMs, or similar approaches, to measure effectiveness in 16 of our services. In some cases this meant using measurement tools that have already been developed and validated by research institutions – for example, the heart nursing service is using The Minnesota Living with Heart Failure Questionnaire, which assesses the impact of chronic heart failure on quality of life.

During 2011-12 96% of our services have developed PROMs. Overall, there were positive initial results from the areas that used PROMs in 2011/12. In each case, the measurements helped us to see evidence of positive results from the patient's point of view.

Case Study

Embedding patient reported outcome measurement into standard clinical practice within the Community Rehabilitation service

The Community Rehabilitation services are now regularly using the Goal Attainment Score (GAS) as their PROM. The GAS involves patients setting some goals they would like to achieve during the course of their rehabilitation therapy. The patient then rates their score on how close they are to achieving these goals, and then after the therapy has finished the patient is asked to rate their achievement of these goals again. The corresponding increase or decreased in report goal achievements can then be used as a measure of the effectiveness of the therapy.

The GAS PROM found that 509 clients had a total of 764 goals agreed. 83% of these goals achieved a score of 10 or more which is a meaningful change.

An improved approach for making sure we are up to date with the latest NICE guidelines

NICE (National Institute of Clinical Excellence) Guidelines *refer to nationally agreed best practice guidance for the management of conditions.*

Really good implementation practice of new guidelines depends upon a robust system to make sure that our staff have the most recent NICE information at their fingertips. In particular, our NICE manager is dedicated to monitoring and disseminating NICE guidance across the whole of our organisation. The introduction of an electronic voting system has enabled the process to speed up the process.

- NICE guidelines are published each month and cascaded to all professional leads for assessment of their relevance to every CLCH service.
- NICE champions in each service review the guidance.
- Where practice is not in line with the guidance, changes are made to clinical practice and monitored by the clinical audit team. Areas of practice which are not in compliance with NICE guidance are identified on the Risk Register.

Case Study
A good example of how assessment and reviews of guidance work is demonstrated by the Tuberculosis (TB) service which is located on two sites, at Charing Cross and Hammersmith Hospitals. Reviews of new guidance are undertaken in collaboration with Imperial College Working Group. The service makes a brief summary of methods of evaluation and any recommendations for further improvement.

Continuous improvement using clinical audit
Clinical audit is a way of improving the quality of patient care; it means analysing a service to see whether it meets particular standards (for example, NICE guidance), and identifying ways in which the service could improve. We see it as a very important way of understanding how we can continuously improve the quality of our services.

In 2011/12 we conducted 79 clinical audits, 20 of the audits have been completed and 59 are currently ongoing. These audits have helped us to identify many specific areas for improvement. In 2012/13 we plan to expand and improve our programme of clinical audit. We see this as one of the main ways in which we can continue to improve clinical outcomes overall.

Case Study: National Audit of Psychological Therapies (NAPT):

The results from the NAPT were released this financial year. Important findings included:

- Data completeness for age and gender was 100%, but only 58% for ethnicity
- 92% of patients referred with anxiety or depression received a NICE-compliant treatment – above average compared to other services
- 84% of patients reported a high level of satisfaction with the treatment received
- The proportion of therapists in this service who had completed formal training or are currently in training in at least one therapy was 67%.

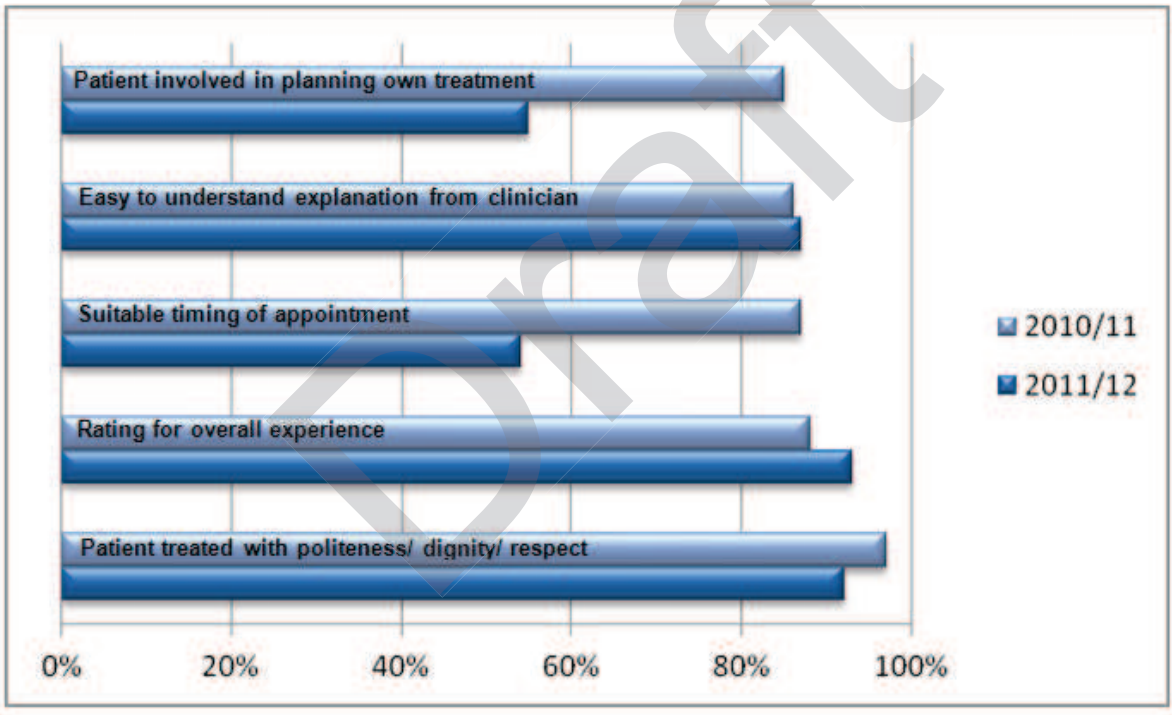
Following the results an action plan has been drafted and implemented, some of the actions are:

- All therapists have been provided with ethnicity reporting cards and are expected to ask clients routinely during triage or initial assessment stages of the care pathway. To date in 2011/12 (Apr-Dec) the service is reporting an average of 89% data completeness in relation to ethnicity.
- The service will incorporate the findings, regarding the proportion of therapists in the service who had completed formal training or are currently in training in at least one therapy, into the planned training needs analysis work being completed with the Professional Development Department within the Trust.

More detail on our patient experience performance

Looking back: What have we done over the past year to improve patient experience?

Comparative Percentage results of patients rating their experience as "good" or "excellent"



(Note: For the question around whether you would recommend the service to others, the figure reported is for those who answered "yes" to this yes/no question.)

The data in this graph provides only a general indication of how patients responded across all of our service areas. In each area, the questions were asked slightly differently and so when we combined the results we had to compromise some of the statistical robustness in the data. In other words, we have combined information that was not collected in exactly the same way.

The questionnaire we used this year is slightly different to the one used last year. Last year's included an additional set of two questions that does not feature in the

first phase of the PREM exercise for this year. The two additional questions were "Did the healthcare professional listen to the patient carefully" and "Would you recommend the service to others". We were not able to compare the responses for those questions as they were not featured in this year's questionnaire.
The chart indicates that the number of patients involved in planning their own treatment is on a downward trend as was the number of patients saying their appointment was at a suitable time. It is possible that there are changes in the ratings due to a reduction in the patient face to face contact time or how the question is interpreted by patients.

This year the PREMs Exercise is on-going and has drawn responses from 12,657 patients over a period of seven months.

This year we have strengthened the process and whilst we have been able to establish trends in the responses at an earlier stage there is on-going work to ensure we have a processes in place to identify and include sections of the community that are harder to reach so the patient experience data is representative of the communities we serve.

Adjustments have been made to the organisational-wide programmes for capturing patient feedback to cater for groups that we know would have difficulties engaging. For example, child-friendly PREMs are in development and a learning disability version of the PREMs has been very successfully delivered using hand held devices.

In 2012/13 we will strengthen the reliability of this data by updating our PREM surveys again. Each service will continue to select specific questions that relate to the patients in that particular context, but all services will also include a core set of standard questions in their surveys. This core set of questions will be the same right across CLCH and will therefore give us much more robust data to report on overall patient experience next year. It will also help us to compare service areas with each other to identify where there might be need for improvement in a certain area.

What our patients told us and how we responded

In addition to the quantitative data that we collected, we also received a large number of free text comments from patients last year. These came both through the PREMs and through other compliments and complaints that patients sent to us.

Patient comment

'I had to wait a very long time for an appointment. The system needs to be sorted to get a sooner appointment'

We collected and analysed these comments in each area, and together with the quantitative data this helped us to identify a number of ways in which we could improve the experience that patients are having with our services.

The most common area for improvement that we identified is around timely access to services and healthcare professionals and involvement in decision making about treatment.

There is evidence to suggest from the responses received that on the whole our patients were happy with the services they used. And whilst there was positive feedback overall, we are pleased our patients took the opportunity to highlight to us the areas they felt fell short of their expectations. These included:

- information, communication and involvement in decision-making about care
- better provision of information to and communication with patients
- engagement of the patient in shared decision-making about treatment options

We are aware from patient feedback that some improvements are needed to ensure that our patients do not wait too long for appointments and also to reduce waiting times to be seen by a clinician.

In particular we are working on making sure that patients who do want to be involved in the process of planning their treatment and care delivery are given the opportunity to do so.

The wealth of data from responses from our patients provides the organisation with the intelligence necessary to make inroads to better understand and improve patient's experience. The services have this independent source of data at their disposal to inform decisions and take actions that will lead to the provision of better quality of patient care. This year we will be building on capturing views from the seldom heard and focusing on developing patient stories and other ways of engagng patients.

Complaints and PALS

Review of complaints and compliments is an important source of patient feedback. The Customer Service Team delivers the Patient Advice & Liaison Service (PALS) and Complaints & Compliments function. This service received 126 formal complaints and 420 compliments in 2011-12 from across the organisation. It also resolved311 issues . The team has recently revised its advertising materials and will be promoting the service to staff and patients.

Social media

Digital technology has revolutionised the way in which people communicate and share information – at local, national and international levels. Social media is a term used to refer to online technologies and practices that are used to share opinions and information, promote discussion and build relationships. They can use a variety of different formats, for example text, pictures, video and audio. The term 'social media' is applied to the tools in question, their applications and collaboratively developed practices.

It is essential that CLCH starts using social media to capture the views and experiences of the people who are using our services – especially children and young people who are often less likely to feedback using more traditional methods. In redesigning the bed-wetting (enuresis) care pathway, the pathway lead responsible piloted the use of social media sites (Mumsnet and Netsmum) to capture the views of parents regarding this highly sensitive service. Although only a small pilot, it has shown the usefulness and ease of using this methodology and our

communications team and patient and public engagement lead are now considering how this methodology could be used to harness views on a wider scale.

Equality Delivery System

The Equality Act (2010) requires the Trust to publish an annual equality profile of our patients to better understand the equality issues in service delivery, including any differential experience of using services, access to services and complaints received. In developing the annual profile, patients' equality data (e.g. ethnicity, age, gender and disability) will be collected, analysed and published. Within the framework of the Equality Delivery System developed by the Department of Health to help NHS Trusts assess their equality performance, we have delivered a number of focus groups to identify the views and experiences of patients and interest groups across the nine protected characteristics. This evidence has informed the development of our four year Equality Objectives.

Section Four – useful information

Values &Behaviors/Culture Development within CLCH

Our commitment to Quality is underpinned by a set of values and behaviors, which all staff are expected to commit to.

Research clearly shows a link between strong shared values and improved organisational performance, improved staff commitment, lower turnover rates, increased staff engagement, improved patient safety, patient experience and quality.

A review of the work previously undertaken within CLCH and Barnet in this area was carried out by the Culture Development Steering group. A series of workshops and consultations were conducted to develop a proposed/refreshed set of Values and Behaviours. Feedback from these events emphasised themes round quality, performance, relationships, innovation and caring and formed the basis of the revised more concise proposals from those previously developed in 2009/10.

CLCH Values and Behaviors

Quality: We put quality at the heart of everything we do

1. I take responsibility for the standard and outcomes of my work
2. I provide services which are safe, effective and deliver a good experience
3. I use best practice and feedback to innovate and constantly improve my service

Relationships: We value our relationships with others

1. I work collaboratively and in partnership
2. I am caring compassionate and kind
3. I support the development of skills talents and abilities

Delivery: We deliver services we are proud of

1. I treat people with courtesy dignity and respect
2. I work hard to achieve the aims of my service and the organisation
3. I make the best use of resources and provide value for money

Community: We make a positive difference in our communities.

1. I am visible accessible and approachable.
2. I ensure people, partners and purchasers are actively engaged in planning service and care.
3. I embrace difference, diversity and fairness.

Case Study – Health Information

HealthInform is a free and confidential health information service, based at Edgware Community Hospital. The service offers patients and members of the public quality, evidence-based health information about medical conditions and treatment options and information about support groups and helplines. HealthInform also offers training on how to access good quality consumer health information on the internet.

HealthInform is specifically designed to empower patients to make decisions about their own health and care; it facilitates their involvement in treatment and care planning by giving them the tools they need to make informed choices. It enables patients to be active partners in discussions and decisions about their care.

Glossary of terms not explained elsewhere

Clinical coding
The use of nationally and internationally understood codes to describe a patient's complaint, diagnosis and treatment. Clinical coding assists in the recording of patient data.

Clinical coding errors
When medical complaints, diagnoses or treatments are coded incorrectly which leads to incorrect data collection.

Commissioners
Commissioners are the people responsible for buying services from us for the patients and staff in a particular area or organisation. Commissioners include primary care trusts (PCTs), other health organisations, local councils or private enterprise.

Deprivation indicators
These are the factors that are looked at to help determine the needs of a community. Indicators include income, employment, health, education, housing and crime. Find out more from the Office for National Statistics: **www.statistics.gov.uk**

Hospital Episode Statistics (HES)
HES is a data warehouse that contains information about hospital admissions and outpatient attendances in England. The data in HES comes from the Secondary Uses Service (SUS), which collects data that's passed between healthcare providers and commissioners. The data is published monthly for the last year. (Source: NHS - The Information Centre **www.ic.nhs.uk**) You can also find out more at **www.hesonline.nhs.uk**

Payment by Results (PbR)
A system used to reimburse hospitals in England for their activity. It means that payment is directly related to the number of operations and other activity undertaken.

Qualitative data
Information that cannot be measured or counted numerically, such as a patient's story about their experience or their description of the quality of a service.

Quantitative data
The type of information that can be measured or collected numerically, such as numbers of patients or someone's height and weight.

Useful contacts and Links

CLCH NHS Trust

CLCH Communications
e:communications@clch.nhs.uk
t:0207 798 1420
w:www.clch.nhs.uk

CLCH Patient Advice and Liaison Service (PALS)
e:pals@clch.nhs.uk
t:0800 368 0412

Switchboard for service contacts
t:020 7798 1300

Partners mentioned in our Quality Account

Hospitals

Chelsea and Westminster Hospital NHS Foundation Trust
w:www.chelwest.nhs.uk

Imperial College Healthcare NHS Trust
w:www.imperial.nhs.uk

Primary Care Trusts (PCTs)

Inner North West London Cluster
(Currently based at NHS Westminster – details below)

NHS Hammersmith and Fulham
w:www.hf.nhs.uk
NHS Kensington and Chelsea
w: www.kensingtonandchelsea.nhs.uk
NHS Westminster
w:www.westminster.nhs.uk

NHS Barnet
w:www.barnet.nhs.uk

Local Involvement Networks (LINKs)

Hammersmith and Fulham LINk
e:hflink@hestia.org
t:020 8969 4852
w:www.lbhflink.org.uk

Kensington and Chelsea LINk

e:rbkclink@hestia.org
t:020 8968 7049/ 6771
w:www.rbkclink.org.uk
Westminster LINk
e:general@vawcvs.org
t:020 7723 1216
w:www.vawcvs.org

Barnet LINk
e:link@communitybarnet.org.uk
t:020 8364 8400
w:www.barnetlink.org

Local councils (for Overview and Scrutiny Committees)

Hammersmith and Fulham
e:020 8748 3020
w:www.lbhf.gov.uk

Kensington and Chelsea
e:information@rbkc.gov.uk
t:020 7361 3000
w:www.rbkc.gov.uk

Westminster
e:info@westminster.gov.uk
t:020 7641 6000
w:www.westminster.gov.uk

Barnet
e:first.contact@barnet.gov.uk
t:020 8359 2000
w:www.barnet.gov.uk

Healthcare organisations

Care Quality Commission
w: www.cqc.org.uk

Department of Health
w:www.dh.gov.uk

King's Fund
w: www.kingsfund.org.uk

National Institute for Health and Clinical Excellence (NICE)
w:www.nice.org.uk

National Patient Safety Agency
w:www.npsa.nhs.uk

NHS Choices

References

1. NHS Statutory Instruments 2002 No. 3048 www.legislation.gov.uk/uksi/2002/3048/contents/made
2. NHS Outcomes Framework, December 2010, definition of the safety domain
3. Definitions from the National Patient Safety Agency www.npsa.nhs.uk
4. For further information on clinical effectiveness, see the following useful overview from NHS Scotland: www.clinicalgovernance.scot.nhs.uk/section2/clinicaleffectiveness.asp
5. Example question from the daily living PROM used in the New Zealand points system for cataract surgery, quoted by the King's Fund, 2010, "Getting the most out of PROMs"
6. PH – Public Health guidance www.nice.org.uk/Guidance/Type PH
7. TA – Technology Appraisals www.nice.org.uk/Guidance/Type TA
8. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
9. For further information on patient experience, see the following helpful website from NHS surveys: www.nhssurveys.org/improvinghealthcare
10. This scenario, that uses assumptions reflecting local circumstances, is on page 37 of "North West London Strategic Commissioning and QIPP Plan 2014/15 (15 December 2010)" http://hillingdonlink.org.uk/wp-content/uploads/2010/12/NWL-Approved-Strategic-Commissioning-and-QIPP-Plan-2011_14-Main-Document-20101215-FINAL.pdf
11. 11 NHS Kensington and Chelsea's Draft QIPP plan 2011/12 www.kensingtonandchelsea.nhs.uk/media/78327/2.1-qipp-plan2011-12.pdf
12. 12 Page 9 of the paper "Budget Setting and Cost Improvement Plans 2011/12" that was taken to the CLCH Board of Directors on 3 February 2011: www.clch.nhs.uk/about/board/Documents/CLCH%20NHS%20Trust%20Board%20Papers%203%20Feb%202011.pdf

Feedback

Now that you have read our Quality Account, we would really like to know what you think, how we can improve and how you would like to be involved in developing our Quality Accounts in future.

Please use the following links or contact details to complete our short feedback survey. The survey should only take five minutes to complete. We appreciate your time.

Go to: www.finaladdresstobeconfirmed.nhs.uk and fill out the survey online.

Alternatively you can download a copy of the survey, fill it in and post it to:
Patient and public engagement
Central London Community Healthcare NHS Trust
7th Floor 64 Victoria Street
London
SW1E 6QP

Write to us if you would like us to send you a paper copy using the address above or via email to **communications@clch.nhs.uk**

Alternatively, if you or someone you know would like to provide feedback in a different format or request a copy of the survey by phone, call our communications team on **020 7798 1420**.

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Barnet and Chase Farm Hospitals NHS
NHS Trust

Quality Accounts 2011-12

Welcome from the Chief Executive

The Trust Board welcomes you to our third annual report on quality. The aim of this document is to improve our accountability and transparency to the public and to outline the Trust's quality improvement agenda, both in relation to the outcome of last year's quality account and taking this forward into the Trust programme for 2012/13.

Barnet and Chase Farm Hospitals NHS Trust is one of the largest trusts in the country, providing modern standards of clinical practice combined with traditional values of professional care. We hold clinics in easily accessible community hospitals – Edgware, Finchley Memorial, Potters Bar and Cheshunt, as well as our two main sites. We continuously seek new ways to provide our local communities with excellent care and to deliver year on year improvements.

We are proud of the many improvements we made to the quality of our clinical services in 2011-12. These include reducing the number of hospital-acquired infections and patient falls, and increasing the input of senior clinicians into the Trust's emergency process. We have launched an Appointment Reminder Service to ensure patients are kept aware of their upcoming appointments, opened a Macmillan Information Centre in Barnet Hospital that provides user-friendly advice to both cancer patients and their relatives/carers, become the first Trust in London to perform Aquatheresis (a new excess fluid removal procedure) on Cardiology patients, and attained Gold accreditation for our TIA (mini-stroke) services. I am confident that these and other successes will inspire us towards achieving our five clinical priorities for the year ahead, which are explained within the next section.

The Secretary of State has made two major decisions in this regard since last year's report. The first is that North London's health services are to proceed with the BEH Clinical Strategy, which will see emergency and maternity services focused in large specialist centres at Barnet Hospital and North Middlesex University Hospital. This decision was made following a lengthy review involving all major stakeholders. The second decision is that, following a Feasibility Study into the possible creation of a single acute trust for Enfield (that would have merged Chase Farm Hospital with North Middlesex University Hospital), both organisations are to remain in their current form

These decisions enable us to focus our energies on implementing all aspects of the Clinical Strategy in time for a planned completion date of autumn 2013. The Board wishes to reassure all users of our services that, throughout the implementation process, we will remain committed to ensuring that every patient is treated with dignity, compassion and respect whilst receiving the highest quality of clinical care. As always, our patients come first and are at the centre of everything that we do.

The Trust Board wishes to assure you that all members of staff, both clinical and non-clinical, at Barnet and Chase Farm NHS Trust continue to welcome and encourage feedback from patients and carers so that we may learn from experience and continue to develop both the quality and range of services that we offer to our local public. The Trust is committed to senior clinical input into the decision making processes of the Trust and is continuing to drive forward a programme of increasing clinical autonomy. By this and other means the Trust seeks to involve clinicians at all levels in the development of their services as we feel that this is the best way to ensure that our services thrive for the benefit of our patients.

I hope you find this report interesting and I believe that it reflects our ongoing dedication as an organisation at all levels to improve the quality of care and services that we provide. The production of this report has received input from members of staff at all levels within the organisation who have been enthusiastic in bringing to the fore ongoing achievements within the integrated high quality service that the organisation aims to provide. As an organisation we aim to build upon our previous achievements reporting again to you on our progress in 2013.

It is a requirement of the quality account regulations that the Chief Executive takes personal responsibility that information within this document is accurate and I am happy to give you my reassurance that this is indeed the case.

1. Quality priorities for 2012-13

The Trust will be focusing on the following areas of care in 2012-13 as it seeks to improve quality of service:

- The Liverpool Care Pathway (LCP) for the dying patient

The Liverpool Care Pathway (LCP) 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. The LCP is a multi-professional document that guides professionals to provide the best care, transferring the hospice model of care into the acute setting where currently 58% of deaths occur.

The LCP is the tool recommended by The End of Life Care Strategy (2008) and Quality Markers and Measures for End of Life Care (2009). It 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.

Areas of the LCP to work towards for 2012-2013 include:

The number of patients who die supported using the LCP

The Trust has recently taken part in the National Care of the Dying Audit for Hospitals (NCDAH) undertaken by The Marie Curie Institute Liverpool. At

present, 16% of patients who die in the Trust are supported using the LCP. An important aim for the next 12 months is for this number to increase significantly to meet the expected average target of 29%.

This will be achieved by promoting the use of tools such as advanced care planning and education and training for all staff, not only in the use of the LCP.

This will be monitored by recording the number of patients who die with an LCP in place. The bereavement office currently records the number of patients who die supported by the LCP. The End of Life Care Matron will monitor this information on an ongoing basis and report it through the patient experience group; an audit will be undertaken in December 2012.

Anticipatory prescribing

Anticipatory prescribing refers to ensuring all patients who are identified as dying have a prescription in place (in line with nationally agreed guidelines and good practice) in order to treat commonly occurring symptoms at the end of life. These include pain, nausea and vomiting, breathlessness and restlessness/agitation.

The Trust's result of the NCDAH showed 67% (median 83%) compliancy with anticipatory prescribing. The reason for this 'low 'percentage is that the anticipatory prescribing section on the LCP was incomplete (not ticked).

The national audit did not, however, cross reference with the drug charts. Therefore, we undertook an audit reviewing the drug charts of these LCPs and found that 82% were prescribed the correct anticipatory drugs.

We aim to increase this figure over the next year through education and training of medical and nursing staff in anticipatory prescribing. We will also develop 'user friendly' guidance by developing the back page of the LCP to clearly guide clinicians in anticipatory prescribing. This will be monitored by an audit in September 2012.

Correctly completed LCPs

The NCDAH show that it is impossible to measure the care if the LCP is not completed correctly. Many areas of the LCP document were left blank or not completed. We aim to increase the number of correctly completed LCPs in order to have a true reflection of the care we provide to patients at the end of life, as well as their family/friends. We are developing an information leaflet for professionals, which will be available to staff as well as increasing the amount of education and training available.

Below are a list of key performance indicators (organisational and clinical) identified by the NCDAH. The above highlights the importance of prioritising the following four indicators in particular:

KPI 1: Access to Information relating to death and dying

KPI 3: Care of the Dying: Continuing Education, Training and Audit

KPI 5: Anticipatory prescribing for the main symptoms that may develop in the last hours or days of life

KPI 8: Compliance with completion of the LCP.

Organisational Key Performance Indicators (KPIs):

KPI 1: Access to Information relating to death and dying

KPI 2: Access to support services for care in the last hours or days of life

KPI 3: Care of the Dying: Continuing Education, Training and Audit

KPI 4: Clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient.

Clinical Key Performance Indicators (KPIs)

KPI 5: Anticipatory prescribing for the main symptoms that may develop in the last hours or days of life

KPI 6: Communication with the relative and carer around the plan of care (LCP), to promote understanding

KPI 7: Routine review and assessment of the patient and their relatives/carers

KPI 8: Compliance with completion of the LCP.

National Care of the Dying Audit Hospitals (NCDAH) 2011-2012
Marie Curie Palliative Care Institute Liverpool

Measure	**Source of Data**	**Frequency of collection**	**Data collected and reported by**
Number of patients who die supported by the Liverpool Care Pathway (LCP) for the Dying	Bereavement office	Monthly	Matron for End of Life Care, as part of the performance review
Anticipatory prescribing – all	Patient Notes Drug Charts	3 monthly	Matron for End of Life Care

patients identified as dying have a prescription in place to treat commonly occurring symptoms			Patient Experience Group Reported by audit
Number of staff attending training	Record of attendees	6 monthly	Matron for End of Life Care Reported by audit

- Prevention and Management of Pressure Ulcers

Pressure ulcers remain a key indicator of the quality of nursing care. During 2012-13 further work will be undertaken to embed the zero tolerance approach to hospital acquired pressure ulcers.

Pressure ulcers (also commonly referred to as bed sores) cause distress and pain to patients when they occur. The Trust has continued its strong commitment and focus over the last two years in implementing strategies to reduce the occurrence of these ulcers.

Ongoing work in this area focuses on:

- A continued mattress and bed replacement programme to ensure that patients are nursed on the correct surface
- A continued programme of education on pressure ulcer prevention and management
- A continued route cause analysis of all hospital acquired category 2, 3 and 4 pressure ulcers
- Review of results of audit of SKIN bundle and modification of intentional rounding and SKIN bundle tools.

The key standards set out below will be subject to audit. The audit will highlight, over the course of the year, the further improvements made as a result of the initiatives outlined above.

Our key outcome measures will be a reduction in the harm caused to patients by pressure ulcers.

Monitoring and Measurement of Progress/Key Performance Indicators

Measure	Source of data	Frequency of collection	Data collected and reported by
Number of patients who develop a category 2 hospital acquired pressure ulcer	DATIX	Monthly (Reported Quarterly)	Matrons as part of performance review T McHugh

Number of patients who develop a category 3 hospital acquired pressure ulcer	DATIX	Monthly (Reported Quarterly)	Matrons as part of performance review T McHugh
Number of patients who develop a category 4 hospital acquired pressure ulcer	DATIX	Monthly (Reported Quarterly)	Matrons as part of performance review T McHugh
Prevalence of patients who develop a category 2 or above hospital acquired pressure ulcer	Safety Thermometer	Monthly	Collected by Ward Sisters Collated by Imran Hussain

- 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

Health inequalities and poor access to health services start early in life for people with learning disabilities. As a group they experience more hospital admissions (26%) than the general population (14%).

Valuing People (Department of Health 2001) and Treat me Right (Mencap, 2004) highlight the poor quality of care and lack of dignity and respect experienced by this vulnerable group in both primary and secondary care.

Recent reports and inquiries emphasise the issues of ignorance and indifference to the needs of people with a learning disability within health services and stress the poor and inadequate care. Death by Indifference (Mencap, 2007 and 2012) and the subsequent Ombudsman investigation highlight the 'distressing failures in the quality of health and social care' and a 'lack of leadership, responsibility and accountability'. The Health Ombudsman recommended that all health services are required to make reasonable adjustment to improve the care and treatment of people with a learning disability.

In order to provide people with a learning disability a positive patient experience when accessing services, the Trust will work in partnership with the Acute Learning Disability Liaison Nurse to ensure reasonable adjustments are made to meet the needs of the individual. The Acute Liaison Nurse will provide support with planned and unplanned admissions, case conferences, Mental Capacity Act 2005 assessments, Best Interests Decisions and discharge planning.

Working together, we can ensure that national experiences of poor care for this vulnerable group do not happen locally.

Monitoring and Measurement of Progress/Key Performance Indicators

Measure	Source of data	Frequency of collection	Data collected and reported by
Patients with a Learning Disability admitted to Barnet and Chase Farm Hospital who require reasonable adjustments in order to access our services will receive input from the Acute Learning Disability Liaison Nurse	Acute Learning Disability Liaison Nurse	Quarterly	Acute Learning Disability Liaison Nurse
Patients with a Learning Disability who have been assessed as lacking capacity to be involved in decisions concerning their treatment options will have all Best Interests Decisions accurately documented in their medical notes	Medical Notes	Quarterly	Acute Learning Disability Liaison Nurse/ Clinical Governance

- **Infection Control – maintaining standards**

We have a good reputation for reducing healthcare associated infections and improving cleanliness in all areas since 2008/9. During 2012/13 the focus will

be on continuing to maintain these high standards whilst working to reduce levels of healthcare associated infections further.

This will be achieved through various working forums and key stakeholders. For example: the Safety Thermometer initiative to reduce the incidence of urinary catheter associated infection; IV working group to improve standards in intravenous device management, focusing central lines; and developing a Care Bundle to reduce the incidence of Hospital Acquired Pneumonia.

The 'Going for Gold' campaign is being used to ensure staff are kept informed about how many MRSA and C.difficile infections have occurred in the year to date (against the set annual target) and also the current compliance rates for hand washing. The 'Gold standards' for these measures is fewer than **four incidents of MRSA**, fewer than **33 incidents of C.difficile**, and 95% for hand hygiene spot checks every week in all areas.

The Hand Hygiene component of the 'Going for Gold' campaign will be further reinforced by pocket cards, listing the five most important times when staff should be washing their hands in relation to patient care.

2. Review of quality performance 2011-2012

Our 2010-11 Quality Account identified the following priorities for improvement in 2011-12:

- Improving the Patient Experience
- Reducing the number of cardiac arrests
- Increasing the input of senior clinicians into the Trust's emergency process
- Introducing a sub-specialty gastrointestinal medical rota
- Updating governance structures

It was also decided to continue with the following two priorities from 2010-11:

- Recognition and care of the deteriorating patient
- The reduction in risk for venous thromboembolic events for all hospital inpatients

Improving the Patient Experience

Why we made this a priority:

Our Patient Experience Strategy continues to focus our attention on issues that patients say are most important to them. We know that a stay in hospital, or a visit to our outpatient department, can be a worrying or stressful time for any patient. Our staff have signed up to our 'We Care' standard with a commitment to be Welcoming, Empathetic and Courteous, to have an Attitude

that's positive, to be Ready to help and to maintain standards of clinical Excellence.

In 2011-12 we asked *5500* people for their feedback. People who told us their opinions included adult inpatients, outpatients, women having babies, children, teenagers and their parents, people using the Emergency Department and patients having X-rays or physiotherapy. People consistently reported high levels of satisfaction with being made to feel welcome and being treated with respect and dignity. On average, 93% of patients rated the overall care they received as excellent or good.

There are areas where we still need to do better, and we will be focusing on what more we can do to better involve people in decisions about care and treatment, explaining the side effects of medication, and making sure that patients can talk to someone about any worries or concerns they may have.

Patient Experience Strategy

Our Patient Experience Strategy (PES) campaigns are:

Patient feedback

Accident prevention and safeguarding

Treating you with respect and dignity

Infection prevention and keeping clean

End of life care

Nutrition and hydration

Transforming care through leadership

Safe and effective care

These campaigns entail the following:

Patient feedback -

- Using patient feedback trackers at every opportunity in all wards and departments
- Working in partnership with our Patient Advisory Group and Local Involvement Networks (LINKs) to identify and address issues of concern.

Accident prevention and safeguarding -

- Continuing to improve on prevention of falls and hospital acquired pressure ulcers

- Better care for vulnerable people such as those with dementia or learning disabilities.

Treating you with respect and dignity -

- Further developing the Trust's values and behaviours standards
- We have implemented the Butterfly scheme to support people with dementia and will continue to use this approach.

Infection prevention and control -

- Maintain our control of hospital acquired infections.

End of life care -

- Improve 'anticipatory prescribing' for patients approaching the end of life
- Develop 'advanced care planning' booklets.

Nutrition and hydration -

- Protected mealtimes led by ward sister/charge nurse and involving all the ward team
- Green cups for patients with dementia to help them keep well-hydrated.

Transforming care through leadership -

- Leadership programmes for Band 6 and Band 7 nurse leaders and other disciplines
- Leadership change projects planned and delivered by programme participants.

Safe and effective care -

- Comfort rounds to ensure patients are clean, comfortable, have enough to drink and any pain is being managed
- Recognition and care of a deteriorating patient.

How did we do over the last year?

The following list demonstrates how well we achieved our Patient Experience goals for 2011-12:

We have reported on Patient Experience at every public Trust Board meeting, showing the 'patient view' alongside our own audits of performance - **Met**

We had feedback from 5500 patients and this has helped us to see which areas are doing well and where we need to make further improvements – **Met**

There will be no more than four cases of hospital acquired blood-borne MRSA bacteraemia in the year – **Not met, we had seven cases – the same number as the previous year**

We have reduced the number of hospital acquired pressure ulcers – **Met**

We have reduced the number of patient falls – **Met**

Mealtimes are better organised under the leadership of the Ward Sister/Charge nurse – **Met**

14 people have completed leadership development programmes - **Met**

Reducing the number of cardiac arrests

The introduction of a heart failure inpatient referral service at the Trust in the last two years has led to earlier involvement of Cardiology and - where appropriate - end of life planning, including do not resuscitate decisions and advanced directives. Additional work is ongoing in risk stratifying heart failure patients early.

The Resuscitation Officers have been particularly focused on the implementation of the Do Not Attempt Resuscitation (DNAR) policy and audit of its usage and effectiveness. This should mean that patients for whom attempts at resuscitation would be inappropriate are identified sooner, consulted about their wishes and the outcome recorded in a standardised way.

The Trust now requires all cardiac arrest calls to be the subject of an IR1 process with the intention of gleaning as much information as possible about the circumstances of every such event. The process of reviewing this information is about to get under way and will involve the senior Resuscitation Officer (and/or the Chairman of the Resuscitation Committee), the Lead Nurse for Patient Safety and the Medical Director.

The working group 'Recognition and Care of the Deteriorating Patient' has redesigned the observation charts to enable earlier identification of patients who are deteriorating and the Resuscitation Officers have been actively training staff in the use of this scoring system and the 'SBAR' communication tool. The Resuscitation Officers and other members of the Resuscitation Committee have supported the proposed development of a Medical Emergency Team (MET) which Dr. Chandi Vellodi and the RCDP group are aiming to pilot at the Barnet site. The aim of such a team would be to mobilise senior staff to review and treat patients before they deteriorate to the point of needing the attention of the cardiac arrest team.

Increasing the input of senior clinicians into the Trust's emergency process

A&E have actively been trying to recruit to the additional six consultant posts that were approved to support the department to increase clinical leadership support and shop floor presence. We have been successful so far in recruiting to two of these posts and are continuing to recruit to the remaining posts. In the meantime, a rota of additional hours by existing Consultants during peak times in evenings and at weekends has been implemented.

In addition, during the winter months, A&E sought additional support from specialty area Consultants and middle grade doctors such as medicine, surgery and Paediatrics. This provided direct clinical care, leadership and senior decision making in A&E at times of peak demand.

A&E Consultants continue to provide 24 hour telephone advice and support to the departments and set hours of attendance in the A&E departments at weekends relevant to clinical activity and need.

The Directorate regularly audits all shifts to ensure sufficient medical supervision for training grade doctors which has been achieved. The above success has ensured a safe planned level of senior medical supervision, support and attendance in both A&E departments.

Introducing a sub-specialty gastrointestinal medical rota

The Trust is now in advanced negotiations with its medical Gastroenterology team to facilitate the introduction of this 24 hour Consultant-delivered emergency rota. In the interim, emergencies are treated every morning on Endoscopy lists across both sites.

Updating governance structures

The governance structure was revised and following Trust Board approval in July 2011, the new system started in November 2011. The Quality and Safety Committee also held its first meeting in November. It is chaired by a Non-Executive Director and is a NED committee, attended by the Chief Executive, Medical Director, Director of Nursing, Director of Information Management and Technology, and the Directors of Operations for both Planned Care and Emergency Care. The sub-committees - Risk, Clinical Governance and Information Governance - reviewed their terms of reference at this time and report on a scheduled basis to the Quality and Safety Committee.

The Datix Web reporting system has been successfully rolled out to all areas of the two main sites. A few of the outlying sites e.g. Cheshunt Community Hospital still use the paper based system. We have also invested in the Datix web risk register module and all risks are now managed electronically.

All clinical directorates completed their annual audit programmes, including those related to the National Audits for inclusion in the Quality Account.

Recognition and care of the deteriorating patient (see reducing the number of cardiac arrests)

The Trust is looking at the AMBER care bundle, an initiative within the End of Life Care Programme to support best practice in identifying patients at the end of life and transferring them into their preferred place of care. The AMBER care bundle is for patients who are at risk of dying within 1-2 months and complements the Liverpool Care Pathway which focuses on the last few hours/days of life. The aim of this bundle is to systematise best practice for patients at this time. AMBER stands for:

Assessment
Management
Best Practice
Engagement of patient and carers
for patients whose **R**ecovery is uncertain.

As we are going to implement this care bundle during 2012/13, recognition and care of the deteriorating patient will remain a quality priority for the coming year.

The reduction in risk for venous thromboembolic events for all hospital inpatients

This was a priority that was carried over from the 2009-10 Quality Account into the 2010-11 report. The Trust's progress in this field over the last year has included the following:

Mandating VTE electronic risk assessment

In July 2011 the Trust began mandating a VTE Risk Assessment task list after 18 hours of patient admission. This was reduced to three hours by December 2011. Since then, the Trust has achieved over 90% in the target; the VTE performance for the last quarter of 2011-12 (January to March 2012) is 91.66% (21820 out of 23806).

Setting up a forum to discuss VTE

VTE performance is monitored weekly at each directorate meeting. The forum will review incorrect processes for booking day cases, e.g. at Canterbury Ward and in the Surgicentre.

This was the responsibility of the Director of Operations. However, only A&E and medicine information was received by May 2011.

VTE training at induction for new junior doctors, nurses, midwives, pharmacist induction

VTE and anticoagulation were added in the induction programme and clinical essential programme for nurses and pharmacists in May 2011.

Patient Information Leaflet should be given to patients on admission and discharge

These leaflets were distributed in July 2011. They can be found on the Trust's intranet site; an email reminding Matrons and Ward Managers of their presence was sent in Feb 2012.

In April 2012, a request was made to the Director of Nursing by the Thrombosis Committee chair to put the information leaflet in the patient admission pack to ensure all patients receive the information.

Board statements

This section contains the Mandatory Statements concerning the quality of services provided by Barnet and Chase Farm Hospitals NHS Trust.

Review of services

The Trust has reviewed all the data open to it on the quality and care in all of these services.

During 2011/12 Barnet and Chase Farm Hospitals NHS Trust provided and or subcontracted XXXX NHS services. The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS Services by Barnet and Chase Farm Hospitals NHS Trust for 2011/12.

Participation in Clinical Audits

The National and Clinical Audit and National Confidential Enquiries that Barnet and Chase Farm Hospitals NHS Trust was eligible to participate in during 2011/12 are as follows

Audit Category	No.	Current programme (as at 1/4/11)	Did we participate	Directorate	Audit Lead	Is this continuous Yes/No
Cancer	1	National Bowel Cancer Audit Programme (NBOCAP)	Yes	Surgery / Gastrointestinal	Steve Warren	Yes
	2	Data for Head and Neck Oncology (DAHNO) (also known as Head and Neck Cancer Audit)	Yes	Surgery / Head & Neck	Janavikulam Thiruchelvam	Yes
	3	National Lung Cancer Audit (NLCA)		Pathology Leading	Assisted by: Sajid Khan	
	4	Oesophago-Gastric Cancer Audit (OGC)				
Women's & Children's Health	5	National Neonatal Audit Programme (NNAP)	Yes	Children's Directorate	Dr Tim Wickham	Yes

	6	Paediatric Intensive Care Audit Network (PICANet)	No	Not applicable to BCF		
	7	Heavy Menstrual Bleeding Audit (HMB)	Yes			Yes
	8	Epilepsy 12 Audit (Childhood Epilepsy)	Yes	Children's Directorate	Dr Jackie Taylor Dr Juliet Pearce	No
Heart	9	Adult Cardiac Surgery Audit				
	10	Congenital Heart Disease Audit (including Paediatric surgery)				
Heart (continued)	11	Angioplasty Audit (also known as Percutaneous Coronary Interventions)		*Not Applicable to BCF.*		
	12	Myocardial Ischaemia National Audit Programme (MINAP) /	Yes	General Medicine	Dr Robert Greenbaum	Yes

		Cardiac Ambulance Services				
	13	Heart Rhythm Management Audit (HRM)	No	General Medicine	Dr Robert Davies	
	14	Heart Failure Audit	Yes	General Medicine	Dr Ameet Bakhai/Dr Noor	Yes
Long-term Conditions	15	National Diabetes Audit (Adult)	No	General Medicine	Dr Jonathan Katz	
	16	National Diabetes Audit (Paediatrics)	Yes	Children's Directorate	Dr Vaseem Hakeem	No
	17	Renal Services Audit (Vascular access; Patient transport)				
	18	National Joint Registry				
	19	Inflammatory Bowel Disease Audit (IBD)	Yes	General Medicine	Dr Steve Mann	No
	20	Pain Database		Critical Care & Anaesthetics	Khaled Ayazi	LS followed up
	21	Food and Nutrition Audit (1 year development project)		General Medicine	Dr Steve Mann	DH contacted Noor f/u 19/4

Mental Health	22	Dementia Audit		Elderly Medicine	Dr S Noor ? may not go ahead this year?	DH contacted Noor f/u 19/4 with PW
	23	National Audit of Psychological Therapies (NAPT)				
	24	National Audit of Schizophrenia (NAS) (formerly Treatment Resistant Schizophrenia)				
Older People	25	The Sentinel Stroke Audit	Yes	Elderly Medicine	Dr Daniel Epstein & Dr Nathan	Yes
	26	Carotid Interventions Audit (CIA)				
	27	Falls and Bone Health Audit	Yes	Elderly Medicine	Dr Patrick Harbinson Dr Andrew Weinstein	Yes
	28	Continence Care Audit	Yes	Elderly Medicine	Dr Tim Gluck & Dr C Hettiarachi	No
	29	Hip Fracture Database Audit	Yes	Surgery / Orthopaedics	Stella Legge	Yes

Participation in Clinical Research

The Trust continues to work actively with new NHS and commercial trials being approved throughout the year. The management of the Research & Development (R&D) function has been maintained through the R&D Governance Committee, chaired by an Associate Medical Director. The main income to support the activity comes from the Comprehensive Local Research Network (CLRN) and Commercial Trials. The CLRN Portfolio Research is primarily NHS research and is in the form of multicentre trials. The recruitment of patients for NHS trials has fallen at the end of last year, which will reduce our income from the CLRN. However, a new process is in place which decides support costs at the start of a trial and is more sophisticated than merely depending on recruitment numbers, with funding allocating by intensity of the intervention with some recognition to the type of centre.

Developments

The increasing level of R&D in the last three years has enabled the Research Governance Committee to agree to fund posts in Pharmacy and Cancer in 2011. The Pharmacy post has been successfully filled. The R&D department is actively looking at the feasibility of recruiting a generic research support nurse as recruitment to studies is often delayed from centre approval. This measure is a metrics of our R&D performance. The current nursing support is allocated to departments active in research and staff do not have overlapping clinical responsibilities.

We have R&D partnerships with University College London and the Royal National Orthopaedic Hospital Trust (RNOH). We are currently concentrating on updating our policies and procedures in line with Government and Medicines and Healthcare products Regulatory Agency (MHRA) requirements.

The Trust is considering the development of the R&D programme by the recruitment of a full time business manager to support the R&D committee and develop its profile.

The department has also developed a hand book which is in final proof stage to help aspiring clinicians understand how to embark on research and the processes they have to complete to satisfy the governance requirements. We have successfully started a rolling educational program to make available in-house the key training requirements to our Trust employees for good clinical practice needed to participate in R&D studies. This has increased the awareness and quality of the research being undertaken.

Patient Involvement

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2009-2011 who were recruited during that period to participate in research approved by a research ethics committee was **430.** The numbers

can vary from year to year depending on the trial design and the stage it has reached, e.g. active recruiting stage, monitoring stage.

The current situation is that the Trust is supporting **in excess of 40** CLRN studies across the organisation. This has recruited **120** patients up to the end of February 2011 so it is anticipated that this should be around **150** by the end of the year. A total of **327** patients have been recruited to Commercial Studies which have been approved through the same governance processes.

Income

The income for 2011-12 from the Comprehensive Local Research Network to Barnet and Chase Farm Hospitals NHS Trust was **£69k**, based on recruitment activity to CLRN adopted studies the previous year and paid in quarterly installments. Until now, income has been assessed retrospectively from the previous year but, in future, new trials will be assessed for their costs and anticipated recruitment so that we will receive income in real time. Income from commercial sources totaling around **£150k over the last 3 years** was also raised and is used to support the R&D staff, primarily in Cardiology and more recently Orthopaedics.

The Trust has the opportunity to create a major reputation in research with our large patient population and our varied clinical workload. We are an active but currently smaller contributor to our CLRN and hope to grow to our full potential.

Quality and Innovation (CQUIN) scheme targets 2011/12

The Trust agreed a number of national, regional and local quality improvement targets with Co-ordinating Commissioners (NHS NCL) and the London Specialised Commissioning Group under the Commissioning for theCQUIN scheme. The Trust programme consisted of:

Nationally Mandated

- VTE Assessments
- Patient Experience

Regionally Agreed

- Enhanced Recovery Programme

Locally Agreed

- Discharge Planning
- Care Closer to Home
- TIA

London Specialised Commissioning Group

- 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.

Performance Achievement 2011-12

The trust continues to meet the national key performance indicators. We did not meet out MRSA case reduction of no more than 5 cases. The Trust had 7 cases throughout the year. The table below sets out our performance for 2011/12.

Domain	Healthcare Targets Domains and Indicators	Year-to-date Performance	2011/2012 Target
Quality	% Urgent Referrals seen within 14 days	95.22%	93.00%
	% Urgent Referrals seen within 14 days - Breast Symptomatic	95.65%	93.00%
	% Cancers treated within 31 days of Decision to treat	98.26%	96.00%
	% Cancers treated within 62 days of Referral	89.03%	85.00%
	% Consultant Upgrades treated within 62 days	98.92%	90.00%
	% Screening Services treated within 62 days	95.87%	90.00%
	% Subsequent treatments treated within 31 days of DTT - Drugs	100.00%	98.00%
	% Subsequent treatments treated within 31 days of DTT - Surgery	96.63%	94.00%
	Total time in A&E - 95% of patients should be seen within 4hrs	96.00%	95%
	Percentage of Patients that have spent at least 90% of their time on the stroke unit	95%	80%
	Percentage of high risk TIA patients who are treated within 24	74%	60%
	% Delayed Discharges	0.20%	3.50%
Womens Health	% Maternities Breastfeeding	86%	78.0%
	% Maternities not Smoking	92%	90.0%
Access	% Diag. Tests. Excl Audiol. waiting > 6 weeks	0.35%	< = 1%
	% Audiology tests waiting > 6 weeks	0%	< = 1%
	RTT Waiting Times 95th Percentile - Incomplete*	24.79	36 Weeks
	RTT Waiting Times 95th Percentile - Admitted*	17.83	27.7 Weeks
	RTT Waiting Times 95th Percentile - Non-Admitted*	14.23	18.3 Weeks
	RTT Waiting Times Median - Incomplete*	5.77	7.2 Weeks
	RTT Waiting Times Median - Admitted*	8.76	11.1 Weeks
	RTT Waiting Times Median - Non-Admitted*	5.69	6.6 Weeks
	18 Weeks - Admitted 90% Target*	95.77%	90%
	18 Weeks - Non-Admitted 95% Target*	99.30%	95%
Patient Experience	% Ops. Canc. at last minute	0.8%	0.80%
	% Canc.Ops not Re-Admitted within 28 days	0.57%	5.00%

	Number of Mixed Sex Breaches	43	0
	Number of Never Events	1	0
Safety	Clostridium Difficile – meeting the Clostridium Difficile objective	23	60 (5 Per Month)
	MRSA – meeting the MRSA objective	6	5 (1 Per Qtr)
	MSSA - number of Cases	13	N/A

Feb 2012 Month End Position

Mortality rates shown to be below national average in 2011 Good Hospital Guide

The 2011 Dr. Foster Hospital Guide showed Barnet and Chase Farm Hospitals to have a lower than expected Hospital Standardised Mortality Ratio for 2010-11. In particular, against the standardised national average of 100, the Trust scored below this with 88.

In addition to this, the Trust's mortality ratio was lower than expected for the new Summary Hospital-level Mortality Indicator (SHMI) with a score of 89.

Data Quality

Reliable and accurate data about the healthcare we provide is really important to us. For example clinical coding plays a vital role in many aspects of a patient's diagnosis, treatment and management, which in turn ensures the Trust gets paid correctly for the treatment the patient has received.

Barnet and Chase Farm Hospitals NHS Trust submitted records during 2010/11 (excluding March 2011) 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:

2010/11	
96.3%	for admitted patient care
96.5%	for outpatient care
82.4%	for outpatient care

2011/12	
97.7%	for admitted patient care
97.9%	for outpatient care
88.8%	for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

2010/11	
100.0%	for admitted care
99.8%	for outpatient care

2011/12	
100%	for admitted care
100%	for outpatient care

100.0%	for accident and emergency care	100%	for accident and emergency care

Review of data quality
To follow

Involvement

Although the quality of our data is seen as the responsibility of all staff we also have a team who specifically monitor data quality. They provide a help desk for staff and are a resource for advice to new projects as well as holding awareness sessions, attending staff meetings, reviewing and documenting processes & procedures and monitoring & reporting on data.

Payment by Results Assurance Framework

To follow

Trust highlight for 2011/12

TIA services attain Gold accreditation

The TIA (Transient Ischaemic Attack) service at Barnet Hospital has been 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 makes us the first Trust in the sector to be accredited with this standard.

A Transient Ischaemic Attack is often referred to as a mini-stroke. It is caused by a loss of blood flow to either a region of the brain, spinal cord, or retina that does not result in tissue death. Patients with TIA are at high risk of developing a full blown stroke in the following days. Rapid investigation of patients with TIA reduces the risk of this happening.

Daniel Epstein, Consultant Stroke Physician, said: "I would like to thank everyone involved for their hard work and support in making this possible."

Our patients amongst the best-fed in England

A Care Quality Commission report published in autumn 2011 warned of poor national practice over nutrition for the elderly, with protected mealtimes coming in for criticism. However, in spite of this national picture, Barnet and Chase Farm was amongst the trusts that performed at the very best end of the scale, with less than 1% of meals being refused by patients. Only two other trusts in England can match this figure.

Meals in Barnet and Chase Farm Hospitals are provided by our private contractors who use a food technology called Steamplicity. This uses the

water content naturally found in fresh food to steam-cook meals from fresh in just a few minutes. Due to its cooking speed, patients choose their dish only hours before they eat it. This means that patients away from their beds during meal times can have their meal cooked on their return, cutting wastage.

Macmillan Information Centre

A new Macmillan Information and Support Centre for anyone affected by cancer officially opened its doors at Barnet Hospital in November 2011 (it began delivering its service in June 2011). The Centre provides vital free information and support for anyone affected by cancer, including relatives and carers as well as patients.

The relaxed and informal space includes a main area offering information booklets, leaflets, a quiet room and online resources supported by the Macmillan Cancer Information Manager and trained volunteers. Visitors can drop in without the need to make an appointment.

The Centre has been funded with money awarded by Macmillan Cancer Support, from an original donation from the Milly Apthorp Charitable Trust. An outreach service to Chase Farm Hospital is being introduced early in 2012.

Histopathology Team accreditation following CPA visit

The Trust's Histopathology team has retained its accreditation following a laboratory inspection by the Clinical Pathology Accreditation Association (CPA).

The CPA conducts a full inspection such as this every four years, together with interim inspections at the two-year midway point. This year's inspection lasted two days. The external inspectors carrying out the visit looked at both laboratory and mortuary facilities cross-site and interviewed several users of the service, including four Consultants.

Every aspect of the service was examined, such as how specimens are handled, whether the staff are given appraisals and other aspects of Continuing Personal Development, and whether systems to ensure improvements in quality are in place. One objective of the visit was to check that every written procedure comes under document control practices, ensuring that they are read and acknowledged by all staff in the department. The inspection found that this was the case.

Aquatheresis: a first-in-London experience for Trust Cardiology patients

Of all heart failure admissions, 90% are due to fluid overload, with up to 30% of patients becoming resistant to diuretic therapy over time.

Aquapheresis (AQ) is a procedure used to achieve to rapidly provide symptom relief for appropriate patients with fluid overload. It has been used

predominantly in the USA, but the Trust is one of the very few users in the UK to date.

Between April and December 2011 the team performed the first pilot in London of Aquapheresis on four patients, and they are now in the process of obtaining funding to purchase the AQ device permanently.

Award for the North London Breast Screening Service

The Radiography team at the North London Breast Screening Service were awarded Radiography Team of the Year for London by the Society of Radiographers. The North London Breast Screening Service is one of the largest breast screening services in England and was the first London service to become fully digital in 2009.

The prestigious awards ceremony was held at the House of Commons in November 2011 and honoured professionals who have demonstrated clinical excellence and best practice in diagnostic and therapeutic radiography. The awards were presented by Chief Health Professions Officer Jacqui Lunday.

Appointment Reminder Service

The Trust launched its free Appointment Reminder Service for patients in January 2012. This incorporates a convenient text messaging service delivering a discreet reminder direct to the patient's mobile telephone or to their home telephone.

The service is intended to reduce non-attendance rates for Trust appointments. Each year around 4500 patients fail to turn up for their appointment having not called in advance to cancel it.

This inconveniences other patients, who are left waiting for no reason and could have taken the earlier slots. But it also has a negative impact on the Trust's finances. By reducing non-attendances as much as possible, waiting lists will be worked through more efficiently and the extra money can be reinvested into patient care.

How the patient can opt out of the reminder service

If the patient does not wish to receive an appointment reminder message they can opt out of the service. They can later opt back in at any time.

New Caldicott Guardian appointed

The Trust said farewell to long-serving clinician Dr. Andy Nicol in December 2011. Dr. Nicol had worked for the Trust and its predecessors for 29 years, and became Caldicott Guardian in 1998.

He was replaced in this role in January 2012 by Dr. Kilian Hynes, an A&E Consultant with a wide range of experiences, having worked both overseas and as a GP during earlier stages of his career.

Workforce

Staff survey

The Trust is pleased to report that our staff had the **highest response rate in London for the 2011 National NHS Staff Attitude Survey for the 2nd year at 59.3%** and scored above national average for Staff Engagement. In addition, the Trust is amongst the top 20% acute Trusts and improved significantly in areas such as staff having a quality job design, job content, feedback and staff involvement. Staff said that they were having well structured appraisals, they are able to contribute towards improvement at work and they were receiving equality and diversity training.

The Trust is committed to working with managers and staff to improve in the areas staff identified as gaps within the survey i.e. using flexible working options through the implementation of e-rostering. More staff said that they were witnessing potentially harmful errors and misses an incidents and the Trust encourages managers to discuss how staff can use the new Datix system to report incidents. There were staff reporting work related injuries from manual handling, sharps injuries, work related stress, and bullying and harassment and the Trust's Occupational Health team is accessible to provide support and advice, please contact the team on telephone number 0208 375 1137 to help to reduce workplace injuries.

Equality and diversity

The Trust formally launched its Equality Delivery System (EDS) on Tuesday 24 January 2012. The event attended by over 120 delegates, engaged both internal and external stakeholders to score the Trust's performance on equality and diversity outcomes supported by Trust facilitators who are leads on various aspects of equality across the Trust. It gave delegates the opportunity to discuss and ask questions in a fun and safe environment, as well as think creatively on how to move the equality agenda forward.

The Trust has had further discussions with the lead managers and staff and as a result developed the equality objectives for the next 12 months. The scores from the EDS event have been incorporated into the action plans and all the outstanding areas within the Single Equality Scheme have been aligned within the Equality Objectives and action plans. These plans were discussed with and signed off by the lead Directors for each area.

3. The views of our stakeholders

4. How you can provide feedback on the Quality Account

This important document sets out how we continue to improve the quality of the services we provide.

Your views on quality

We welcome your views and suggestions on our Quality Priorities for 2012-13 set out in this Quality Account.

We welcome feedback at any time on our Quality Account. This can be sent to the Director of Communications, Chase Farm Hospital, The Ridgeway, Enfield EN2 8JL or emailed to feedbackBCF@nhs.net .

You can read more about the national requirements for Quality Accounts on the NHS Choices or Department of Health websites.

You can download a copy of this and all our published documents from www.bcf.nhs.uk or www.nhs.uk (listed as Barnet and Chase Farm Hospitals NHS Trust).

AGENDA ITEM 9

Meeting	Health Overview and Scrutiny Committee
Date	16 May 2012
Subject	**Health Overview and Scrutiny Committee Forward Work Programme 2012/13**
Report of	Overview and Scrutiny Office
Summary	This report outlines the Committee's work programme during 2012/13.

Officer Contributors	John Murphy, Overview and Scrutiny Officer
Status (public or exempt)	Public
Wards affected	All
Enclosures	Appendix A – Health Overview and Scrutiny Committee Forward Work Programme 2012/13
Reason for urgency / exemption from call-in	N/A

Contact for further information: John Murphy, Overview & Scrutiny Officer, 020 8359 2368

1. RECOMMENDATION

1.1 That the Committee consider and comment on the items included in the 2012/13 work programme of the Health Overview & Scrutiny Committee, as set out in the Appendix.

1.2 That the Committee discuss and identify items to be taken forward for inclusion in the 2012/13 Forward Work Programme.

2. RELEVANT PREVIOUS DECISIONS

2.1 Annual Council, 17 May 2011– Council agreed the scope and terms of reference of the Overview and Scrutiny Committees.

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

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

3.2 The three priority outcomes set out in the 2012-13 Corporate Plan are: –

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

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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

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

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 None in the context of this report.

8. CONSTITUTIONAL POWERS

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

included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution).

9. BACKGROUND INFORMATION

9.1 The Health Overview & Scrutiny Committee's Work Programme 2012/13 indicates forthcoming items of business for consideration by the Committee.

9.2 The work programme of this Committee is intended to be a responsive tool, which will be updated on a rolling basis following each meeting, for the inclusion of areas which may arise through the course of the year.

9.3 The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

10. LIST OF BACKGROUND PAPERS

10.1 None

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Appendix 1 - Health Overview and Scrutiny Work programme 2012/13

16 MAY 2012			
ITEMS FOR CONSIDERATION	**INFORMATION**	**REPORT ORIGIN**	**LINK TO CORPORATE PLAN**
London Trauma Service	To receive an update report from the London Trauma Service in relation to services in Barnet.	External – Health Partners	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
NHS Quality Accounts	To receive and comment upon the Quality Accounts of NHS service providers	External – Health Partners	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
12 SEPTEMBER 2012			
ITEMS FOR CONSIDERATION	**INFORMATION**	**REPORT ORIGIN**	**LINK TO CORPORATE PLAN**
Aging Well Programme Update	To receive an update on the progress of the Aging Well Programme	Internal - AdSS	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
CLCH Quality Stakeholder Group Update	To receive an update on the work of the stakeholder group	Internal	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities

BEH Clinical Strategy	To receive an update on the development of the BEH Clinical Strategy Outline Business Case and Regeneration Business Case	External – Health Partners	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
FUTURE MEETINGS			
Aging Well Programme Update	To receive updates on the progress of the Aging Well Programme	Internal - AdSS	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
CLCH Quality Stakeholder Group Update	To receive updates on the work of the stakeholder group	Internal – Cllr Old	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
Foundation Trust Status Attainment	To receive updates and monitor the attainment of NHS Foundation Trust Status by Health Partners	External – Health Partners	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities
Health & Well-Being Board	To receive updates and monitor the development and work of the H&WB Board	External – Health Partners	A Successful London Suburb/Sharing Opportunities, Sharing Responsibilities

Annual Report of the Director of Public Health	To scrutinise the Annual Report and monitor the success Health and Well-Being Board in achieving its health targets	External – Health Partners	A Successful London Suburb/Sharing Opportunities
Health and Social Care Integration	To receive updates and scrutinise and monitor the integration of health and social care services	External – Health Partners	A Successful London Suburb/Sharing Opportunities
Barnet LINK	To receive updates on the work of Barnet LINK and monitor the transition to HealthWatch	External – Health Partners	A Successful London Suburb/Sharing Opportunities

Future Meetings

12 September 2012	**11 December 2012**	**12 February 2013**
9 May 2013	**26 June 2013**	**12 September 2013**
12 December 2013		

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AGENDA ITEM 10

Meeting	Health Overview & Scrutiny Committee
Date	16 May 2012
Subject	**Cabinet Forward Plan**
Report of	Overview and Scrutiny Office
Summary	This report provides Members with the current published Cabinet Forward Plan. The Committee is asked to comment on and consider the Cabinet Forward Plan when identifying future areas of scrutiny work.

Officer Contributors	John Murphy, Overview and Scrutiny Officer
Status (public or exempt)	Public
Wards affected	All
Enclosures	Appendix 1 – Cabinet Forward Plan
Reason for urgency / exemption from call-in	Not applicable
Key decision	No

Contact for further information: John Murphy, Overview and Scrutiny Officer, 020 8359 2368

1. RECOMMENDATION

1.1 That the Committee comment on and consider the Cabinet Forward Plan when identifying areas of future Scrutiny work.

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

4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

5. EQUALITIES AND DIVERSITY ISSUES

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

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.
- The Council is required to give due regard to its public sector equality duties as set out in the Equality Act 2010 and as public bodies, Health partners are also subject to equalities legislation; consideration of equalities issues should therefore form part of their reports.

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

6.1 None in the context of the report.

7. LEGAL ISSUES

7.1 None in the context of the report.

8. CONSTITUTIONAL POWERS

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution; the Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution).

9. BACKGROUND INFORMATION

9.1 Under the current overview and scrutiny arrangements, the Health Overview & Scrutiny Committee will ensure that the work of Scrutiny is reflective of Council priorities, as evidenced by the Corporate Plan and the programme being followed by the Executive.

9.2 The Cabinet Forward Plan will be included on the agenda at each meeting of the Health Overview & Scrutiny Committee as a standing item.

9.3 The Committee is encouraged to comment on the Forward Plan.

9.4 The Committee is asked to consider items contained within the Forward Plan to assist in identifying areas of future scrutiny work, particularly focussing on areas where scrutiny can add value in the decision making process (pre-decision scrutiny).

10. LIST OF BACKGROUND PAPERS

10.1 None.

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London Borough of Barnet

Forward Plan of Key Decisions

April 2012

Contact: Jeremy Williams, Governance Service, 020 8359 2042

Jeremy.williams@barnet.gov.uk

Subject	Decision requested	Cabinet Member/ author	Consultation	Last date for reps	Documents to be considered
Cabinet, 20 June 2012 (subject to confirmation by Council)					
Transitions Strategy	To consider a transitions strategy	TBC			Full report
Skills and Enterprise Action Plan / Supporting Young People into Employment	To consider the skills and enterprise action plan.	TBC Andrew Travers			Full report
Arrangements for Commissioning a New School at Mill Hill East	To agree arrangements in light of recent legislation.	Education, Children and Families Robert McCulloch-Graham			Full report
Designated Public Place Order	To grant approval to proceed with a statutory consultation on the creation of a borough wide Designated Public place Order.	Community Safety and Resident Engagement			Full report
Finchley Church End – Final Strategy for Adoption	To adopt final strategy.	Planning			Full report
Cabinet Resources Committee, 20 June 2012 (subject to confirmation by Council)					
Final Outturn and Performance Report	To consider final outturn and performance report	Resources and Performance			Full report
Replacement of High Volume Xerox Machinery	To replace high volume Xerox machinery.	Resources and Performance			Full report

Risk Management Policy	To agree the risk management policy.	TBC			Full report
Cabinet, 17 July 2012 (subject to confirmation by Council)					
Corporate and Business Planning	To consider corporate and business planning for 2013/14.	Leader / Resources and Performance Andrew Travers			Full report
Day Opportunities for Older People	To consider the results of Consultation and Recommendations for a Future Service	Adults			Full report
Grahame Park and Brent Cross Regeneration		TBC			
Chipping Barnet Town Centre Planning Briefs – Draft for Adoption	To approve and adopt the draft final planning briefs.	Planning			Full report
Highways Asset Management Plan and Highway Maintenance Plan	To approve the Highway Asset Management Plan, including the Highway Maintenance Plan.	Environment			Full report
Safeguarding in Barnet	To consider a report on Safeguarding across Barnet.	Education, Children and Families / Adults / Public Health			Full report
Events in Parks Policy	To consider the events in parks	Environment			Full report

	policy.	Pam Wharfe			
LDF Core Strategy and Development Management Policies DPDs	Adoption of the Core Strategy and Development Management Policies DPDs as part of the Barnet LDF	Planning Lucy Shomali			Full report
Cabinet Resources Committee, 17 July 2012 (subject to confirmation by Council)					
Month 2 Monitoring 2012/13	To seek the Committee's approval of the recommendations and forecast within the report and to approve virements and transfers.	Resources and Performance			Full report
Music Service – Moving to New Model	Agreement to allow a new company with charitable status to e formed and contract to be put in place for the new Music Service to deliver council and government priorities in music education.	Education, Children and Families Mick Quigley			Full report
Children's Centres – Proposed Changes to Funding Allocation	To agree changes to Children's Centres funding formula.	Education, Children and Families Stav Yiannou			Full report