MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

MONDAY 11TH MAY, 2015

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

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

Chairman: Councillor Alison Cornelius
Vice Chairman: Councillor Graham Old

Councillors

Graham Old	Arjun Mittra	Barry Rawlings
Philip Cohen	Gabriel Rozenberg	Amy Trevethan
Val Duschinsky	Caroline Stock	

Substitute Members

Councillor Shimon Ryde	Councillor Maureen Braun	Councillor Laurie Williams
Councillor Daniel Thomas	Councillor Kath McGuirk	Vacancy

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

Andrew Charlwood – Head of Governance

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Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	
2.	Absence of Members	
3.	Declaration of Members' Interests a) Disclosable Pecuniary Interests and Non Pecuniary Interests	
4.	Public Question Time (If Any)	
5.	Report of the Monitoring Officer (if any)	
6.	Members' Items (If Any)	
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AGENDA ITEM 7

	**Health Overview and Scrutiny Committee** **11 May 2015**
Title	**NHS Trust Quality Accounts 2014/15**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	Appendix 1 – Community London Healthcare NHS Trust Quality Account 2014/15 Appendix 2 – Royal Free Hospital NHS Foundation Trust Quality Accounts 2014/15 Appendix 3 – North London Hospice Quality Account 2014/15 Appendix 4 – Barnet Health Overview & Scrutiny Committee 2014 Quality Accounts Submissions
Officer Contact Details	Anita Vukomanovic, Governance Team Leader, 020 8359 7034, anita.vukomanovic@barnet.gov.uk

Summary

This report presents the Quality Accounts from NHS health service providers for 2014/15. Health providers are required by legislation to submit their Quality Accounts to Health Scrutiny Committees for comment. The appendices set out the Quality Account of NHS providers who have a requirement to report to the committee. 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.

With respect to the Quality Accounts of the Barnet, Enfield and Haringey Mental Health NHS Trust, a sub-group of the North Central London Joint Health Overview & Scrutiny Committee (comprising representatives from the boroughs of Barnet, Enfield and Haringey) will meet on 19 May 2015 to agree a joint statement to be included in the Account of the Trust. On that basis, the Mental Health Trust's Quality Account will not be presented to this committee for consideration.

Recommendations

That, noting the requirement of NHS health service providers to produce Quality Accounts for 2014/15, the Committee provide a statement for inclusion in each of the Quality Accounts of the Health providers as set out in Appendices 1 to 3.

1. WHY THIS REPORT IS NEEDED

1.1 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.

1.2 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.

1.3 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.

1.4 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.

1.5 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.

1.6 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.

2. REASONS FOR RECOMMENDATIONS

2.1 This committee has 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 on-going operation of and planning of services.

2.2 The powers of overview and scrutiny in relation to the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee 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).

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The committee are not required to make submissions on Quality Accounts submitted by NHS health service providers; the duty is on the providers to submit the accounts to the Health Overview and Scrutiny Committee for comments. In order for the committee to discharge its scrutiny role effectively, it is recommended that the committee provide comments.

4. POST DECISION IMPLEMENTATION

4.1 The Health Overview and Scrutiny Committee is asked to scrutinise the Quality Accounts and to provide a statement to be included in the Account of each health service provider.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

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

5.1.2 The 2015 – 2020 Corporate Plan sets out Barnet's vision to 2020 which includes the following strategic objectives which relate to the work of the Health Overview and Scrutiny Committee: –

- Redesigned local services - integrated, intuitive and efficient;
- Health and Social Care services will be personalised and integrated, with more people supported to live longer in their own homes; and
- Public Health will be integrated as a priority theme across all services

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 None in the context of this report.

5.3 **Legal and Constitutional References**

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

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

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

5.3.4 The Terms of Reference of the Health Overview and Scrutiny Committee are included in Responsibility for Functions, Annex A, of the Council's Constitution. They delegate the following responsibilities to the Committee:

1. 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.
2. To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which 9 Chairman, Vice-Chairman, Members and substitutes to be appointed by Council Responsibility for Functions – Annex A – March 2015 27 affect or may affect the borough and its residents.

3. To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, Health Watch and/or other health bodies.
4. To scrutinise and review promotion of effective partnerships between health and social care, and other health partnerships in the public, private and voluntary sectors.
5. Both Council and the Health Overview and Scrutiny Committee are authorised pursuant to Regulation 30 Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218 to establish together with the health overview and scrutiny committees of one or more other local authorities a joint overview and scrutiny committee. Any such joint overview and scrutiny committee shall have such terms of reference and shall exist for so long, as the appointing Overview and Scrutiny Committees may agree.

5.4 **Risk Management**

5.4.1 None in the context of this report.

5.5 **Equalities and Diversity**

5..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.

5.5.2 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 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 and this Committee should consider these issues when commenting on the reports.

5.5.3 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

5.6 **Consultation and Engagement**

5.6.1 Each local NHS body has a duty to consult the local overview and scrutiny committee 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).

6. BACKGROUND PAPERS

6.1 Health Overview and Scrutiny Committee, 12 May 2014, - the Committee received and made formal comments on the Quality Accounts of health partners: http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MID=7475#AI7282

CLCH
QUALITY ACCOUNT 2014/15

CONTENTS PAGE

1. ABOUT OUR QUALITY ACCOUNT 2014/15

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2014/15. The Quality Account is a summary of our performance in the last year in relation to our quality priorities and national requirements. We have incorporated a number of patient stories this year explaining the impact of our care on their lives.

What is a Quality Account?

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

Why has CLCH produced a Quality Account?

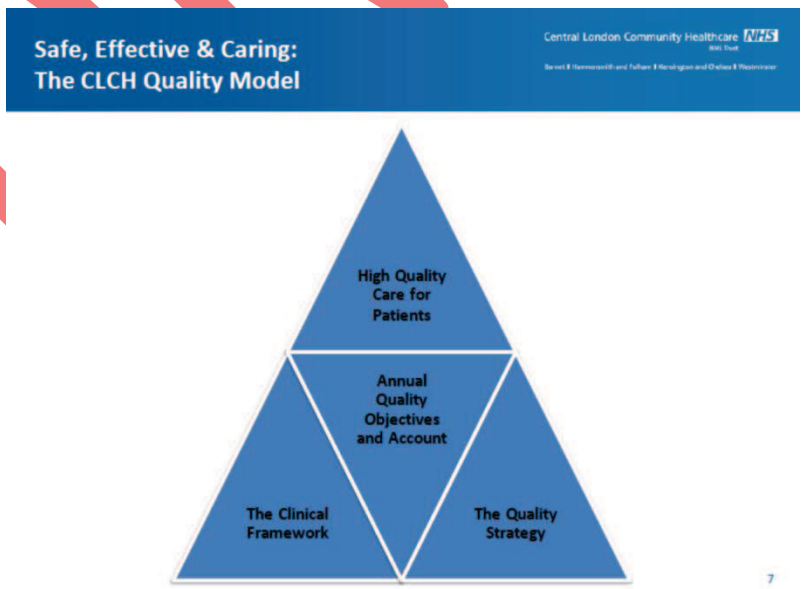
CLCH is a community healthcare provider, providing healthcare to people in their homes and the local community and therefore we are statutorily required to publish a Quality Account.

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 (2014/15) and to identify where we could improve over the next year, and we have defined six main priorities for improvement.

Developing the Quality Priorities 2015/16

The development of the Trust's Quality Account and Quality Priorities has been done in consultation with a variety of internal and external stakeholders. To make sure that our priorities matched those of our patients, carers, partners and commissioners and the wider public, we invited a range of individuals and groups to contribute to our Quality Account. We also have a Quality Stakeholder Reference Group (QSRG), with representatives from Healthwatch and local authority Overview and Scrutiny Committees (OSCs) which provided comments and feedback. More detailed information regarding the response to the consultation can be found at the end of the section on our quality priorities for 2015/16. Our clinical framework, quality strategy and quality account fit together, the clinical framework is our overarching direction, our quality strategy is a 3 year plan and our quality account is annual setting our quality priorities to compliment our strategy.



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

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

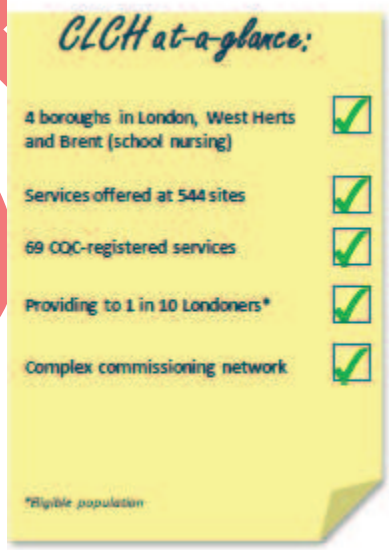
2. ABOUT CLCH

We provide health care in people's own home and in over 400 community settings including GP Practices, school and early years' centres.

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.
- End of life care – for people with complex, substantial, ongoing needs caused by disability or chronic illness
- Specialist services to include offender health services – at HMP Wormwood Scrubs
- Continuing care – services for older people who can no longer live independently due to a disability or chronic illness, or following hospital treatment
- Specialist services – including elements of long term condition management (diabetes, heart failure, lung disease), community dental services, sexual health and contraceptive services, psychological therapies
- Walk-in and urgent care centres – providing care for people with minor illnesses, minor injuries and providing a range of health promotion activities and advice

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



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3. STATEMENTS

CHIEF EXECUTIVE'S STATEMENT

I am pleased to present the quality account for the year ending March 2015; it has been a busy year for CLCH especially as we were preparing for our CQC inspection which took place in April 2015.

We welcomed the opportunity to highlight the work our clinical services deliver; during the three day visit the CQC inspected our four core services:

1. Community health services for adults
2. Community health services for children, young people and families
3. Community health inpatient services
4. Community end of life care

Another exceptional event occupying us this year has been the switch over from Rio to SystmOne being completed in Adult Services, walk in and urgent care centres. I was encouraged to hear, in two recent sessions I had with community nursing staff in Westminster and Hammersmith & Fulham, that they were already experiencing some of the benefits of the new system – saving them time in entering data and in interacting with key partners, particularly GPs.

SystmOne is a significant step forward towards our patients having a single care record and joint care plans for our patients to enable more positive multi -disciplinary working. I look forward to the summer when we will have completed to roll out to all the remaining services in the Trust.

This year we have rolled out a number of projects and initiatives to improve quality which our outlined in section 4.3 of the account. I would like to extend my thanks to our users, memebrs of the public and staff who played a significant role in making these such a success.

I'm also pleased to report that this year's audit of clinical record keeping has shown a clear improvement over what was already considered a good performance last year. Keeping up-to-date and accurate records is one of the hallmarks of a good professional and is vital for safe and effective patient care. Good record keeping is also essential in demonstrating that we are delivering our contractual requirements. Whilst we can be encouraged by the progress we have made in this area, we must all continue to work to create timely, accurate records within our teams.

In the next 18 months we will undergo a range of different assessments by the Trust Development Agency and Monitor. Also crucial to our success will be continued support from commissioners for our plans.

I confirm that the information contained in this document is an accurate reflection of our performance for the period covered by the report.

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James Reilly, Chief Executive

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

2014 saw the introduction of the Associate Director of Quality posts in each clinical division, The purpose of this role is to provide leadership within the division in order to ensure and consistently develop a high quality efficient service for patients and service users. The post holders support the Divisional Directors to deliver the quality agenda.

The Trust Quality Committee has continued to review progress against both our quality strategy and our quality account and we have made improvements in a number of areas including:

- a reduction in medication errors that caused harm,
- a reduction in falls that caused harm,
- the proportion of patients who rated their care as excellent or good increased,

We continued to concentrate of the reduction of pressure ulcers in the community and the committee reviewed a no. of actions that the Chief Nurse and her team have put in place this year to reduce the overall incidence – this includes working with other providers of care to support their education and knowledge regarding pressure damage.

We also had our external Monitor quality governance assurance framework (QGAF) assessment in September 2014 as part of the application for Foundation Trust status. The Trust was required to achieve a score of 3.5 in the assessment. I'm pleased to say that the external assessment scored the Trust as 3.0.

In 2015/16 the Quality Committee will continue to monitor progress against the objectives set in year three of the Quality Strategy as well as developing our new Three Year Quality Strategy (2016/17 - 2019/20).

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Julia Bond, Non-Executive Director, Chair: Quality Committee

PATIENT STORY - Continuing Care Team

Patient X is a 3 year old boy with a congenital condition. He lives with his parents and older sister. This is his mother's story.

`My son was born in 2011. He was in hospital for about ten months. I was introduced to the Continuing Care Team just before I was due to go home. I was introduced to C first. She came to meet my son and she introduced me to the Health Visitor. C also gave me a rough idea of how things would be when my son came home.

My son was supposed to come home and then it was delayed for a month or a month and a half. Before he came home what I found helpful was that C came to the house. X came home on oxygen, so she helped me with the oxygen, the feeding pump and everything that we needed to know about bringing him home, so that made it quite easy. She came a few times before he came home to help me set things up. C helped with his discharge home, with a couple of nurses from the Whittington Hospital, so that was helpful.

When he came home at ten months we did have a lot of help from the carers, because I have another child, a daughter and she needed to be taken to school. X was very susceptible to the bad weather and we had to be very careful with him. There were also very few people who actually look after him, so we had help from the community.

Whenever I needed anything I would call C and she would get what I needed, whether it was things for the suction machine or anything to do with his feed. Gradually, as he got older, I was introduced to the Dietician, the Paediatrician, Speech and Language Therapist and Physiotherapist, so there were a lot of people in the community who played a big role. As he got older he got stronger. Since he turned one and a half or so we don't have carers because we are more used to what happens and how to take care of him. Most of the time people are available for advice. For example when he has problems with his stoma I have called for help. The nurses, physios and dieticians are quite easy to reach for advice but it would be great if people were available at weekends as well.

Other than that, the team has been very helpful. My son got to know and like the carers. It was good having them around and it was really helpful at a crucial time for us. C is still always around if we need anything, whether it was help getting him to nursery, which he now attends, or advice when we needed to get things rolling.'

4. LOOKING BACK - QUALITY IN 2014-15

4.1 Progress against our Quality Strategy

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

- Campaign one: Positive patient experience;
- Campaign two: Preventing harm;
- Campaign three: Smart, effective care

Each of the campaigns was divided into two key components; gathering feedback and improving services, and all have clear high level vision statements of where we aim to be as a Trust in year one, two and three.

For year 2 (2014/15) the **Quality Strategy** objectives were as follows:

QUALITY STRATEGY CAMPAIGN: Positive Patient Experience

Objective
Teams analyse the data from their reports and are able to demonstrate simple, effective action plans to improve the patient experience.

Progress
Feedback and data is collated by our team of Patient Experience Facilitators into a monthly Divisional and Clinical Business Unit report. The report is presented at monthly quality meetings and each team can use any of this data to develop local action plans.

In some areas we have introduced 'You said – We did' type boards to show what patients have told us and the changes we are making if necessary. We also learn from positive feedback and make sure we capture compliments to boost staff morale. The monthly patient experience report, collated by the patient experience team, includes a section on 'You said – We did' to share best practice and capture the changes and improvements.

Examples of the many improvements from what patients told us (*You Said)* included the following:

- Training has been implemented for night staff within the district nursing team to ensure that they have the required skills
- The process for cancelling a rehabilitation clinic was tightened to ensure it does not happen unless absolutely necessary.
- The Falls CLCH transport contract was re-negotiated with an alternative provider to ensure there was sufficient support to assists clients to get on and off the transport vehicle safely.
- Magazines and a water machine were provided at Edgeware hospital

Objective

Each Division will be able to demonstrate improvements in the patient experience based on the achievement of their objectives.

Progress

Each Division has a Quality Committee structure in place where each of the indicators or quality is discussed. Managers review the feedback they have received, from all the sources including patient stories, 15 step Challenge visits, patient focus groups, and discuss the improvements they have put in place as a result. The Trust Patient Experience Group monitors divisional progress against engagement plans. Additionally there are in depth reports from the divisions at every meeting.

Objective

Each individual member of staff will be able to demonstrate at least one improvement they have made to their patients'' experience.

Progress

Each member of staff will discuss service improvements they have been involved in throughout the year, and in summary at their annual staff appraisal.

The appraisal process requires each person to review their contribution to the Trust values and specifically asks the question: *'I use best practice and feedback to innovate and constantly improve my service'*. This rating against this question will inform the overall performance rating for that year.

Objective

There will be a 10% (against 2012/13 data) reduction in complaints and incidents relating to poor communication and attitude.

Progress

In 2012/13 the Trust received 44 complaints regarding communication/staff attitude which reduced to 29 complaints for the 2014/15. This represents a decrease of 34.1% for complaints regarding communication/staff attitude and so this target was met.

PATIENT STORY- District Nursing

`I am 56 years old and have been receiving District Nursing care for over 2 years. I've always been extremely happy with the care I receive from the District Nurses and feel that they go out of their way for me. I'm visited twice a day to help me with my Nebulisers. On every occasion I feel like I'm respected and treated as an individual. The Nurses are always very kind, considerate and compassionate and always communicate with me very well. They always explain what they are doing and ensure that I understand what is happening. Often the District Nurses will pop down to the shops for me and take my rubbish down to save me having to walk down a flight of stairs. They always ensure that I have everything I need before they leave and often make me a drink and sandwich. It's very easy to contact the District Nurses (DNs) though I haven't had to very often. In the past I've left a message and been called back within 30 minutes. Sometimes I think it's a shame when people leave – I don't like high turnover or when I get used to someone, and then they're gone. The nurses who see me though are so professional and pleasant. They are happy to refer me to other services in the community and suggest ways in which I can be supported. I can't really fault the DNs and I'm very happy with the service I receive'.

QUALITY STRATEGY CAMPAIGN - Preventing Harm

Objective
Risk registers will be mature and will be used as a service improvement tool from team level to board and teams will be able to demonstrate service improvements based on analysis of risk factors.

Progress
Risk registers are discussed at all levels of the organization and there is a comprehensive system of reporting risks upwards and ultimately to the board as appropriate. The registers have been in place for several years and are embedded throughout CLCH.

Using the registers has led to improvements for example in information technology (IT) at school nursing and 0-19 service at Normand Croft School This was the case as the register picked up ongoing issues around connectivity and staff ability to use the IT to access patient records. Another example was the issue of faulty call bells at Jade and Marjorie Warren wards. Using the register highlighted the issue; the risk was referred up through the governance structure leading to a new system being introduced.

Objective
95% of incidents will be reviewed by the handler within 7 days, 100% within 14 days.

Progress
This target was partially achieved with 91.4% incidents reviewed by the handler in 7 days and 99.6% within 14 days.

Objective
Level of harm is reduced by 20% (against 2012/13 data).

Progress
This was only partially achieved as the level of harm was reduced against 2013 data by c.15%.

Objective
Incidents reported with no harm increased by 20% (against 2012/13 data).

Progress
This was fully achieved with the number of no harm incidents increased by 51%. In 2013 40.8% of incidents were no harm and in 2014/14 54.5% were no harm.

Objective
Being Open (Duty of Candour) contractual requirements to be achieved for all incidents directly affecting patients where the harm was moderate or above. All serious incident reports will be completed and returned to the commissioners within the required timescales (currently 45 /60 days)

Progress

(AW DATA) – full reporting on compliance available May 2015

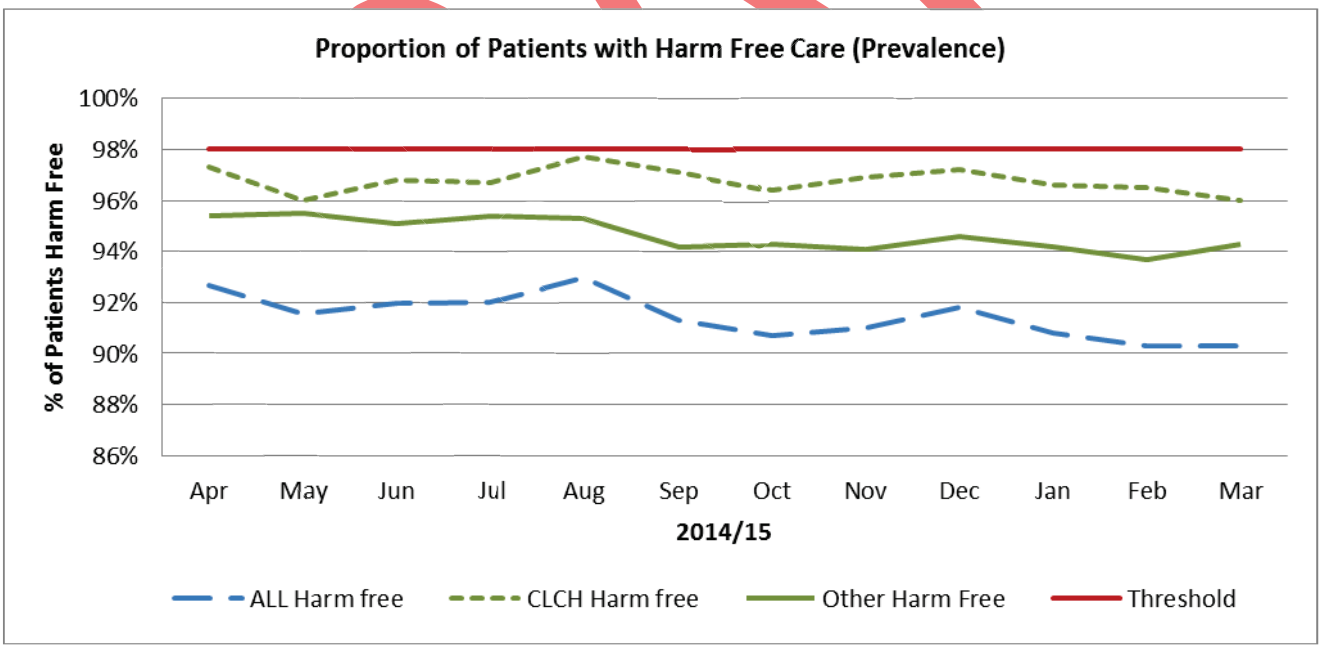
Objective
The trust will continue to meet the 100% data collection target for the NHS Safety Thermometer.

Progress
This target has been met. Of the teams that participate in the NHS Safety Thermometer, there has been a 100% collection of the data.

Objective
There will be a 40% reduction in harm against all 4 areas (as measured by NHS Safety Thermometer) (against 2012/13 data).
The NHS safety thermometer is a national prevalence survey. On one, nationally determined, day each month all relevant patients in the Trust are reviewed to determine if they have suffered any harm as a result of their healthcare. The categories include pressure ulcers, falls, catheter associated urinary tract infections (CAUTIs) and venous thromboembolism (VTE). The data is collected by the nursing staff caring for patients on that day and fed back to a national data base which is used for comparison and benchmarking. All data is presented at www.safetythermometer.nhs.uk as well as being used locally for quality improvement. A national target has been set that 96% of patients should be harm free; this applies to the overall scores and the individual categories.

Progress
Our prevalence of harms as measured by the NHS safety Thermometer was 96.75% harm free against the national threshold of 96%. We narrowly missed the Trust target to have 98% harm free care.

The following shows our rate of new harms (those caused under our care), All harms (all patients in our care) and the national average for harm free care.



PATIENT STORY– Homeless Outreach Team

`I met the Homeless Outreach Team and they told me about all of the services they have here. That was 14 years ago. The services here helped me. I volunteer here now.

The health team have always been very helpful. It's good to have a good receptionist who comes out and gets everyone's names. They get on with the guys, and the nurses have always been more than helpful here. I think it's a good service compared to going to an outside service, like a normal surgery. When you're homeless, I found that other services look down their nose at you. The medical staff here are very understanding of homelessness, and I think that's what places like this need. In other surgeries I've felt that people are thinking "you're homeless, why are you in my surgery?"

I've used the service a lot over the years. They keep monitoring my health problems. They wait for me to get in touch with them but might ask me to come back in a few days or something. If something needs to be followed up, they remember and will walk down the passageway and see you, and they might say "What's happened? Any progress?" They help me physically and emotionally.

You get your name down on a list if you want to see a nurse or doctor that day. It's done fairly. I do think that sometimes people expect miracles, and want to see a doctor and they want to see them now, but it's not a doctor's surgery; they get here at specific times when they're due, then you have to wait. The doctors I've seen here have been fine and I'm fine with waiting.

I believe that I'm part of the decision making myself. They're not saying "this is what you need to do". They just advise you. They keep me involved with what is happening, and they'll always go to somebody else and ask if they don't know the answer to something.

I think it breaks down barriers with the clients here, that the medical staff walk up and down and people can ask them questions. Even though the receptionist walks up and down and asks who wants to see the nurse, if the nurse is visual, and they see that the nurse is there, they may be more likely to say 'can I see you?' than talking to somebody coming round with a clipboard.

I've never worried about anything I've seen. I just think that everything needs to be more accessible. There are no notices for where the medical team is. Hopefully when the refurbishment work is finished this'll be better and there'll be more signs showing where everything is'.

QUALITY STRATEGY CAMPAIGN – Smart Effective Care

Objective

There is a NICE programme in place to identify new NICE clinical guidance and ensure services are reviewing and adopting those that are relevant.

The process measures are;
100% of NICE guidance is assessed by a multi-disciplinary team.
80% of services have completed the assessment of relevant guidance.

Progress

During 2014/15 NICE guidance was reviewed systematically for relevance through the NICE Core Group meetings, chaired by the Medical Director and consisting of a panel of quality and professional clinical leads. Specialty teams have been tasked with reviewing the guidance and implementing where appropriate.

The NICE process and policy has been reviewed and redesigned during 2014/15, and as a result quantitative recording measures were established.

Objective

A Clinical audit programme will be in place to ensure all services are conducting regular reviews of clinical practice. Additionally, stringent monitoring processes are in place to track progress of clinical audits.

The process measures are;
100% of agreed audits are completed annually
100% of audits have SMART action plans

Progress

The Trust has achieved a compliance level of 72% ('*moderate assurance*') with regard to clinical audits in 2014/15. The audit programme opened with 58 audits at the beginning of the year, including local, national and Trust-wide audits, and 42 audits were completed. This represents an increase of 9 audits on the previous year.

All audits have an associated action plan and there is an action log where the actions and their completion are monitored.

Objective

There is a programme in place to ensure services are measuring the outcomes of their practice and using the data to drive improvement.

The process measures are;
66% of services have defined a set of 3 or more clinical outcomes, with associated electronic data collection, to monitor the effectiveness of their clinical practice

Progress

- All services have been tasked to identify at least three clinical outcomes to evidence the effectiveness of their clinical interventions. To date 75% have identified 3 clinical outcomes with associated electronic data collection.
- National benchmarks for clinical outcomes in community services are being developed but progress is slow.
- In the absence of nationally agreed metrics, services are testing 'good enough' indicators to enable them to drive improvements in service quality.
- A clinical outcomes reporting system is being developed to allow teams to easily access their outcomes data and to enable effective analysis/interpretation.
- Services will set improvement goals for their service based on current performance.
- Monthly data will be reported back to clinical teams, operational managers and assurance groups enabling ongoing monitoring of clinical effectiveness and evaluation of improvement efforts.

- As nationally agreed metrics are developed, they will be incorporated into the local frameworks.

PATIENT STORY– Dietetics services

`It started off when my son was 2-3 months when he started having reflux and in the afternoon he was having cramps and feeling unsettled. I was breastfeeding at the time. I went to the GP and he referred me to see the dietician. And then what I started to do myself was, I read about things on the internet- the causes for reflux and one of the reasons was dairy. I don't have much dairy anyway, but I cut it out completely and it got a lot better. The dietician said it was important that I am taking calcium myself, especially when I started weaning, I really needed the support.

When he was 5 months old my son had another episode because my daughter put some food into his mouth, it was something dairy. And he started to get this mad rash on his face which proved to me that he is intolerant. The dietician had given me some formula to try. I continued to breastfeed longer than usual. And they really supported me through the weaning process.

I somehow felt during this, that he was not as sensitive anymore and I was keen on giving him some dairy products. And then we thought let's see if we can try and reintroduce the foods and she gave me a good guideline of what sort of foods to try first. And he was tolerating it all fine. She taught me how to try things and what time to. And she explained how other foods can cause a reaction like soya and fish. And she was giving me lots of advice on paper. I didn't know what the typical foods were that cause allergy, because my other child was normal. And she said it could happen with other things, which she explained to me well.

I saw the dietician about 4-5 times. I saw her every two months. And that was really useful. I didn't think I needed to see her more than that because in my case, it wasn't that serious. And she timed it perfectly so she saw me just before weaning and then after. At the times it was important for me to get the support. The overall booking process was good. The GP referred me and then someone called from the centre, it was all really straight forward. I had a choice in what times I wanted to see the dietician. If someone else has a similar case to ours, I would recommend your service'.

4.2 OUR QUALITY IMPROVEMENTS 2014/15 - QUALITY ACCOUNT PRIORITIES

This section describes how we performed against the six quality priorities we set ourselves last year. Where we have not achieved a priority we will continue to progress this work into the coming year. Where we have achieved a priority we will continue to monitor progress in order to ensure improvements are sustained.

QUALITY ACCOUNT PRIORITY – Positive Patient Experience

Our priorities for improving the patient experience in 2014/15 were:

Priority: We will improve user involvement and participation in developing and improving services at the trust

Progress:

Listening to our patients is vital for us to improve services so ensure our staff encourage patients and service users to provide feedback on a regular basis. We are very keen that we use a wide variety of other methods to get feedback, rather than just surveys. We also collect patient stories, where we can hear the real experiences of individuals that we care for, within our teams. Teams have the ability to look up patient experience feedback data through the Trust's intranet and use this to improve the patient experience.

We also carry out 15 Step Challenge visits to services. The 15 Step Challenge team, including Non-Executive Directors, Directors and patient representatives, will visit a service and explore the quality of care under four categories; Is the service well prepared, do patients feel safe and cared for, are patients and carers involved, and is there good communication? They use structured questions and talk to patients but are focused on 'First Impressions'.

To further understand patient views, some services also run patient groups. This can give us much richer feedback. It is so important that we also learn from when things have not gone well, through complaints and any feedback through the PALs service. People need to know that we have listened, responded and made changes as a result.

CLCH wants to hear from all our service users and their about any concerns you they have as well as ideas as to how we can shape our services going forward. To do this we developed a programme of *Listening Events*, these were held in all four Boroughs starting in February 2015. Additionally CLCH has signed up to the national campaign '*Sign up to Safety*' where we have joined a range of acute and community trusts to 'establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world'. Our approach to this campaign is rooted in involvment and participation. Amongst other things, the events in February 2015 were designed for patients, members and the public to advise us on the best ways to communicate messages about safety.

The Trust holds a Quality Stakeholder Reference Group where patients and representatives meet regularly throughout the year to help us test new ideas, develop new methods and learn from feedback. The group and its members are a vital source of feedback and guidance to develop and improve our services.

Each Clinical Business Unit has developed their own Engagement Plan to ensure that CLCH is involving patients, members and the public in improving services across the trust. We are pleased that involvement and participation is being developed in local services and look to continue this next year.

Priority: All services will actively use patient feedback for improvement, including using new feedback through the Family and Friends Test (FFT).

Progress:
The FFT asks the question: *How likely are you to recommend our service to friends and family if they needed similar care or treatment?*

Each service has the ability to seek feedback from their patients using a Patient Reported Experience Measure (PREM) Survey. Each service can decide how they go about this and some services are using a kiosk, a tablet device, or a paper survey. In addition to this we carry out a sample (800) of telephone surveys every month from patients across the whole trust. The FFT question is asked of our patients and the results are collated with all our other feedback, and presented to our Divisions and Business Units. 75 of our services have provided PREMs feedback, including the Friends and Family Test question, with 15,762 surveys being completed between March 2014 and February 2015. The majority of these (10,021) were collected via telephone interviews with patients.

The results of this feedback show that 80% of patients would be extremely likely or likely to recommend our services to friends or family members, with 91% of patients rating their care as excellent or good. 96% of people felt they were treated with dignity and respect (February 2015). Most positive comments received were about our staff, and the treatment, care and efficiency of the service. Most negative comments were about waiting times.

PATIENT STORY – STOMA NURSES
`I was temporarily in the care of District Nurses post-operatively before hand over to stoma nurses. The hand over process was smooth and hassle-free. Everyone involved seemed fully aware of past and current medical history. The administrative side of the clinic was very efficient. Patients could always get an appointment in a reasonable timeframe. The issues with the stoma kit were dealt with quickly and compassionately. I was told that even if I did not have an appointment, I should still make contact (with the service) and the stoma nurses will fit me in somewhere.

The stoma nurses were very professional, very kind, warm hearted and very well informed about all matters stoma. The treatment was very much personalised/tailored to them, which helped me relax and have trust in the nurses. The standard of care was uniform and very high, and I felt very fortunate to receive such care. The nurses took personal responsible for me. There were no oversights in the treatment, which was meticulous and precise throughout and I had absolute confidence in the approach taken by the nurses. The service was like a well-oiled machine and there was not a single thing that I could suggest they could do differently'.

QUALITY ACCOUNT PRIORITY - Preventing harm

Our priorities for improving the prevention of harm in 2014/15 were:

Priority : We will continue to demonstrate an increase in the reporting of incidents across the trust whilst reducing the level of harm caused to patients

Progress:
There was a 12% increase in the total number of incidents reported across the Trust (from 2012/13) but there has been a 15% reduction in the levels of harm. However from 13/14 to 14/15 there was a small reduction in the number of incidents that were reported. We are pleased that overall incident reporting is now embedded throughout CLCH.

Priority: We will reduce the incidence of medication errors across the Trust by a minimum of 10% (from 177 per annum to 159 or fewer)

Progress:
We achieved this target with the number of medication errors reduced to a total of 93, representing a 49% reduction. Medication errors were recorded last year so that **actual harm** was recorded and not **potential harm** as was the case previously.

PATIENT STORY– Community Nursing
`I ended up in hospital after I had a bad chest infection which was affecting my breathing. My oxygen had gone down. I was in hospital for 5 days. It freaked me out being in hospital. I was saying to myself what was I doing in here and it felt like I was having a nightmare.
A gentleman in hospital by the name of Richard was worried about me and I think he set up the nurses to see me at home. The first nurses (*rapid response nurses)* came to see me initially after coming out of hospital and they helped me with oxygen, my diabetes, check me over and checked my chest was alright. They would sit down and talk to me. Make me feel more confident. It was nice and they didn't make me feel rushed. They helped me with my inhaler as well because I was doing it wrong and my breathing since has been better.
Then the virtual ward case manager came to see me and she initially did the same. She would sit down and chat with me. If I had concerns I was able to speak to her about my health. I felt easy around her and she showed that she was concerned about me. She also got the Respiratory Nurses to come and see me at home which was also a help.
I can't complain with this treatment cause I have come out of hospital before and been forgotten. When I had my open heart surgery, it was around a Christmas time and the hospital sent me home with no one. I really lost confidence at that time but now I feel more comfortable coming home since having this service'.

QUALITY ACCOUNT PRIORITY – Smart Effective Care

Our priorities for improving smart effective care in 2014/15 were:

Priority: We will seek further improvement in consistent communication between the community nursing teams and the patient's GP after initial assessment of a patient and following discharge.

Progress:
All our community nursing teams are now using SystmOne as the main electronic based patient care record. SystmOne is the same electronic care record as our local GP colleagues. This allows us to work within one patient one record, for the benefit of our patients. The progression of SystmOne alongside the use of mobile working devices allows for patient care to be visible in the right place at the right time and accessible to the most appropriate health care professional. This is the first time that patient care provided can be shared between community nurses and general practice in real time. When our community nursing teams have successfully completed delivering patient care, SystmOne allows us to inform general practice immediately of their discharge from our care. The benefit of one patient, one record also ensures that patient's care is not fragmented when e.g. they are discharged from a service, as the care that was successfully delivered is still available for the most appropriate health care professional.

Additionally, Barnet District Nursing (DN) service reconfigured in 2014 in order to organise their work into 3 localities. Each locality is now managed by a clinical locality manager, who is responsible for attending locality General Practice (GP) meetings and for liaising with the GP groups. The realignment confirming which GP practices are attached to each DN team. District nursing team leads attend 'Gold Standard Framework' meetings relating to advances care planning for patients reaching end of life care. GP referrals are sent to a single point (SPA) where triage and allocation to the team occurs. Standardised communication back to the GP following an initial assessment is under development with the implementation of a new clinical recording system.

Priority: We will ensure that, where national clinical guidelines have been produced by the National Institute for Health and Care Excellence (NICE) which are relevant to the care we provide, we will demonstrate we are using them in everyday practice

Progress:
In order to ensure that the implementation of national clinical guidelines is clinically effective, the trust uses a system of clinical standards, clinical audit and clinical outcomes measurement, as listed below, to ensure that care is safe and effective.

Clinical standards

- An evaluation of the clinical standards programme is currently under way. The NICE clinical standards relate directly to the NICE published guidance, which are not always relevant to clinical services at CLCH. Individual clinical teams also use standards which are more relevant to their clinical areas, and these may be produced by their own professional bodies or other recognised national organisations.

Clinical audit

- There have been 18 audits of NICE clinical guidelines included in the audit projects in 2014/15.
- The Key Performance Indicators established for 2015/16 include the auditing of two NICE guidelines in each Clinical Business Unit during the course of the year.

Clinical outcomes

- All services have been tasked to identify at least three clinical outcomes to evidence the effectiveness of their clinical interventions. To date 75% have identified 3 clinical outcomes with associated electronic data collection.
- National benchmarks for clinical outcomes in community services are being developed

- In the absence of nationally agreed metrics, services are testing ‘good enough’ indicators to enable them to drive improvements in service quality.
- A clinical outcomes reporting system is being developed to allow teams to easily access their outcomes data and to enable effective analysis/interpretation.
- Services will set improvement goals for their service based on current performance.
- Monthly data will be reported back to clinical teams, operational managers and assurance groups enabling ongoing monitoring of clinical effectiveness and evaluation of improvement efforts.
- As nationally agreed metrics are developed, they will be incorporated into the local frameworks.

PATIENT STORY– Primary Care Psychological Health (PCPH)

`I got to a point where I wasn't in a great place at all. It's just not like me to think about getting help, and it was probes from my mum and dad and family and friends saying that something's not quite right that made me go to my GP. I felt that I needed something extra. I had got to a point where I felt I couldn't even control my own emotions, and found it difficult to decide what was right and what was wrong. I needed some sort of support and I knew that my family couldn't help me with that, so I needed someone outside the box who I could talk to freely about how things have been. That's why I said yes to being referred, and came here. The GP suggested that I had a referral and that I should take some medication, but I refused the medication.

I had no idea at all what it would be like here [PCPH] and what to expect. I knew I'd be talking to someone about my problems. I didn't realise that there'd be different aspects of the meetings that would be able to point me in the right direction, not having had any counselling or self-help sessions before.

I had a phone call from the service before I started my sessions. I think it was really fair and right to have that. I think it was a stepping stone to suddenly coming here and talking to somebody. I think it was really helpful to speak to someone initially about my problem and having a designated time for it as well, rather than someone just ringing me at any point in the day; having an actual slot to raise concerns about how I had been feeling, as I could then have a list in front of me of things that I needed to say that I thought needed to be picked up on. It was very clear who I was talking to on the phone and they made their role clear. I never felt that I was rushed or needed to stop talking – 100%. I spilled a whole load of information about everything, and we worked together about which direction would probably be the best to go down. [The triager] gave me the options and we worked out that low intensity cognitive behavioural therapy (CBT) would be probably the best.

To a certain extent, seeking support was quite daunting at first because I've never needed support. Even my physical health has always been brilliant. I have a sister who has all the support in the world, and me being the one who needs a little bit of help has been a bit bizarre, so actually having that initial conversation about what it involves really helped.

I don't think I'd change anything about the service. I think it's really good to have the first telephone appointment because then you can determine what's best for that person, and the first face to face session was more about me just talking about my issues. That helps the practitioner understand what I'm talking about.

When I begin talking I can think of loads of things to say because I think so much, but I've never felt overly restricted as I know that we can talk about it more next session if we don't have the time. I think the sessions have taken the right length of time for me too, so that's ok. It's been really helpful having someone to talk to about things, and I wouldn't have been able to talk to anyone at home about half the stuff I've been able to talk about, just because I wouldn't want to upset anyone or feel a burden so it's been really helpful having a set time to bring up things. It's been really good and very supportive'.

4.3 TRUST QUALITY PROJECTS AND INITIATIVES

Achieving Excellence Together

Five groups have been established to take forward the Achieving Excellence Together Campaign which focusses on improving the morale of staff and the quality of care within our district nursing teams. Each group has a range of representation and is taking forward a plan focussed on the following themes; staff morale, recruitment and retention, competence of staff and confident in their role, community nursing models and clinical leadership. The progress of each group is reported to our steering group which meets every 2 months

Compassion in Care

The Compassion in Care project aims to promote dignified and compassionate care through appreciative, evidence-based, and relationship-centred-methods that focus on making a difference to the lived experience of service users and carers (both paid and unpaid). The Project Lead is working directly with frontline staff, in a range of different clinical contexts, to support local change projects, that promote the 6Cs (care, compassion, competence, communication, courage and commitment) in line with the NHS England Compassion in Practice vision and strategy (http://www.6cs.england.nhs.uk/pg/dashboard). She is also taking a whole systems approach to ensure compassionate care is embedded across the whole of CLCH.

Examples of outcomes achieved include:

- Appointment of a Compassion in Care Co-ordinator to lead transformational change across the Trust using appreciative, evidence-based and relationship-centred approaches that are focused on making a difference.
- Development of 50 named Compassion in Care Champions (CCCs) who are actively engaged in implementing and evaluating local Compassion in Care change projects at CLCH, across all of the Trust.
- Attracting the interest of senior staff from the Department of the Health who visited the Trust in November 2013 and again in May 2014. In particular, they were interested in the Compassion in Care Compass Model and the development of evidence-based outcomes to measure success in compassionate care.
- A visit by Jane Cummings (Chief Nurse for England) visited the Trust on International Nurses' Day (12th May 2014) as a guest speaker at a celebratory event where many Compassion in Care Champions (CCCs) presented their various projects, and where she presented the CCCs with awards for their work.

End of Life Care

CLCH is committed to the delivery of high quality, compassionate care and the involvement and engagement of all key stakeholders in decisions about end of life care. Our End of Life Care Strategy (2015-2018), through the End of Life Care Model of Care and work programmes aims to ensure the continued delivery of holistic, competent, compassionate care for the dying and their families regardless of where they are cared for. It includes the provision of end of life care for children and adults with any advanced, progressive or chronic illness regardless of diagnosis.

In order to achieve the aims of the Strategy the Adults work programme will focus on six objectives as follows:

- High quality, relationship centred, compassionate care
- Advanced care planning/risk stratification
- Assessment and care planning
- Symptom management, comfort and well being
- Support for families including bereavement care
- Education and training

The aim of the trust's service improvement plan

To embed the Sign up to Safety campaign's five pledges (see Appendix 1) into a plan to engage the ambition of staff by identifying the changes in their practice that are required to identify, implement and evaluate one change in their service that will improve its quality.

Reason for focus on frontline staff engagement

Historically, the trust's safety campaigns have not affected all of its dispersed and diverse services as they have focussed on the outcome of reducing pressure ulcers, falls, catheter associated UTIs and VTE. It is hoped that by focussing on the process of engagement and learning, this campaign will encompass those services who traditionally have not had involvement in patient safety initiatives and support them to identify and resolve safety issues relevant to their particular context.

Objectives

1. To engage a wide range of people in a series of conversations about what can support their leadership for improvement in their service.

2. To offer local champions the opportunity to review, evaluate, develop and share their skills and experience about how to lead improvement projects.

3. To organize resources around the requirements of each project to enable the local leadership of improvement.

4. To gather data to evaluate what works in particular contexts and spread the results throughout the trust, using them specifically to develop the trust wide approach set out here.

5. To align the work of the trust service improvement plan with the wider trust quality improvement initiatives.

The trust has worked hard at developing and implementing its quality strategy and preventing harm campaign. The focus remains on improvement in reporting incidents whilst reducing harm caused to patients. However, the trust wants to continue to learn more about how to intervene to improve things for patients. In particular, how to lead and resource improvements in an organization characterized by geographic spread; diverse service cultures; lead by a variety of professions; in a governance framework that must reflect a range of contractual relationships with commissioners and providers.

The two questions we have asked ourselves developing the service improvement plan are:

1. *If our organisation's quality and safety culture depends on our staff focusing on how they learn about how to improve things for patients and service users; how do we help our local leaders develop their skills to facilitate this learning*
2. *If our current approach to quality and safety does not exhaust what is possible in terms of local leadership, how do we now need to behave, think and organize as the leaders of the SIP project in the Trust?*

The approach we have designed to guide the set up phase of the service improvement plan is based on practical engagement. Simply put, we will 'reach out' to local champions within services to have a conversation to identify what it is they want to improve; the resources they may need; how they can measure progress; how they wish to report progress centrally; and what they may need from those to whom they report. In having these conversations we will be mindful that some frontline staff will not have had the opportunity to lead service improvement before. It is the reliance on centrally set priorities that we are interested in changing to see if it increases frontline staff engagement and consequently local improvement and spread.

Support to local projects

In parallel, we will engage those who have a designated quality and safety role in the trust. We will require the central quality team to explicitly deploy their expertise in support of local leaders; their teams and service users. Key to this work will be the development of local action plans.

Local action plans

The local action plans will be developed at the service improvement workshops. Frontline staff will consider the following sorts of questions prior to the workshop:

1. What needs to be different in my service now?
2. What would patients and others notice if I helped make these changes?
3. What needs to be measured and who can help me?
4. What methods are available to present my findings and how would I report this in the clearest manner?
5. Who has a view that I need to take into account?
6. What resources would help me and my team to be successful?
7. What do I need from others?
8. What are the implications for my leadership ability; do I have the right skills, knowledge and experience to achieve what I want to achieve?
9. What could undermine the work and what can I do to reduce this risk?

Patient Experience

We will also 'reach out' to patients to discuss how they think their safety could be improved. We will work alongside the patient experience team to achieve this. As part of The Patient and Public Engagement Strategy, listening events were run during February, May and November in each of the boroughs in which CLCH is the primary community care provider: Kensington and Chelsea, Hammersmith and Fulham, Westminster and Barnet. The overarching objectives of these events was to:

1. Share information about health related issues and CLCH
2. Ask what matters to patients most
3. Listen to feedback about what is working well and what could be improved
4. Open up the discussion about health matters and services to as wide an audience as possible to contribute

A link to our listening events for patients and users this year:
http://www.clchlistening.citizenscape.net/core/portal/home

5. LOOKING FORWARD - OUR PRIORITIES FOR IMPROVEMENT 2015/16

In this section we detail our quality improvement priorities for the coming year. The identification of specific priorities, including the consultation process is described in more detail in the next section.

Positive Patient Experience

- We will improve patient engagement in relation to working together in partnership to change/improve quality
- We will work to support a single point of access for patients with long term conditions

Preventing Harm

- We will improve service users involvement in service improvement projects and safety campaigns
- We will continue to reduce medication errors in practice

Smart Effective Care

- The Trust will work to provide improved information publically for people to be able to make an assessment about how Central London Community Healthcare NHS Trust performs on quality
- We will improve % of relevant NICE clinical guidance that have been assessed by eligible clinical teams

How will we monitor progress on these aspects of quality improvement?

All of these elements will be measured; some monthly, some quarterly so that the Trust can show that it is improving the experience of patients, their safety and the effectiveness. The progress on all planned quality improvements will be monitored monthly by the Trust Quality Committee. This committee will report at least quarterly to the Trust Board.

CLCH will continue to involve our service users in monitoring aspects of quality improvement. For example we will continue to involve our service users in the 15 Step Challenge. We will also continue to engage with our service users via the Trust's governance structure and in particular via the Quality, Safety Reference Group (QSRG) and Patient Experience Groups.

WHO DID WE INVOLVE AND ENGAGE WITH TO DETERMINE OUR QUALITY PRIORITIES?

An initial long list of quality priorities was drawn up based on discussion with Senior Clinical and Quality Staff as well as by looking at our performance against a range of quality indicators. We then consulted on the long list with members of the public and staff via the survey as detailed below. In addition we wrote to the Chairs of Health watch, Overview and Scrutiny Committees and Clinical Commissioning Group (CCG) Chairs asking for suggestions to be included in the account and we also reviewed the proposed quality priorities with the Quality Stakeholder Reference Group (QSRG) as part of the consultation on the draft Quality Account.

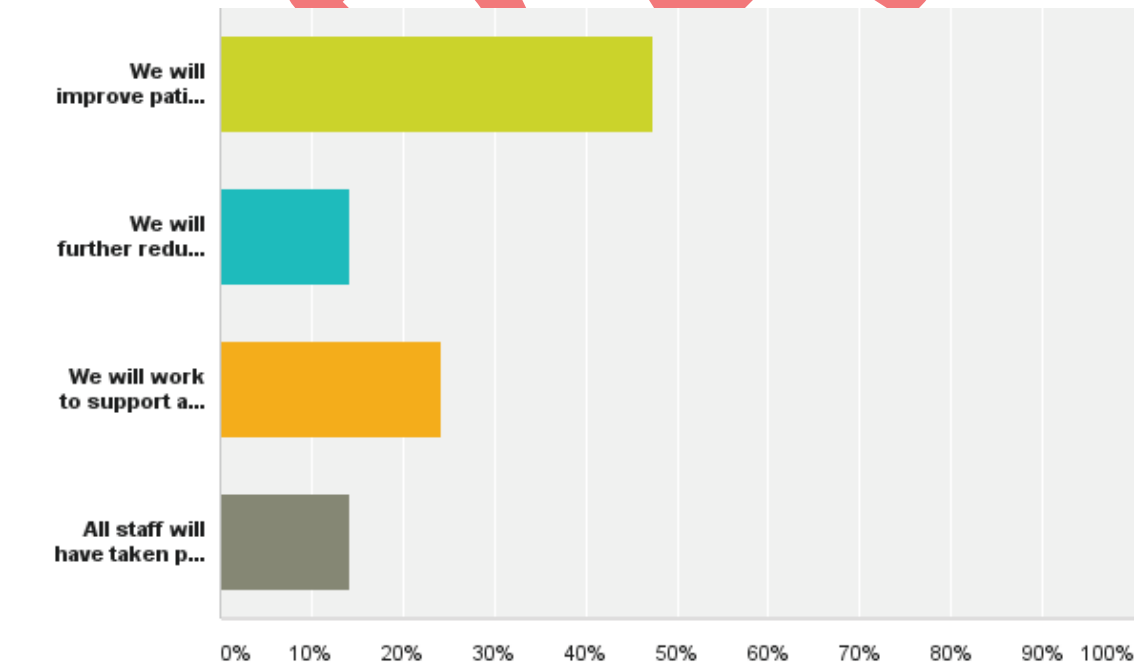
Based on this we chose our list of quality priorities for 2015/16

The following information shows how, following consultation, our proposed quality priorities were ranked by the 104 who responded to our consultation.

POSITIVE PATIENT EXPERIENCE

99 people responded to this question

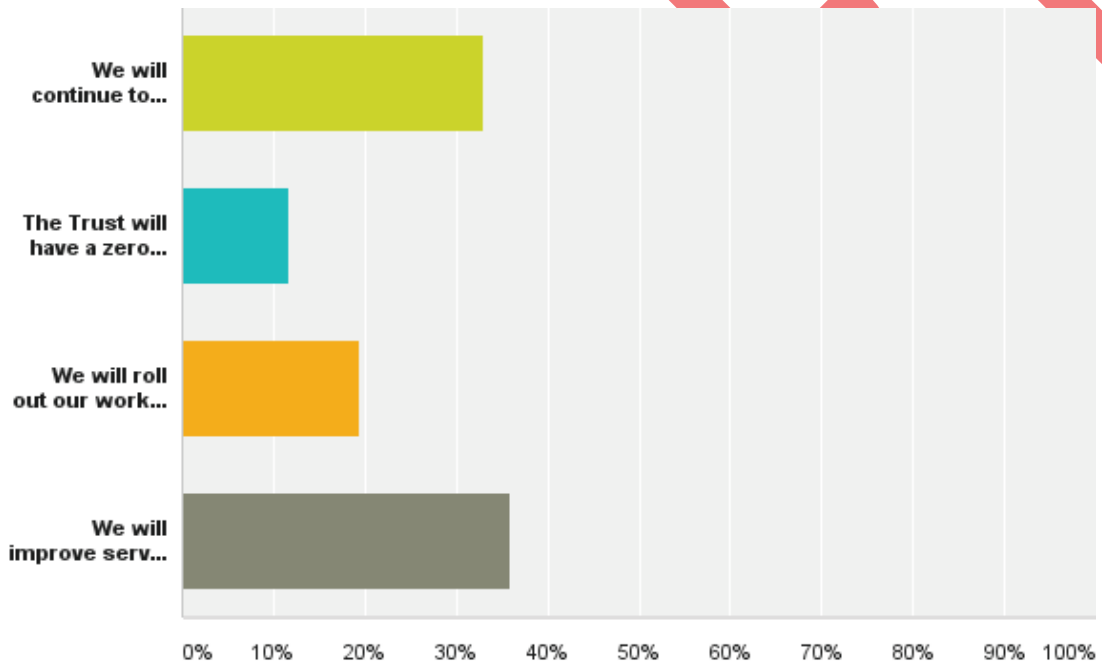
Answer Choices	Responses	
We will improve patient engagement in relation to working together in partnership to change/improve quality	**47.47%**	47
We will further reduce comments, concerns and complaints about staff attitude	**14.14%**	14
We will work to support a single point of access for patients with long term conditions	**24.24%**	24
All staff will have taken part in dementia awareness training	**14.14%**	14
Total		**99**



PREVENTING HARM

103 people responded to this question

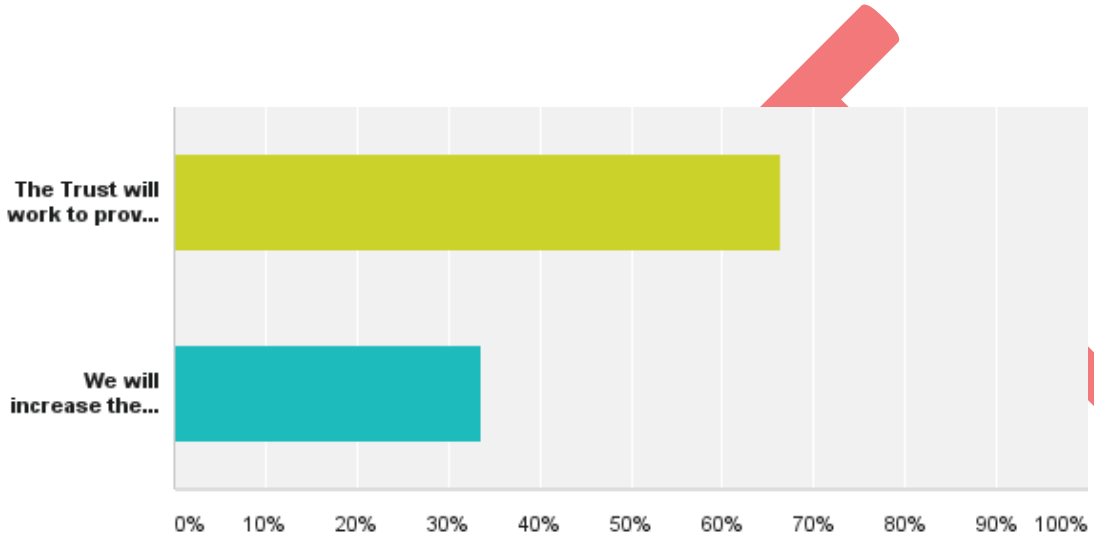
Answer Choices	Responses	
We will continue to reduce medication errors in practice	**33.01%**	34
The Trust will have a zero tolerance target for immunisation errors	**11.65%**	12
We will roll out our work on the national sign up to safety campaign implementing safety improvement plans click here	**19.42%**	20
We will improve service users involvement in service improvement projects and safety campaigns	**35.92%**	37
Total		**103**



SMART EFFECTIVE CARE

98 people responded to this question

Answer Choices	Responses	
The Trust will work to provide improved information publicly for people to be able to make an assessment about how Central London Community Healthcare NHS Trust performs on quality	**66.33%**	65
We will increase the number of relevant NICE clinical guidance that has been assessed by eligible clinical teams	**33.67%**	33
Total		**98**



PATIENT STORY - PODIATRY

`Today I came to see the biomechanics specialist to whom I was referred by another podiatrist. I have some problems with the skin on my feet and various [foot pains] that I had been to see my GP about and that's how I was originally referred. Because I didn't know anything about podiatry before I came, I admit I was a bit sceptical as I didn't really understand was you did and how you could help but now that I've had my appointment I feel it was worthwhile and very interesting. Now that my treatment plan has got started I'm very confident that it will help my [foot pains] and that the situation is in hand.

With regards to booking my appointments, compared to my recent experience, which was awful, I'd say that this is a model service, my best NHS experience so far. I was seen punctually without any problems.

My only slight negative is that I'd like to know more about the findings and thinking around my biomechanical assessment. Today the specialist had a student with her, which she asked about if this was okay and I didn't mind at-all, and when they were analysing the way I walked I could hear the specialist explaining things to the student. I understood that this was part of the teaching process but I was interested to know more about what they were seeing. It wasn't a big deal, I'm just very intrigued.

I really am very happy, my only suggestion would be to try and supply a little more information about the biomechanics service before people attend so they know more about what to expect. Maybe a leaflet or a web link. I have been prescribed orthotics That I'll need to come back to have fitted so I don't know if all my problems have been solved yet but I'd be happy to talk with you again to continue my experience. Yes, I would certainly recommend this service to my family and friends'.

6. REVIEW OF QUALITY PERFORMANCE – REQUIRED INFORMATION

CARE QUALITY COMMISSION

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS Trusts have been legally obligated to register with the CQC. CLCH is registered with the CQC and its current registration status is *registered without conditions.* Furthermore the CQC has not taken enforcement action against CLCH during 2014/15 and CLCH has not participated in any special reviews or investigations by the CQC during the reporting period.

Summary of inspections

During 2014/15 the CQC undertook 3 unannounced inspections at 3 of the trusts registered locations.

HMP Wormwood Scrubs – Inspection Date: 12th/13th May 2014

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 7 – Safeguarding people who use services from abuse
Outcome 9 – Management of medicines
Outcome 14 – Supporting workers
Outcome 16 – Assessing and monitoring the quality of service provision

Garside House Nursing Home – Inspection Date: 7th August 2014

The Trust was found to be meeting the following standards
Outcome 4 – Care and welfare of people who use services
Outcome 16 – Assessing and monitoring the quality of service provision

Princess Louise Nursing Home – Inspection Date: 16th March 2015

The report from the inspection has not yet been published.

If you would like further information about the Trust's registration and the CQQ's inspection reports, please see the following website http://www.cqc.org.uk.

CQUIN PAYMENT FRAMEWORK

A proportion of CLCH's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between CLCH and Barnet Clinical Commissioning Group (CCG), and CLCH and the three CCGs which make up North West London (NWL) Clinical Commissioning Groups

Our achievements against the CQUIN goals for 2014/15 are detailed in the following table:

CQUIN	Goal	Plan TOTAL £	Forecast 13/14 £
Friends & family test	Implementation of staff and patient friends and family tests	191,495	191,495
NHS safety thermometer	25% reduction in prevalence of pressure ulcers, including those acquired within CLCH and those acquired under the care of other providers.	191,495	tbc
Shared patient record and real time information system	Access to and two way information exchange within a common clinical IT system / shared electronic record between GP & care provider.	765,837	765,837
Improving the emergency care pathway	Reduce emergency patient referrals and re-attendances at hospitals.	382,918	306,335
Improving the planned care pathway	To reduce the number of patients with long term conditions attending hospital through supporting self-management and long term condition management in the community.	382,918	306,335
INWL TOTAL		**1,914,592**	**1,569,965**

Friends & family test	Implementation of the friends and family tests for staff and patients.	73,913	73,913
NHS safety thermometer	35% reduction in prevalence of pressure ulcers, including those acquired within CLCH and those acquired under the care of other providers.	73,913	tbc
Value based commissioning (Long term condition management)	Reduce unplanned admissions into hospital or attendances at A&E for patients over 65	177,390	177,390
Integrating Care	Increased effectiveness of multidisciplinary meetings, improve patient care using rapid care and integrated care services, improve shared decision making with patients.	206,955	110,869
Prevention – smoking / alcohol	Improvement in stop smoking offers in community health services and referrals to stop smoking services and increase screening for patients at risk from alcohol use.	110,869	84,930
Pressure ulcer stretch	Reduce the number of pressure ulcers in residential homes through training their staff.	96,086	96,086
NCL TOTAL		**739,126**	**543,188**

Diabetic retinopathy screening – smoking cessation	Increase screening for smoking cessation	2,647	2,647
Diabetic retinopathy – uptake of screening services	Increase uptake of screening services	10,590	10,590
Early years – smoking cessation	To train 80% of staff to give smoking cessation education. For health visitors to record that smoking cessation advice had been given on the patient electronic record.	74,165	74,165
Early years – CHIS to CHIS	To create an interoperable Child Health Information System (CHIS) across London and improve documentation of Hep B vaccinations for all children and of all immunisations for looked after children (LAC)	296,659	296,660
Offender health – staff vacancies	To decrease staff shortages.	53,166	53,166
Offender health – TB screening	To increase screening and treatment for TB.	53,166	53,166
Offender health – Hep B vaccination	To increase the uptake of the Hepatitis B vaccination.	53,166	53,166
Offender health – mental health screening	Improve access to mental health screening.	53,166	53,166
NHSE TOTAL		596,724	596,725
TOTAL		**3,250,442**	**2,709,878**

QUALITY AND INFORMATION GOVERNANCE

CLCH recognises that good quality data is essential for the effective delivery of patient care and to enable continuous improvements in the quality of this care. The Trust is therefore fully committed to improving the quality of the data in use across all of its services. The following is a summary of the actions that CLCH has taken to improve its data quality.

- The data quality strategy implementation plan was revised, improved and implemented during 2014-15.
- A data quality manager was appointed on a substantive basis. A key responsibility of the role is to liaise closely with operational staff in order to drive improvements in the level of data recording on the Trust's patient information systems, as well as raising awareness of specific data quality issues and developing the Trust's data quality culture in general.
- A data quality assurance framework (DQAF) was established.
- A dedicated online data quality training course was rolled out to all attendees of the Trust's information systems training courses
- Members of the Business Intelligence, Performance and Analytics (BIPA) team liaised with the SystemOne project team to effect improvements to the system to optimise data entry, and raise levels of data recording and data quality.

CLCH will continue to improve the quality of its data during 2014-15 by:

- Extending the DQAF to the assessment and audit of patient activity based key performance indicators.
- Investigating the possibility of submitting both admitted patient and outpatient records to the SUS for inclusion in the Hospital Episode Statistics during 2014-15 (see below), and continuing to work to improve the quality of the data submitted across all treatment pathways.
- Provision of a comprehensive list of data quality reports for service validation on the new patient information system (SystemOne)

NHS number and General Medical Practice Code Validity

CLCH submitted records during 2014-15 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: **95.4%** for accident and emergency care. The percentage of records in the published data which included the patient's valid General Medical Practice code was: **99.9%** for accident and emergency care.

CLCH did not submit records during to the Secondary Uses service for inclusion in the Hospital Episode Statistics for either admitted patient care, or for outpatient care.

Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2014/15.

Information Governance Toolkit Attainment Levels

The Trust achieved a score of 77% against the toolkit. This represents overall satisfactory compliance.

PARTICIPATION IN RESEARCH 2014/15

CLCH remains committed to research as a driver for improving the quality of care and patient experience.Our Research strategy approved by the Board in May 2014 signaled CLCHs commitment to research. The Director responsible for research is the Medical Director; and research activity is monitored through the Clinical Effectiveness Steering Group, overseen by the Quality Committee (a subcommittee of the Board).

The current research goals are to:

- Develop a Robust Research Governance Framework
- Develop a Research Culture within CLCH
- Establish Communication about research activity and support internally & externally
- Demonstrate visible research leadership: identifying research opportunities, offering research support and supervision, research training
- Increase the amount of research funding and resources for research
- Improve research partnerships and collaborative working
- Support the implementation of research into practice
- Promote CLCH and its strengths as an essential research partner.

Participation in clinical research demonstrates CLCH's commitment in improving the quality of care we offer and making our contribution to wider health improvements. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to the successful patient outcomes. Our focus on patient health outcomes in CLCH underpins our commitment and understanding that clinical research leads to better treatments for patients.

The number of patients receiving NHS services provided or sub-contracted by CLCH from 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 104.

CLCH was involved in 25 clinical research studies in a number of specialities during 2014/15 including; Diabetes, Offender Health, Children's health, COPD, Stroke, Ulcer care, Dementia and Compassionate Care.

There were over 50 (5 CLCH) clinical staff participating in research approved by a research ethics committee during 2014/15, these staff participated in research covering 8 specialities.

This year our key achievements included:

- Board approval for a Trust Research Strategy and a Trust Research Governance Policy
- Successful applications fora Research Fellowship to the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Northwest London
- Successful application for funding for a research nurse

The following are examples of studies that CLCH is currently involved in:

- So what sort of nurse are you? Nursing in a social care setting: Looked after children's views and stories.
- Survey study for patients with Type 2 diabetes and atrial fibrillation on the risks and benefits of medication
- **T**he delivery of compassionate care: the role of the middle manager
- Experience of intravenous drug users with leg ulceration

PARTICIPATON IN CLINICAL AUDIT

During 2014-15, the Trust undertook extensive work towards achieving the key performance indicators set for clinical audit; namely, ensuring a proportion of clinical audits and key actions are completed within specified timeframes and that information and data from a proportion of the national clinical audits the Trust is committed are delivered within stated deadlines.

The start of the financial year saw the launch of a comprehensive clinical audit programme based on national and mandatory requirements as well as locally driven priorities specifically identified by Trust divisions and services. In addition, CLCH undertook Trust-wide audits incorporating areas of high risk and concern affecting the entire organisation. Further to peer review by the Clinical Effectiveness Steering Group and ratification by the Quality Committee, a sub-Committee of the Trust Board, a forward clinical audit plan was approved and agreed for 2014-15.

During 2014/15, the Trust was not eligible for participation in any national confidential enquiries; we were however registered for 2 national clinical audits.

National Clinical Audits	Participation	Number of cases submitted or reason for non-participation
Chronic Obstructive Pulmonary Disease (COPD)	Yes	Data collection phase Data collection for the pulmonary rehabilitation work stream is underway. The publication of the national organisational audit report is expected in November 2015.
SSNAP (Sentinel Stroke National Audit Programme) (Previously known as the National Stroke Audit).	Yes	Data collection phase The 2014 acute organisational audit measured stroke service organisation in acute hospital settings. The audit now is now focusing on post-acute organisations and measures the extent to which specialist stroke rehabilitation is being organised and benchmarks the quality of community services, regionally and nationally.
Intermediate Care National Clinical Audit	No	Due to unforeseen circumstances that included the merging of services and staff shortages, the Trust did not register no participate in this audit.

Local and Trust-wide audits

No	Item	Division	Service	Outcome and Actions 2014/15
1	Audit of Intervals of Taking Bitewing Radiographs in Children	APC	Dental	Overall compliance level was 73%. Recommendations: the dissemination of results to all clinicians to ensure 100% compliance on re-audit.
	Diagnostic Quality of Radiographs Sent in by Referring Dentists	APC	Dental	Awaiting final report

2	X-ray interpretation acumen of clinicians working in the Finchley Walk in centre	APC	Walk-in centres	This audit found the overall percentage of abnormalities being missed by clinicians in the service remains low (< 2% of the total number of images taken) reflecting continuity of the good practice identified in 2013 audit. Recommendations: continued professional development to maintain clinicians' scanning skills.
3	Re-audit of patients presenting to the Finchley Walk in Centre with a complaint of chest pain	APC	Walk-in Centres	71% of the patients who required secondary care follow up following a visit to the walk-in centre with non-traumatic chest pain either received drugs as recommended by NICE or a good rationale for why the drugs were not given. This represents a considerable improvement from the previous audit where compliance was less than 30%.
4	CASH (Contraception and Sexual Health Service) Notes Re-audit	APC	Sexual Health	This audit of the electronic record keeping system (EMIS WEB) indicated no change since the previous audit.
5	Clinical audit for service adherence to NICE guidelines for the treatment of depression	APC	Primary Care Psychological Health	Overall, this audit indicated unchanged similar scores when compared with 2013-14. Guidelines met scored 70-100%; percentage of guidelines partially met scored 10-70% while the unmet percentages were 0-10%. An action plan with February 2016 was implemented.
6	Maternal Mood Assessment Re-audit	CHD	Health Visiting	Postnatal depression [PND] is an important category of depression, with prevalence within the first few postnatal months of between 10% and 13%. Health visitors follow NICE guidance concerning maternal mood assessment. The compliance was found to be good regarding the questions asked by health visitors. Results were circulated for review and feedback.
7	8-12/2-2.5 Year Health Review	CHD	Health Visiting	HPV Health Promotion Tools Audit
8	Food Allergy Clinical Assessment	CHD	Children's Therapies	HPV Health Promotion Tools Audit
9	HPV Health Promotion Tools Audit	CHD	Health Visiting	HPV Health Promotion Tools Audit
10	Paediatric Nasogastric Tube Feeding Management	CHD	Paediatric Dieticians	CLCH policy aims to support best practice in the management of nasogastric feeding. The need for guidance is based on the increased risk of tube displacement and thus accidental feeding into to the lungs resulting in aspiration pneumonia and potential fatality. This audit examined clinician compliance to this policy and found that overall, there was compliance of 3 out of the 5 key performance

				indicators set in the policy. Action plans included allowing other documentation to be used as risk assessment proof as well as a re-audit in 2015/16.
11	Baby Friendly Initiative - Mothers Audit (bottle Feeding and Breastfeeding)	CHD	Health Visiting	This audit is a continuation of the UNICEF Breastfeeding Audit and measures whether mothers were asked by health visitors about breast milk hand expressing including information on the importance and procedure. 82% of the mothers asked reported they had had this conversation.
12	Re-audit of Dysphagia Outcome Measure (DOM)	NCNR	Speech & Language Therapy (SLT) (adults)	The DOM is used by speech and language therapists to measure the safe management and progress of patients with dysphagia. All DOM graphs for the period March to May 2014 were audited to act as a direct comparison with previous audits. The audit concluded the DOM had been used consistently and that the service would continue to monitor outcomes and patient experience.
13	GAS (Goal Attainment Scaling) Goal Audit for Community Independence Services	NCNR	Community Independence Services	This audit, which aimed to evaluate the quality of GAS goals set with patients receiving therapy from the service, recognised that a proportion of patients struggled in identifying and setting goals and that additionally, a robust electronic system is required to document the goals. As a result, the service has worked closely with the Trust's IT department and is recommending all new staff complete GAS goal training as part of their local induction.
14	NICE Pressure Ulcer Prevention compliance to guidelines. Re audit	NNCR	District Nursing Community Independence Service (CIS) and Bedded Rehabilitation	This audit achieved an overall 85% response rate. 81% (of patients had a pressure ulcer risk assessment completed. Also indicated: there is variable adherence to NICE Guidance with regard to information and advice on pressure ulcer prevention given to patients and carer if applicable (63%), timely provision of pressure relieving equipment (52%) and updating of patient held records (74%).

15	Use of stroke guidelines	NNCR	Community Rehab & Neuro	*Awaiting final report*
16	Use of compliance devices & transcribing for medication management	NNCR	District Nursing	*Awaiting final report*
17	Adult Home Enteral Feeding Audit Team Compliance with NICE guidelines	BCSS	Dietetics	*Awaiting final report*
18	Venous Leg Ulcer Assessment and Management	BCSS	Tissue Viability	Overall, the audit highlighted that both services are 90 % compliant with best practice standards in relation to venous leg ulcer assessment and management. Recommendations: development and implementation of Leg Ulcer Assessment & Management policy and re-audit in the next audit programme.
19	Hospital at Home (HaH) for patients with acute exacerbations of Chronic Obstructive Pulmonary Disease (COPD)	BCSS	Respiratory	This audit, aimed at reviewing performance against quality and standards of care which included NICE and British Thoracic guidelines provided for HaH COPD patients, found that there were improvements in elements such as quality of life although it although showed a slight increase in patient anxiety levels. Only 10% of patients were re-admitted after discharge within 30 days and there were no mortalities. This service was provided only during the winter. Although it was noted that COPD admissions were higher in winter, it was felt that service could be embedded into practice to allow preventative self-management care in preparation for winter.
20	Audit of CLCH anaphylaxis kits and face masks in the Podiatry Clinics of Hammersmith and Fulham	BCSS	Podiatry	This re-audit involved reviewing the adherence to current guidelines of access to anaphylaxis kits within Podiatry clinics. Two out of six clinic sites required new anaphylaxis kit to achieve 100% compliance. Action plan: delivering in new anaphylaxis kits to the appropriate clinics.
21	Introduction of SKIPP within the Pembridge Palliative Care Centre	BCSS	Pembridge Beds	SKIPP (St Christopher's Index of Patient Priorities) is an outcome measure which enables hospices/palliative care providers to assess the impact on patients of the care they deliver and show changes in symptoms over time. This audit, which aimed to assess SKIPP's benefits within the service, found that less than 50% of referrals had SKIPP completed, even partly. Recommendations: review on whether the service continued using the index.

22	Endoscopy audit	Medical Directorate	Infection Control	This audit, aimed at decontamination, implemented an action plan which would ensure weekly AER validation was documented and accessible; appropriate space identified to store equipment and that surfaces were to be replaced.
23	Hand Hygiene Validation Audits – bedded services	Medical Directorate	Infection Control	CLCH is signed up to the ***cleanyourhands*** campaign and has a schedule of hand hygiene audits that is based on a risk assessment. 12 wards were re-audited during the period under review, out of these, 11 received 100% compliance scores, the remaining received 90% compliance. E-learning for Food Hygiene level 1 and 2 has been launched. Attendance compliance rolling programme including F:F 46.78%.
24	Hand Hygiene Audits – Community Services	Medical Directorate	Infection Control	*Awaiting final report*
25	Dental audits	Medical Directorate	Infection Control	Audits were carried out at all Community Dental Services (CDS) sites in 2014 to assess compliance with Health Technical Memorandum (HTM) 01-05 - *Essential Quality Requirements* and *Best Practice*. All CDS sites met the - Essential Quality Requirements and many areas also met the Best Practice requirements. Eleven out of the 16 services scored gold e.g. 98 – 100% compliance; and none of the services scored less than 93%. It was recommended that all teams ensure completion of all decontamination testing records and use of log books and a re-audit is planned for 2015/16.
26	Health centre audits (IC + environmental + waste)	Medical Directorate	Infection Control	*Awaiting final report*
27	Bedded services audits (IC + environmental + waste)	Medical Directorate	Infection Control	*Awaiting final report*
28	Aseptic Non - Touch Technique (ANTT)	Medical Directorate	Infection Control	*Awaiting final report*
30	Surveillance of MRSA wound infections, C diff diarrhoea, and urinary catheters in bedded areas	Medical Directorate	Infection Control	*Awaiting final report*
31	Mealtime mantra audits - bedded services	Medical Directorate	Infection Control	The aim of the audit was to monitor food service at meal times to ensure that the practice of food handlers in bedded areas is compliant with current best practice and

				CLCH Food Hygiene Policy (IPC 13). All scores improved slightly and 4 areas reached 90% and above. Following each re-audit, the staff and managers on duty in the respective areas were provided with immediate verbal feedback. A re-audit report and action plan were sent to managers shortly after the audit.
32	Controlled Drugs Audit - Bedded areas	Medical Directorate	Medicines Management	*Awaiting final report*

33	Controlled Drugs Audit - Sites	Medical Directorate	Medicines Management	*Awaiting final report*
34	Cold Chain Audit - Sites	Medical Directorate	Medicines Management	*Awaiting final report*
35	Safe and Secure Handling of Medicines Audit - Sites	Medical Directorate	Medicines Management	187 audits at Community clinics have been conducted to demonstrate the Trust's compliance with CQC Outcome 9. All reports with recommendations will be sent to services by the end of March 2015. A full audit report is due to be presented to MMG in May 2015.
36	Antimicrobial Audit	Medical Directorate	Medicines Management	*Awaiting final report*
37	Omitted Medicines Audit	Medical Directorate	Medicines Management	*Awaiting final report*
38	Urinary Catheter Care Documentation	Medical Directorate	Infection Control	This audit aimed to evaluate whether all adult patients with a urinary catheter in situ were assessed and monitored regarding the reason and need for a catheter; and whether all catheter care was documented accurately as per urinary catheter policy. The audit found that 53% had a completed assessment form, and for 28%, there was no documented reason in the notes for the presence of the catheter. Key recommendations that were immediately implemented including ensuring all staff had the correct documentation and a re-audit in the next financial year to indicate service improvement.
39 & 40	Health Records Keeping Audit	Medical Directorate	TRUST-WIDE	Two audits were undertaken; the first between July and August 2014, where overall compliance achieved was 76% signifying 'Moderate Assurance'. The compliance level achieved for the re-audit, carried out in January-February 2015, and indicated very good improvement. The Trust achieved a 91% compliance level which indicated 'Significant Assurance'.

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

TBC – AW Data

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged—
(i) 0 to 15; and
(ii) 16 or over,
Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

TBC – AW Data

CLCH considers this data is as described for the following reasons:
CLCH has undertaken the following actions to improve the % / rate and so the quality of its services by:

7. INCIDENT REPORTING

The National Reporting and Learning System (NRLS) reported 2,295 incidents during the first half of 2014. This equates to 58.5 per 1,000 bed days. This puts CLCH in the middle of reporters, within a cluster of similar NHS Community Organisations, and slightly below the median reporting rate for this cluster of 95.18 incidents per 1,000 bed days.

During this period, the Trust reported 89 incidents resulting in severe harm, which is higher than the cluster rate of 0.8%. There was one incident which resulted in the death of a patient lower than the cluster rate of 0.2%. Within the arena of patient safety it is considered that organisations that report more incidents usually have a better and more effective safety culture.

The severe harm cases were CLCH attributable grade 3 and 4 pressure ulcers.

Learning from serious incidents

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in unexpected or avoidable death or serious harm. Within CLCH a root cause analysis (RCA) was (and continues to be) undertaken for every serious incident to enable lessons to be learnt, and disseminated across the organisation. Following the RCAs actions plans were created, monitored and key messages were shared widely.

CLCH has taken the following actions to improve the learning from incidents and so the quality of its services.

- A continued control on the quality of the data entry on incident reports to ensure accurate recording of degree of harm through quality checking by the patient safety managers.
- The maintenance of Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) Groups in each service/division and a Trust wide level to share the learning from serious event.
- The continuation of the CLIPS and TIPS Trust wide newsletter which cascades lessons learnt until January 2012, subsequently changed into the “Spotlight on Quality” newsletter.
- The Divisional Quality newsletters continued up until January 2015. In January 2015, a weekly newsletter, Spotlight on Quality was introduced, which highlights key quality messages across the Trust.
- On-going process around monitoring of action plans that are created in response to RCAs.
- The Quality and Learning Divisional restructure established four Patient Safety Manager Posts which have been recruited to in order to support the Divisions with incident and Risk Management.

During 2014/15 the total number of incidents reported for CLCH was 6, 441. This is 5.1% a decrease from 2013/14 when a total of 6, 788 were reported. The Patient Safety Managers continue to work closely with clinical

colleagues to raise awareness about the types of incidents that should be recorded on the incident reporting system and in addition as part of the Trust induction, an e-learning package was launched in March 2015.

8. REVIEW OF SERVICES

During 2014/15 CLCH provided and or sub contracted 56 NHS services. CLCH has reviewed all the data available to them on the quality of care in 100% services. The income generated by the NHS services reviewed in 2014/15 represents 100 percent of the total income generated from the provision of NHS services by CLCH for 2014/15.

9. STATEMENTS FROM OUR LOCAL OVERVIEW AND SCRUTINY COMMITTEES, CLINICAL COMMISSIONING GROUPS AND HEALTHWATCH

These to be added in post the draft has been sent out

10. FEEDBACK

Now that you have read our Quality Account, we would really like to know what you think, how we can improve and how you would like to be involved in developing our Quality Accounts in future.
We will be putting a short feedback survey on our website which should only take five minutes to complete.

Go to: **www.clch.nhs.uk** and fill out the survey online. Alternatively you will be able to download a copy of the survey, fill it in and post it to:
Patient and public engagement
Central London Community Healthcare NHS Trust
6th Floor 64 Victoria Street
London
SW1E 6QP

Please write to us if you would like us to send you a paper copy using the address above or via email to **communications@clch.nhs.uk**.
Alternatively, if you or someone you know would like to provide feedback in a different format or request a copy of the survey by phone, call our communications team on **020 7798 1420.**

FURTHER ADVICE AND INFORMATION
If you would like to talk about CLCH's services or your experiences
If you would like to talk to someone about your experiences of CLCH services or if you would like to find a service, please contact our patient advice and liaison service (PALS) in confidence via email **clchpals@nhs.net** or on **0800 368 0412**.

USEFUL CONTACTS AND LINKS
CLCH Patient Advice and Liaison Service (PALS)
e: pals@clch.nhs.uk
t: 0800 368 0412
Switchboard for service contacts
t: 020 7798 1300

Local Healthwatch
Central West London Healthwatch - For Hammersmith and Fulham, Kensington and Chelsea and Westminster
Email: healthwatchcwl@hestia.org
Telephone: 020 8968 7049
Barnet Healthwatch
Telephone: 020 8364 8400 x 218 or 219
www.healthwatchbarnet.co.uk

Local Clinical Commissioning Groups
Barnet CCG
Telephone: 020 8952 2381
www.barnetccg.nhs.uk

Central London CCG
Telephone: 020 3350 4321
www.centrallondonccg.nhs.uk

Hammersmith and Fulham CCG
Telephone: 020 7150 8000
www.hammersmithfulhamccg.nhs.uk

West London CCG
Telephone 020 7150 8000
www.westlondonccg.nhs.uk

Local councils
Barnet
Telephone: 020 8359 2000
www.barnet.gov.uk

Hammersmith and Fulham
Telephone: 020 8748 3020
www.lbhf.gov.uk

Kensington and Chelsea
Telephone: 020 7361 3000
www.rbkc.gov.uk

Westminster
Telephone: 020 7641 6000
www.westminster.gov.uk

Healthcare organizations
Care Quality Commission
Telephone 03000 61 61 61
www.cqc.org.uk
NHS Choices
www.nhs.uk

GLOSSARY

15 Steps Challenge
This is a tool to help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience. The idea is to see the ward through a service user's eyes. Members of the 15 step challenge team walk onto a ward or residential unit and take note of their first impressions.

Baseline data
This is the initial collection of data which serves as a basis for comparison with the subsequently acquired data.

Being Open
Being Open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident.

Care Quality Commission (CQC)
The CQC is the independent regulator of health and adult social care services in England. It ensures that the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety.

Catheter
A catheter is a thin flexible tube which is inserted into the body, usually along the tube through which urine passes (the urethra) or through a hole in the abdomen. The catheter is then guided into the bladder, allowing urine to flow through it and into a drainage bag.

Clinical commissioning groups (CCGs)
CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of a local health care budget and commissions healthcare services on behalf of the local population.

Compassion in practice
Compassion in practice is a three year vision and strategy for nursing, midwifery and care staff, drawn up by the Chief Nursing Officer for England and launched in December 2012.

Commissioning
This is the planning and purchasing of NHS services to meet the health needs of a local population. It involves deciding what services are needed, and ensuring that they are provided.

Commissioning for quality and innovation payment framework (CQUIN)
The CQUIN payment framework enables commissioners to reward excellence. It links a proportion of a healthcare provider's income to the achievement of local quality improvement goals.

Exemplar ward
These are wards where consistently high quality care and innovation in clinical practice has been demonstrated

Francis report
The Francis enquiry report was published in February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report made 290 recommendations

Incident
An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.

Key performance indicators (KPIs)
Key performance indicators help define and measure progress towards organisational goals. As the primary means of communicating performance across the organisation, KPIs focus on a range of areas. Once an organisation has analysed its mission, identified all its stakeholders and defined its goals, KPIs offer a way of measuring progress toward these goals

National Institute for Health and Care Excellence (NICE)
Nice provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

National Health Service Litigation Authority (NHSLA)
The NHSLA manages negligence and other claims against the NHS in England on behalf of its member organizations.

Never event
These are are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. A list of incidents described as Never Events is published by the Department of Health.

Palliative care
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with terminal illness. This is through the prevention and relief of suffering by means of early identification and excellent assessment and treatment of pain and other problems that could be physical, psychosocial or spiritual in nature.

Patient led inspection of the care environment (PLACE)
PLACE is the system for assessing the quality of the patient environment. PLACE assessments will see local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance.

Patient pathways
The patient pathway gives an outline of what is likely to happen on the patient's journey and can be used both for patient information and for planning services as a template pathway can be created for common services and operations. You can think of it as a timeline, on which every event relating to treatment can be entered. Events such as consultations, diagnosis, treatment, medication, diet, assessment, teaching and preparing for discharge from the hospital can all be mapped on this timeline.

Patient safety thermometer or NHS safety thermometer
The NHS Safety Thermometer provides a 'temperature check' on harm. The tool measures four high-volume patient safety issues (pressure ulcers, falls, urinary tract infection - in patients with a catheter - and venous thromboembolism). The data is used at national, regional and local level (organisational as well as at ward and team level) to support quality improvements through ensuring harm free care.

Patient reported experience measures (PREMS)
These are more commonly known as patient surveys and can include paper based surveys; the use of electronic kiosks; hand held devices; and telephone surveys

Patient reported outcomes measures (PROMs)
Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

Pressure ulcers
A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also

associated with pressure ulcers. Pressure ulcers are graded according to severity, with grade one being the least severe and grade four the most severe.

Root cause analysis (RCA)
A systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

Serious incident
In summary these are incidents that occurred in NHS funded services and resulted in one or more of the following: unexpected or avoidable death; serious harm; allegations of abuse; a prevention of continuation of the provision of healthcare services; or a *never event*.

Tissue viability
The literal meaning of tissue viability refers to the preservation of tissue. The tissue viability service is a nurse-led specialist service whose aim is to promote the healing of compromised tissue.

Venous thromboembolism (VTE)
Venous thromboembolism is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

APPENDIX 1 – COMPLAINTS ANNUAL REPORT

Not yet finalised

APPENDIX 2 - OUR WORK ON RESPONDING TO NATIONAL ENQUIRIES AND REPORTS

During the year a number of external national reports were published. The following is a summary of how CLCH reacted to them and implemented their recommendations. Full reports with action plans were submitted to the Trust Board in respect of the recommendations.

DEMENTIA

The Prime Minister's 2012 *Dementia Challenge* was followed up by the Department of Health's November 2013 *Dementia: a state of the nation report*. In response to this report, CLCH is currently working with trusts across Inner North West London to deliver a *Dementia Champions Programme*. This three month programme will enable registered health professionals to develop their skills, knowledge and experience in dementia care, and to become future dementia champions within their established workplace. The programme will also focus on improving people's awareness and understanding of dementia, and supporting high quality care within the most appropriate environment. Additionally it will have a particular emphasis on engaging with patients, their carers and families in the provision of training for staff.

REPORT ON *FREEDOM TO SPEAK UP (*WHISTLEBLOWING)

In February 2015, Sir Robert Francis published the *Report on the Freedom to Speak Up.* CLCH's commitment to learning from whistleblowing can be seen in its Achieving Excellence Together campaign. The Trust has collaborated with Buckinghamshire New University, the Royal College of Nursing and the Queen's Nursing Institute to improve staff morale after a concern was raised. Additionally, CLCH's compliance with the new statutory Duty of Candour and Fit and Proper Person Test is encouraging staff to be open about issues and errors which could impact on patient care.

REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Work at CLCH is continuing to progress in response to Robert Francis' 2013 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* and Department of Health update, *Culture change in the NHS: applying the lessons of the Francis Inquiries* (February 2015). The five areas for improvement identified in the report are as follows:

1. Preventing problems
2. Detecting problems quickly
3. Taking action promptly and ensuring robust accountability
4. Ensuring staff are trained and motivated

SIGN UP TO SAFETY/DUTY OF CANDOUR

During the year there was an updated focus on the creation of a more transparent healthcare system along the launch of a new national drive to improve safety in the NHS. In response to these initiatives, CLCH is implementing the Duty of Candour and is one of the twelve trusts in the vanguard of the *Sign up to Safety* campaign (the new safety improvement movement across England)

FIT AND PROPER PERSON TEST FOR DIRECTORS

In accordance with national guidelines, the '*fit and proper person'* test for directors was introduced at CLCH to ensure a more robust approach to accountability for the quality of care service users receive.

Appendix 2 - Royal Free London NHS Foundation Trust

DRAFT

Quality Accounts and Quality Report 2014/15

The Royal Free London NHS Foundation Trust

PART ONE

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It gives me great pleasure to introduce our 2014/15 quality report. This report is designed to assure our local population, our patients and our commissioners that we provide high-quality high clinical care to our patients. In addition it shows where we could perform better and what we are doing to improve things.

The last year has been a particularly important year in the history of the Royal Free. On July 1st we acquired Barnet and Chase Farm Hospitals NHS trust to become one of the largest NHS acute trusts in England. We now employ nearly 10,000 staff and own three major hospital sites. I am pleased to report that the integration of the two organisations has gone very well and we have maintained our focus on high quality care throughout the year.

During the forthcoming year we will maintain our focus on integration and on improving the quality of facilities we provide for our patients. We will particularly have a major focus on Chase Farm Hospital. Our staff on that site are dedicated to high quality patient care, but they work under difficult circumstances in buildings that are no longer fit for 21st century healthcare. I am delighted to report that we were recently granted approval to completely rebuild Chase farm hospital. We aim will start work shortly and the new hospital should be fully open for patients in early 2018.

At the Royal Free Hospital in Hampstead we have also been busy making plans for the future. We opened the first phase of the new UCL Institute for Immunity and Transplantation two years ago and we have already seen the results of this exciting new research facility, with important new findings into diabetes already being made by researchers based in the Institute. We will shortly start work on the second phase of the Institute, a brand new multi-million pound building. I have no doubt that this will enable us to attract the very best researchers from around the world, and that this will ultimately lead to great benefit for our patients.

This quality report includes our high-level quality priorities for the next year. We strongly believe that quality improvement takes more than a single year and we have therefore chosen to continue our improvement projects from last year. One of these is our patient safety program which we successfully launched in the autumn of last year with a week of high profile events including invited speakers with national and international reputations in patient safety.

Our governing objective is to provide world class care to all patients at the trust. However during the last year I have been particularly proud of our management of ebola. We host the UKs only High Level isolation Unit for the management of patients with infectious diseases such as this. So far we have successfully treated three healthcare professionals with proven ebola and several others at risk of developing the infection. This has required a major effort by our infectious disease team and many others who are needed to run the unit. I have no doubt that this has provided confidence to those working in West Africa during the current devastating epidemic, and provided additional medical knowledge that will help future patients.

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

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

David Sloman

Chief Executive

The Royal Free London NHS Foundation Trust

Date

PART TWO

Priorities for improvement and statement of assurance from the board

In this part of the quality report we review our performance against our key quality priorities for 2014/15 and provide examples that illustrate how individual services and specialities are focused on quality improvement. We also provide key data relating to our performance and outline our priorities for improvement in 2015/16.

Performance against our key quality objectives

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

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

Priority two: **In- patient diabetes care**

Priority three: **Further develop our patient safety programme**

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

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

Last year, a key quality objective committed to improving consistency of the information that is available to patients and carers over an 18 month timeframe. The provision of high quality accessible information is key in embedding our world class care values and allowing greater choice and preparation for forthcoming procedures and/ or appointments.

In the last year the Trust with support from the Royal Free Charity have created the post of Patient Information Manager, this person will lead on the development and implementation of our patient information strategy with key internal and external stakeholders (including information providers and patient support groups) in line with NHS guidance.

The Trust has undertaken three recruitment campaigns but has not been successful in making an appointment; as such the patient information strategy was not developed and is carried forward to 2015/16 as a priority. The trust intends to recruit to this role.

In embedding the world class care value of 'Positively Welcoming' value, the trust has become a signatory and is pleased to support the 'hello my name is ….' campaign, to encourage and remind all healthcare staff about the importance of introductions in the delivery of care.

In line with public expectation and in increasing accessibility of information the trust proactively uses Twitter and other social media as a vehicle for patient information that does not require person specific detail; the trust currently has over 7800 followers on Twitter.

The trust welcomes the involvement we have received in the development of disease information and are pleased that patients using the Liver Transplant service are designing the web pages to ensure that information is targeted and answers questions that patients have.

On objective for this year was to ensure consistency in how information is presented and the trust has introduced a 'house style' for all letters and communication, this is being extended to telephone etiquette.

The trust recognises that patient information is not solely in the printed form and has invested this year in mobile Induction loops to be used for patients with hearing aids, these are available throughout the trust and can be collected at a number of sights.

One area of success in in the presentation of information during the episode of care in the Emergency Department where the trust above average for 'information given on condition or treatment' in the National A&E Survey.

Priority 2: In- patient diabetes care

We selected diabetes care as our improvement priority for clinical effectiveness for 2014/15 these were to:

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

Royal Free Hampstead and Chase Farm Hospital participated in the National Diabetes Inpatient Audit which reported its findings in 2014, thus providing the opportunity to monitor our improvement on these sites. Our Barnet site has not previously taken part in this audit.

Meals & mealtimes

The most recently-published report from the National Inpatient Diabetes Audit demonstrates an improvement in meals and mealtimes as reported by patients. 64% of patients with diabetes reported that they were always, or almost always, able to choose a suitable meal at our Hampstead site; 78% at Chase Farm.

62% reported that meals were always, or almost always, provided at a suitable time at Royal Free Hampstead; 80% at Chase Farm.

This is an improvement on patients' previous reports for both measures:

National Diabetes Inpatient Audit Report:		2013	2014	Increase/ Improvement
Choice of meals was always, or almost always, suitable	RFH:	53.6%	64.2%	20%
	CFH:	66.8%	78.2%	17%
Timing of meals was always, or almost always, suitable	RFH:	57.6%	62.1%	8%
	CFH:	60.4%	80.2%	33%

RFH= Royal Free Hampstead; CFH = Chase Farm Hospital; Barnet Hospital no data

Foot assessments

Across England, 37.6% of patients with diabetes received a documented foot risk assessment within 24 hours of admission to assess the risk of developing foot disease. Patients identified at high risk can be offered preventative strategies to avoid foot ulcers.

At Chase Farm, we improved the number of patients for whom we undertook a foot risk assessment from 25.6% to 41.9% (a 63% increase) between the two audit periods. Unfortunately, our performance at the Royal Free Hospital site deteriorated from 24.2% to 6.5% (a 73% decrease). We have made improvement in the use of foot risk assessment a priority for next year (see Look Forward section).

5.3% of all inpatients at Chase Farm Hospital and 10.6% at Royal Free Hospital were admitted with active foot disease (2014 report). 50% at Royal Free Hospital were assessed by our specialist multidisciplinary team within 24 hours, an improvement on the previous year's 30%. Of the few patients identified with foot disease at the Chase Farm site, all were seen accordingly.

Medication management

Adjustments to diabetic medication are often required when patients are admitted to hospital, especially in the context of infection or surgery, when the blood sugar may become more difficult to control. Errors in these adjustments are referred to as 'medication management errors'.

We have improved our medication management at both Hampstead and Chase Farm sites but we want to do more. Across England, trusts reported an average of 22.3% errors in diabetes medication management.

National Diabetes Inpatient Audit Report:		2013	2014	Decrease/ Improvement
Errors of medication management	RFH:	31%	27.5%	10%
	CFH:	51.4%	17.9%	65%

At a diabetes improvement workshop, supported by our academic health science partnership, we have explored the drivers of good quality care and have since devised quality improvement metrics which we will use to drive further improvements in the coming year.

Priority 3: Patient safety programme

Our key 2014/15 objectives to develop patient safety culture and capability were to:

- Strengthen our incident investigation and processes for addressing safety issues throughout the organisation
- Improve trust-wide communication on safety issues to ensure that we improve dissemination of learning from incidents
- Improve education and mandatory training in patient safety

We have redesigned the processes around incident reporting, investigation, learning and improving as part of the integration work of the expanded Trust. This has included reviewing incident reporting at all sites and identifying the areas that work best.

We have upgraded the whole trust to using the web-based Datix reporting system, and have merged the practices for reviewing and investigating serious incidents.

We have reviewed the staffing and structures that support our patient safety and risk processes and have updated these to provide the right number of staff, with the appropriate skills and ensure robust review of this at relevant committees, such as the Patient Safety Committee.
We have invested in safety simulation, root cause analysis and after action review training for clinical and non-clinical staff, as well as further leadership development and quality improvement training.

We held a Patient Safety week in October with National speakers to launch our Patient Safety Programme, and have joined the national "Sign Up To Safety" Campaign.

We continue to work closely with UCL Partners collaborating on improvements for Sepsis and Acute Kidney Injury.

Priority clinical areas for improvement

Surgical safety

Our aim was to be more than 95% compliant with all aspects of the 'five steps to safer surgery' guidance (Step one: Briefing, Step two: Sign in, Step three: Time out, Step four: Sign out, Step five: Debriefing).

We have not completely met this aim, but we have made progress, with over 95% compliance with steps two, three and four. The most challenging steps are at the start and end of the process, as this requires all staff to be present, but does not easily fit with the way that theatres are run, with surgeons having to move between patients more quickly than other staff. As the process is most robust at Barnet Hospital we are learning how we can adapt, so that all sites can attain 95% compliance and so we will keep this as a priority for 2015/16 as well.

Medicines safety

Our aim was to reduce missed doses of insulin. We have appointed a medicines safety officer and merged the Medicines safety committee across all sites. We have initiated pilot work on missed doses in 4 ward areas, via the use of Safety Crosses and this has resulted in a reduction in errors.

We are now looking at how we can expand this across the trust. Alongside this, the PARRT has attended those patients who have been escalated when at risk, to ensure a prompt review of their insulin needs.

Procedural safety

We have started a programme of work to reduce complication rates from line insertions, initially by undertaking thematic review of the issues relating to guidewire retention.

Through a task and finish group we have clarified line insertion management and introduced a checklist and additional training through simulation.

Action on abnormal diagnostic images

With the merged organisation we have started a programme of work to ensure all abnormal x-ray images are actioned promptly. This work has been extended to include delayed action on diagnostics such as radiological imaging and histopathology results.

However, there are challenges with the information systems in use and we will be working over the next year to streamline the process across the sites so that staff are using the same systems with the same expectations for results accountability.

Falls and pressure ulcer reduction

We have continued to approach both of these safety incidents with increased vigilance and new ideas.

Our falls improvement programme across all sites has shown a 20% reduction in harm from falls. We have amalgamated the Falls Steering Group to have oversight of the whole trust and have increased education and learning via study days, e-learning and by working directly with wards after an incident to learn the lessons and share good practice.

Pressure ulcers have been reviewed thematically across the trust and a new more robust tool is now used to investigate these incidents, which helps to identify contributing factors such as malnourishment and dementia. Further work is planned to ensure harmonised documentation and further education to enable improvement.

Priorities for improvement 2015/16

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

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

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

The trust board considered the responses and agreed the following three priorities for 2015/16.

Priority one:

Delivering World Class Experience

The trust's mission is to provide world-class expertise and local care. Central to this mission is our five-year strategic objective to ensure excellent experience for patients and staff. Our ambition to provide excellent experience is intrinsically linked with our culture, the decisions we make moving forward about how we engage our patients, carers and staff and the improvements we prioritise.

Historically, the trust has defined and measured patient experience in relation to patient satisfaction. Key performance measures comprise patient Friends and Family Test (FFT) feedback and annual National Patient Survey feedback. FFT performance is fed back to Matrons and reported quarterly to the Patient and Staff Experience Committee. Going forward in 2015/16 The trust's definition of patient experience is:

> "The sum of all interactions, shaped by the culture of the Royal Free, that influence patient and carer perceptions across their pathway"
>
> ***The Beryl Institute***

We want to use our strength as a large acute trust across three hospital campuses with a skilled and committed workforce to catalyse opportunities for enhancing the experiences for those who use our services, their carers and families.

During 2015/16 we will publish a four year patent experience strategy that will see the trust focus on four strategic aims; these aims are derived from a number of sources, public health profiles, legislative changes, national experience survey results and local intelligence; all underpinned by local experience data. Whilst they are derived from multiple sources there is a commonality; if we are successful in positively nudging the experience that those who use our services, their carers and families we know that tangible improvements will be made across the services provided by the trust. They are:

1. Improving the experience of those with a diagnosis of dementia
2. Identifying and improving the experience of carers
3. Enhancing the experience of people diagnosed with cancer
4. Improving common areas of poor experience as identified by those who use our services.

We will achieve these by:

- Appointing four Patient Experience Champions from amongst trust Consultants
- Ensuring 100% of inpatient and day case wards respond to their patient experience data with publically displayed responses from staff
- Providing each inpatient and day case ward with improvement targets mapped to feedback from patients and carers
- Developing and publishing a list of patient experience never events
- Training staff in advanced facilitation and feedback interpretation for patient and carer focus groups
- Achieving the Macmillan Quality Environment Mark ® across campuses
- Establishing a patient reference group for those with a cancer diagnosis to ensure service improvements are important to them and informed by their input.
- Producing & implementing a specifically designed carers' point of information display at each hospital campus.
- Safeguarding:
    - Consult carers on whether and how they would wish to receive training on safeguarding adults.
    - Safeguarding Training to be developed for and delivered to carers
- 20% of inpatient wards will have undertaken the Triangle of Care self-assessment.
- Producing a care and compassion film for staff as a training aide filmed from the perspective of a carer
- Increasing the number of Dementia Awareness trainers
- In partnership with the Picker Institute develop and conduct surveys for carers of people with Dementia
- Undertaking the eligibility and readiness assessment for the Information Standard Certification and set a timeframe for achieving certification.

Priority two:

In-patient diabetes

Whilst we have made progress in improving care for patients with diabetes, we want to do better. Therefore in 2015/16 we will continue our diabetes improvement programme. We will expand the programme to include further elements of diabetes care and extend it to our three sites.

Most patients with diabetes in our hospitals are admitted for reasons other than their diabetes. However, while an inpatient with us we aim for every patient with diabetes to have a good *experience* of *safe*, *effective* diabetes care.

We will monitor our progress and work toward:

- A 20% reduction in prescription errors
- A 20% reduction in severe hypoglycaemia episodes
- Achieving 30% foot assessments within 24hrs of admission
- A 10% reduction in hospital-acquired foot ulcers
- A 10% improvement in patient satisfaction score

We intend to participate in this year's National Diabetes Inpatient Audit on all three of our sites. We will monitor progress through the clinical performance committee.

Priority three:
Our focus for Safety

In response to the national patient safety initiative we have set out the actions that we will undertake in response to the five Sign up to Safety pledges and have created our local Safety Improvement Plan to enable us to deliver our Patient Safety Programme over the next three years.

Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the Royal Free London NHS Foundation Trust (as measured by incidents relating to NHSLA claims) by 50% by 31 March 2018.

Thus our targets are focussed on our three year plan. We will be delivering key milestones along the way, but we are keen that our focus in this document is consistent with the already agreed plan. The measures for the next year set out below will be re-presented in the following year's accounts and will show each area against a three year trajectory, along with relevant milestones.

For 2015/16 we will focus on the following

Safer Surgery

Our goal is to improve compliance with all aspects of the 'five steps to safer surgery' guidance to 95% by 31/03/16. We will achieve this by delivering the following milestones:

- Identification of process issues to enable surgeons to attend steps 1 and 5
- Identification of clinical leaders in all sites
- Review of solutions to staff flow and challenges
- Consolidate WHO policy across all sites
- Review and Refresh workshop to use successes and failures to identify how to move to 95% compliance in all 5 steps

Falls

Our goal is to reduce falls by 25%, as measured by incidents reported on Datix, by 31 March 2018. Our key objectives will be:

- To fully embed the existing improvement programmes for falls prevention across all wards.
- To assess new methods and technology (e.g. electronic patient sensors) to reduce falls risk.

We will achieve this by delivering the following milestones:

- Set-up Trustwide Falls Working Group - to carry out root cause analysis of incidents, identify risk factors and areas for improvement
- Identify Falls Champions in each clinical service line across all sites
- Introduction of Falls Screening Tool (based on NSPA's STRATIFY) and Falls Prevention Plan (care bundle approach) by Division across all sites.
- Continue staff education and development on falls prevention
- Create sharing process to enable learning from falls incidents, especially serious incidents
- Consolidate updated falls-related policies and post falls protocol across all sites
- Set-up Falls Awareness Events and training with Trustwide MDT falls study day
- Initiate Falls podiatry assessment pathway

Acute Kidney Injury

Our goal is to increase the number of patients who recover from AKI within 72 hours of admission by 25% by 31 March 2018 and target:

- 25% reduction in AKI mortality
- 25% reduction in length of stay
- 25% reduction in stage 1 AKI that progresses to AKI stage 2 or 3

We will achieve this by delivering the following milestones:

- Education of staff by App, website and e-learning
- Identification of access to baseline informatics in pilot areas
- Identification of AKI clinical leaders in pilot areas
- Process mapping in pilot areas to understand patient flow and challenges
- Introduction of STOP AKI diagnostic and care bundle in pilot areas
- Introduction of outreach system for moderate AKI using PARRT as well as telemedicine senior renal support in pilot areas
- Monitoring of AKI data, review of progress and continual PDSA cycles for improvement
- Review and Refresh workshop to use successes and failures to identify how to move to 95% compliance

Patient Deterioration

Our goal is to reduce the number of cardiac arrests to less than 1 per 1000 admissions by 31 March 2018.

We will achieve this by delivering the following milestones:

- Initiate case note review of selected 2222 calls and deaths, and feedback lessons learnt to staff
- Identify baseline data required at ward level and create process to feedback to staff in a timely manner
- Provide staff training on SBAR and EWS monitoring
- Identify pilot areas
- Identify ward-based champions in pilot areas
- Educate staff to undertake ward-based case note review
- Review education programmes for clinical staff to further identify current courses that can include SBAR and EWS training
- Monitor implementation of SBAR and EWS and use process mapping to consider where interventions are best placed for improvement

Unborn baby deterioration

Our goal is to reduce the number of claims relating to deterioration of the unborn baby to 2, between 01/01/15 to 31/03/18.

We will achieve this by delivering the following milestones:

- Identify baseline data required at ward level and create process to feedback to staff in a timely manner
- Determine CTG interpretation skills baseline by staff survey
- Identify champions
- Trial CTG testing and simulation training on pilot group of staff
- Survey staff on pilot CTG training to understand impact on practice and confidence

Sepsis

Our goal is to reduce severe sepsis-related serious incidents by 50% across all sites (A&E and Maternity) by 31 March 2018.

We will achieve this by delivering the following milestones:

- Staff training in sepsis recognition in Maternity and Barnet ED
- Testing of improvement tools: sepsis trolley, sepsis safety cross, sepsis grab bag, sepsis checklist sticker.
- Introduction of sepsis improvement tools: Severe sepsis 6 protocol
- Monitoring of data and PDSA cycle improvements
- Review of improvement to attain 95% compliance

Statements of assurance from the board

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

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

Information on review of services

1.1 During 2014/15 the Royal Free London NHS Foundation Trust provided and/or sub-contracted *TBC* relevant health services.

1.1 The Royal Free London NHS Foundation Trust has reviewed all the data available to the trust on the quality of care in *TBC* of these relevant health services.

1.2 The income generated by the relevant health services reviewed in 2014/15 represents *TBC* of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2014/15.

Additional information

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

Information on participation in clinical audits and national confidential enquiries

2. During 2014/15 35 national clinical audits and 3 national confidential enquires covered relevant health services that the Royal Free London NHS Foundation Trust provides.

2.1 During that period the Royal Free London NHS Foundation Trust participated in 100% national clinical audits and 100% confidential enquires of the national clinical audits and national confidential enquires which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquires that the Royal Free London NHS Foundation Trust was eligible to participate in during 2014/15 are as follows:

2.3 The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in during 2014/15 are as follows:

2.4 The national clinical audits and national confidential enquires that the Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, 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 report 2014/15	Data collection completed in 2014/15	Eligibility to participate	Participation 2014/15	Rate of case ascertainment (%)
Prostate cancer	√	√	√ BH	100%
		√	√ CFH	100%
		√	√ RFH	100%
Adult community acquired pneumonia	x	√	√ BH	n/a
		x	x CFH	x
		√	√ RFH	n/a
Pleural Procedures	√	√	√ BH	100%
		x	X CFH	Not eligible
		√	√ RFH	100%
National Diabetes Audit 2013-4	√	√	√ BH	393 (100%)
		√	√ CFH	821 (100%)
		√	√ RFH	1647 (100%)
National Foot care in Diabetes Audit	x	√	X BH	x
		√	X CFH	x
		√	√ RFH	n/a
National Elective Surgery PROMs: Four Operations	√	√	√ BH	166 (100%)
		√	√ CFH	431 (100%)
		√	√ RFH	100%
National Pregnancy in diabetes	√	√	√ BH	8 (100%)
		x	x CFH	Not eligible
		√	√ RFH	17 (100%)
Adult Cardiac Interventions: NICOR Coronary Angioplasty	√	x	x BH	Not eligible
		x	x CFH	Not eligible
		√	√ RFH	889 (100%)
MINAP: Acute myocardial infarction and other ACS (2013-14)	√	√	√ BH	100%
		x	X CFH	Not eligible
		√	√ RFH	100%

National Heart Failure Audit	√	√	√ BH	266 (100%)
	√	x	X CFH	Not eligible
	√	√	√ RFH	279 (100%)
TARN: Severe Trauma	√	√	√ BH	99 (100%)
		x	X CFH	Not eligible
		√	√ RFH	120 (100%)
RCPCH National Paediatric Diabetes Audit	√	√	√ BH	260 (100%)
		√	√ CFH	230 (100%)
		√	√ RFH	179 (100%)
National Joint Registry	√	√	√ BH	79 (100%)
		√	√ CFH	424 (100%)
		√	√ RFH	508 (100%)
Cardiac Rhythm Management (2013-14)	√	√	√ BH	100%
		x	X CFH	Not eligible
		√	√ RFH	100%
National Vascular Registry	√	x	√ BH	100%
		x	x CFH	Not eligible
		√	√ RFH	AORTIC ANEURYSM: 78% CAROTID INTERVENTION: 80%
National Cardiac Arrest Audit (NCAA)	√	√	x BH	x
		√	x CFH	x
		√	√ RFH	237 (100%)
ICNARC Case Mix Programme: Adult critical care 2013-14	√	√	√ BH	100%
		x	x CFH	Not eligible
		√	√ RFH	Data not accepted at ICNARC due to data quality concerns
Sentinel Stroke National Audit Programme (SSNAP)	√	√	√ BH	80-89%
		√ INPATIENT REHABILITATION	√ CFH	<60%
		√	√ RFH	90+%
Initial management of Fitting child (CEM)	√	√	√ BH	51 (100%)
		x	x CFH	Not eligible
		√	x RFH	x
Mental health (care in emergency departments)	√	√	√ BH	50 (100%)
		x	x CFH	Not eligible
		√	x RFH	x
Older people (care in emergency departments)	√	√	√ BH	101 (100%)
		x	x CFH	Not eligible
		√	X RFH	x
National Lung Cancer Audit	√	√	√ BH	212 (100%)
		x	x CFH	Not eligible
		√	√ RFH	104 (100%)

National Bowel Cancer Audit	√	√	√ BH	214 (100%)
		x	X CFH	Not eligible
		√	√ RFH	109%
National Oesophago-gastric Cancer Audit [Diagnostic data only]	√	√	√ BH	61 (100%)
		x	x CFH	Not eligible
		√	√ RFH	30 (100%)
IBD Biological Therapy Audit (Adult)	√	√	√ BH	48 (100%)
		x	X CFH	Not eligible
		√	√ RFH	17 (100%)
IBD Biological Therapy Audit (Paediatric)	√	x	x BH	Not eligible
		x	X CFH	Not eligible
		√	√ RFH	15 (100%)
National Pulmonary Hypertension Audit	√	x	x BH	Not eligible
		x	x CFH	Not eligible
		√	√ RFH	317 (100%)
National Childhood Epilepsy Audit (Epilepsy 12)	√	√	√ BH	20 (100%) 31 Patient-reported experience metrics (PREMs)
		x	X CFH	Not eligible
		√	√ RFH	100%
National emergency laparotomy audit	√	√	√ BH	79 (46%)
		x	X CFH	Not eligible
		√	√ RFH	91 (99%)
National Chronic Obstructive Pulmonary Disease audit programme (COPD)	√	√	√ BH	32 (100%)
		x	X CFH	Not eligible
		√	√ RFH	39 (100%)
Rheumatoid & early inflammatory arthritis	x	√	√ BH	n/a
		√	√ CFH	n/a
		√	√ RFH	n/a
National Comparative Audit of Blood Transfusion: Audit of transfusion in children and adults with Sickle Cell Disease	√	x	X BH	Not eligible
			X CFH	Not eligible
			X RFH	Not eligible
Falls & Fragility Fractures: National Hip Fracture Database	√	√	√ BH	387 (100%)
			√ CFH	
			√ RFH	129 (100%)
Neonatal Intensive Care	√	√	BH	104%
		X	X CFH	Not eligible
		√	RFH	116%
Head & Neck Cancer Audit (DAHNO)	√	√	√ BH	78 (100%)
		x	X CFH	Not eligible
		x	X RFH	Not eligible
Prescribing Observatory for Mental Health	√	x	x	n/a
Paediatric Intensive Care (PICANet)	√	x	x	Not eligible

Congenital Heart Disease (Paeds)	√	x	x	Not eligible
Adult cardiac surgery	√	x	x	Not eligible
Clinical Outcome Review Programme (previously National Confidential Enquiries, and Centre for Maternal & Child Death Enquiries)				
National Confidential Enquiry: Gastrointestinal Bleeding	√	√	√ BH	1/2 CASES [50%]
		√	√ CFH	2/2 CASES [100%]
		√	√ RFH	3/3 CASES [100%]
National Confidential Enquiry: Sepsis	√	√	√ BH	4/4 CASES [100%]
		x	X CFH	N/A
		√	√ RFH	3/3 CASES [100%]
Maternal, newborn and infant mortality (MBBRACE-UK)	√	√	√ BH	0/0
		x	X CFH	Not eligible
		√	√ RFH	1/1

In addition, the Royal Free London NHS Foundation Trust participated in the following national audits by submitting data in 2014/15
Health Protection Agency: Surgical site infection
British Association of Urological Surgeons: Nephrectomy Audit
British Association of Urological Surgeons: Surveillance & Treatment of Renal Masses
Baseline Survey of HIV Perinatal, Paediatric and Young Person's Pathways
UK Neonatal Collaboration Necrotising Enterocolitis Audit
National Audit of Cardiac Rehabilitation
British Association of Endocrine and Thyroid Surgeons: Thyroid and Parathyroid surgery
College of Emergency Medicine: Paracetamol overdose
College of Emergency Medicine: Asthma in children
College of Emergency Medicine: Sever e sepsis and septic shock
NHS Blood & Transplant: Liver Transplantation
NHS Blood & Transplant: Kidney Transplantation
UK Renal Registry
Royal College of Radiologists: National audit of accuracy of interpretation of emergency abdominal CT in adults who present with non-traumatic abdominal pain
Radiotherapy dataset

Royal Free London NHS Foundation Trust reviewed the results of the following national audits and confidential enquiries which published reports but did not collect data in 2014/15
National Potential Donor Audit
Chronic Obstructive Pulmonary Disease
Royal College of Paediatric & Child Health: Epilepsy 12 (Round 2)
National Audit of Seizures in Hospital
Royal College of Physicians: Care of Dying
UK Parkinson's Audit
NHS Blood & Transplant: LIver transplantation
NHS Blood & Transplant: Kidney transplantation
British Thoracic Society: Paediatric Asthma
College of Emergency Medicine: Sepsis and septic shock
National Review of Asthma Deaths
National Confidential Enquiry: On The Right Trach? (2014)
National Confidential Enquiry: Working Together (2014)
Additional Comments: We did not participate in the National Cardiac Arrest Audit at our Barnet or Chase Farm Hospital sites but do intend to participate in 2015/16. We did not participate in the College of Emergency Medicine audits at our Royal Free Hospital site as local quality improvement initiatives were in progress during the audit period. Any results would not therefore reflect these changes. Issues around the quality of our data submissions to ICNARC continued into the 2013/14 dataset such that the Royal Free Hampstead was excluded from national reporting. Data is now being accepted and we look forward to receiving reports on both our Barnet and Hampstead sites in 2014/15. n/a = not applicable

2.5 The reports of 34 national clinical audits were reviewed by the provider in **2014/15** and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National clinical audit	Actions to improve quality
Feverish children in the Emergency Department (2012/13 report)	We have improved our recording of all observations on children, although there is still room for improvement in recording blood pressures, and we are not yet consistently taking vital sign observations within 20 minutes. We plan to set up a temporary triage area to facilitate this before the new Paediatric Emergency Department is complete in November. We will be participating later this year in the College of Emergency Medicine national audit of Vital Signs in Children which will be re-auditing these parameters.
Asthma in children in the Emergency Department	We are achieving many of the parameters but, similarly to children presenting with fever (see above), we are not managing to take

(2013/14 report)	observations within 20 minutes (see above for our intended actions).
Ureteric colic in the Emergency Department (2012/13 report)	We are not recording a pain score and re-evaluating pain as often as we would like. Only 65% of patients are given pain relief within 60mins. We are developing an ambulatory pathway to reduce the need for hospital admission. This will include a focus on pain relief soon after the patient arrives.
Heart failure	The new NICE guideline for in-patient management of heart failure (October 2014) recommends that all patients should have specialist cardiology input, ideally on a cardiology ward, and be seen within 2 weeks of discharge by a specialist Heart Failure team. Currently not all patients newly-diagnosed with heart failure are looked after by cardiologists and there is no facility for early outpatient review by the Heart Failure team upon discharge. A cross-site heart failure pathway is being developed to ensure patients are identified for early and appropriate specialist care.
Pacemakers	We will review our choice of pacemakers for patients with sick sinus syndrome to ensure physiological pacing is used when indicated, in accordance with NICE guidance.
Stroke care	The acute stroke units based at the Royal Free and Barnet hospitals both contribute to the national Sentinel Stroke National Audit Programme (SSNAP), hosted by the Royal College of Physicians. This started in 2013 and our performance at our Hampstead unit has steadily improved in the last year. We plan to improve further by improving access to Speech and Language Therapy following a stroke. We will also be supporting the development of 6-monthly reviews in the community through life-after-stroke meetings. Results at Barnet were also showing improvement but in the last quarter have slipped. In accordance with the Pan-London acute stroke pathway, patients presenting with acute stroke should be referred to the nearest Hyper Acute Stroke Unit, rather than being admitted to the local Acute Stroke Unit, such as ours. The Acute Stroke Unit at Barnet has admitted an unexpectedly high number of patients and we are exploring reasons why some of these patients were not referred to the relevant Hyper Acute Service. We will work with external partners to ensure patients are referred to the appropriate unit in the first instance. As a result of these additional patients, the SSNAP audit has applied many of the standards applicable to Hyper Acute Stroke Units to our Acute Stroke Unit at Barnet. We believe the deterioration in our performance reflects these inappropriate standards and incorrect referral patterns for these patients.
Ulcerative colitis (in adults)	The published audit findings of the National Inflammatory Bowel Disease Audit run by the Royal College of Physicians show that we are in line with national results on stool sampling, prescribing 2nd line therapies and thrombosis prevention. However, only 27% of patients admitted with ulcerative colitis were seen by our clinical nurse specialist. We are recruiting a second clinical nurse specialist to improve the support for our patients.
Asthma in children	Our performance in the British Thoracic Society Paediatric Asthma National Audit 2013 has been particularly good, with 100% adherence to best practice for checking inhaler technique and issuing a written asthma plan, which is well above the national average.
Asthma in adults	Following the publication of the National Review of Asthma Deaths, 'wheeze plans' are being made more accessible in high priority areas, and plans are in place to increase education about asthma across the trust. We have changed our documentation for patients who present with

	asthma to our emergency department at our Hampstead site, to ensure that important information on checking inhaler technique, accessing smoking cessation services and follow-up arrangements are readily available to staff at the point of care.
Diabetes in children	The National Paediatric Diabetes Audit (NPDA) aims to improve the care provided to children with diabetes, their outcomes and experiences and that of their families. HbA1c is a blood test that is thought to represent how well the blood sugar levels have been controlled over the previous 12 weeks. The Barnet & Chase Farm service is below the national average for the percentage of children and young people (>12 yrs of age) achieving HbA1c levels below 58 mmol/l, (Barnet 46%, Chase Farm 43.9%, Royal Free 76.8%). We intend to provide more intensive input from Paediatric Diabetes Specialist Nurses (PDSNs) for patients with poor blood sugar control. We are integrating the services at Barnet, Chase Farm and the Hampstead sites to utilise our existing resources more efficiently and exploring additional resources from adult diabetes specialists, Diabetes Specialist Nurses and paediatricians. We intend to increase dietetic and mental health provision within the service and explore better use of technology (eg glucose meter uploads, continuous glucose monitoring systems and insulin pumps).
Epilepsy in children	Epilepsy12 is a national clinical audit, established in 2009, with the aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Following review of reports from previous years' audits we have restructured our clinics so that patients are seen in a timely manner. The recent appointment of a new consultant with an interest in epilepsy should enable us to improve the frequency of routine review for these children.
Chronic Obstructive Pulmonary Disease	Our overall score was in the top quartile and we were in the top 12% of acute trusts for patients who were reviewed on admission by a senior clinician. We were also notable for integrated care with our primary care colleagues. Access to specialist respiratory care is however limited in the evening and at weekends.
Pleural drains	At the Hampstead site, patients are more than twice as likely to have a pleural drain inserted by a consultant compared to the national average (49% vs 22%) and are much more likely to be supported by a member of nursing staff (85% vs. 34%) and to undergo the procedure in a dedicated room (79% vs. 42%). We have implemented new pleural drain documentation on our respiratory ward which has substantially improved the quality of record keeping; we plan to extend this to some of the other wards which may host other patients who require pleural drainage. We are in discussion with oncology teams to increase the number of patients with pleural effusions which are managed by a respiratory physician.
Lung Cancer	At the Hampstead site we have the 3rd highest surgical resection rates in England and Wales at 31% (vs E&W 15%) which offers our patients the best chance of a complete cure. The high surgical rates also explain our relatively low radiotherapy rates (21% vs 29%) as fewer of our patients require radical radiotherapy. On our Barnet site, the national audit revealed that our patients were unable to have CT scans in advance of diagnostic bronchoscopy. We have therefore introduced designated CT spaces on the same day as the specialist clinic, and bronchoscopy is arranged the following week.
End-of-life care	The National Audit of Care of the Dying in Acute Hospitals is coordinated by the Royal College of Physicians with data collection for Round 4 in 2013. Our results were reported in 2014 and showed that, whilst we achieved well on organisational performance indicators such as providing

	clinical guidelines for staff and information for patients, we performed less well in our documented clinical care. Publication of the audit results coincided with the publication of 'One chance to get it right' following the withdrawal of the Liverpool Care Pathway nationally. The recommendations from the national audit reflected our view that we needed a complete overhaul of clinical guidelines on care of dying patients within our hospitals and a new education programme for staff to support this. New guidelines are currently being piloted with front-line staff and should be in place, accompanied by an education programme, in time for the repeat national audit starting in July 2015.
Tracheostomy	Following the publication of the National Confidential Enquiry into Tracheostomy Care we have identified a number of ways to improve the training we give staff. We will also ensure that all changes of tracheostomy tubes are carried out in operating theatres in case of an emergency arising. We already have facilities for capnography in several clinical areas and will provide portable capnography for our ward-based critical care outreach teams. We will be extending the use of the WHO checklist to the insertion of percutaneous tracheostomies on our intensive care units. We already use endoscopy to confirm correct tube placement where trachesotomies are inserted percutaneously but will ensure this practice is extended to 'surgical' insertions. We will measure and document cuff pressure routinely, and introduce screening for swallowing difficulty at our Barnet site.
Maternal deaths (MBRRACE: national report from the Clinical Outcomes Review Programme)	Key recommendations from this tri-ennial national report into maternal deaths include better management of sepsis and improved uptake of flu vaccination. These already have a high profile in the Maternity Department by means of the Sepsis 6 programme (see below for more detail) and existing efforts to encourage uptake of flu vaccination among women.

2.6 The reports of over 100 local clinical audits were reviewed by the provider in 2014/15 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Aortic aneurysm	With support of the Department of Vascular Surgery, our newly-restructured Aortic Team has begun a 2-year programme to create a new model of care at the Royal Free Hospital with an aim to build a patient-centred, world class service for identification, investigation and treatment of diseases of the aorta which is built on a foundation of evidence and expertise. Our goal is to create a pathway of Personalised Aortic Care from diagnosis to treatment of no more than 8 weeks. Our next challenge in developing a new model of care will be to extend our bespoke approach to the post-operative period. We are challenging the dogma of historic models of post-operative care to find new and more efficient ways to treat our patients safely and effectively through the post-operative phase. Our vascular surgical and anaesthesia teams are working together to develop a post-operative care unit that will optimize resource utilization to address the challenge of limited critical care resources. We aim to lead the field in low dose radiation by using advances in technology and refined surgical techniques. In keeping with our goal to lead the field in investigation and education, we will be joined by our first Aortic Fellow in July 2015. This junior surgeon will work both clinically and academically with the team and will be the first in what we hope to be a long line of doctors, who will carry our model of care to other centres.
Magnesium sulphate for fetal neuroprotection in	The prevalence of preterm birth is increasing. Whilst the survival of infants born prematurely has improved, the prevalence of cerebral palsy has risen.

<table>
<tr><td>premature infants</td><td>Recently published evidence suggest that magnesium sulphate given to mothers shortly before delivery can reduce the risk of cerebral palsy and protect motor function in those infants born preterm. The effect may be greatest at early gestations and is not associated with adverse long-term fetal or maternal outcome, if given before birth from 24 to 30 weeks gestation.

Local guidance on use of this therapy for fetal neuroprotection was developed and introduced in 2013 at both Barnet and Hampstead maternity units. Most women with threatened preterm labour, or those requiring delivery before 30wks gestation, are cared for at our Hampstead unit.

A recent audit has demonstrated good compliance with important precautions for the safe use of this medicine (eg exclusion of renal and cardiac disease, frequent monitoring of vital signs). We intend to improve the timely identification of all women whose babies might benefit from this therapy, for whom it would be safe to do so. We also intend to better monitor the levels of this medicine that reach the babies' blood.</td></tr>
<tr><td>Severe maternal sepsis</td><td>The 2007 National Confidential Enquiry into Maternal deaths identified lessons relating to maternal sepsis as a significant contributory factor for maternal deaths. Clinical features suggestive of severe sepsis may be less distinctive in pregnant women compared to their non-pregnant counterparts.

In response, the Royal College of Obstetricians and Gynaecologists released national guidance in 2012 to highlight the need for early recognition and management of this condition, which is crucial to improving survival.

The recommendations include use of a resuscitation 'bundle' developed as part of the Surviving Sepsis Campaign.

We developed a Sepsis 6 care bundle which has been modified for maternity patients (see box).

This care bundle was successfully implemented in the Maternity unit at our Hampstead site in 2013 but a recent audit has shown that the improvement has not been sustained, in particular in serum lactate measurement and optimal administration of resuscitation fluid.

Maternity Sepsis 6 bundle
Timely commencement of 6 interventions:
• High flow oxygen
• Optimal fluid resuscitation (adjusted for pregnancy)
• 'Septic screen' sampling including blood culture prior to antibiotic administration.
• Commencement of broad-spectrum intravenous antibiotics
• Measurement of serum lactate levels (a measure of inadequate circulation)
• Close monitoring of fluid balance

We are currently also introducing the Sepsis 6 care bundle to our Barnet maternity unit.

We will consider the following initiatives that have helped us improve reliability of sepsis management in other areas of the trust, including an Obstetric Sepsis 6 casenote sticker, a Maternal Sepsis toolkit on both of our labour wards and further education and team training to promote the necessary timely interventions,. We intend also to review regularly the care of women who developed severe sepsis to identify opportunities for improvement and to facilitate shared learning across the directorate. We will also continue multi-disciplinary staff training and education relating to maternal sepsis and our Sepsis 6 care bundle.</td></tr>
<tr><td>Sepsis in children</td><td>The Paediatric Sepsis 6 pathway was introduced in October 2014 to raise awareness and enable early identification and appropriate management of the feverish child. Interim data suggests that the pathway is working well for those who trigger it.

We intend to extend this pathway to more children at risk of deterioration by</td></tr>
</table>

	modifying the entry criteria.
Urinary re-catherisation in the Emergency Department	A recent audit of 75 attendances where the patient required urinary re-catherisation showed that this occurs on average once a day, most often during working hours. Significant resource is required to transport the patient to hospital, treat and then return them to their place of residence. The audit showed that most patients did not require admission nor any specialist input. In conjunction with the TREAT team, we will develop a protocol and offer community training in order to reduce the number of patients that are brought to hospital. The audit also identified that these 75 attendances were by 45 patients, who attended on more than one occasion during this period. We intend to review the availability of appropriate catheters for patients at risk of re-attending, in conjunction with our urology colleagues, and to ensure staff are trained to select the most appropriate catheter.
Heart attacks (Non-ST elevation Myocardial Infarction).	Revised NICE guidance (Sept 2014) suggests that patients should have angiography within 72 hours of first hospital admission following this type of heart attack. We are implementing a new Acute Coronary Syndrome pathway across both Hampstead and Barnet sites) together with service transformation to ensure we are able to provide this treatment to all patients who need it. We expect implementation to be complete by January 2016.
Situational awareness for everyone (The SAFE programme) on our children's wards	This is a 2-year collaborative programme, involving 12 hospitals including the Royal Free Hampstead site, led by the Royal College of Paediatrics and Child Health, which aims to reduce the number of preventable deaths in children. Brief "huddles" are used to enhance situational awareness and thereby improve the early identification of signs of deterioration and prevent missed diagnoses. In these regular 5 minutes briefings, all the professionals looking after a child come together and share information about the child's clinical status and care. Audit, since the programme's inception in October 2014, shows that safety huddles are occurring reliably each morning but slightly less consistently in the evenings. Feedback from staff has been positive. More patients have been referred for intensive care support (through referral to the trust's Patient At Risk & Resuscitation Team). We intend to re-audit our use of paediatric early warning scores (PEWS) and our unified handover tool (SBAR) and redesign the patient white board to better highlight patients 'at risk'. We will also review clinical notes of patients who received intensive or high dependency care to identify potential improvements to safety. We intend to extend the same project to our Barnet children's ward.
Delivery of individualised care in our neonatal service	Evidence suggests that babies have better long term outcomes if they have 'individualised care' rather than traditional neonatal care. We are pioneering the delivery of this new style of neonatal care that emphasises the importance of the baby's environment and the various stimulations to which babies are exposed. We have started to emphasise important aspects of individualised care across the neonatal unit especially in our dedicated individualised care rooms (ICR), and have shown with audit that parents have seen the benefits of the programme. We intend to embed a culture of individualised care and to review staff and parent satisfaction with the environment we provide for babies.

Asthma education in schools	We have been working with local schools to improve asthma symptom awareness. This is a joint project between the Royal Free London, University College London and the charity Asthma UK; medical students become the teachers in an effort to boost asthma awareness among young children. We were successful in bidding for a grant from the innovation fund that will allow us to progress this work in the community.
Bone marrow aspiration	Many patients with haematological malignancy require bone marrow investigations, often at repeated intervals. The procedure has historically been performed under local anaesthetic by doctors in training and the experiences of the patient were sub-optimal with some experiencing discomfort. After reviewing the service we have introduced a nurse-led bone marrow service and reviewed the audit findings of the clinic over the last year. Our audit findings show improved wait times, improved patient experience with comfort and consistency. The service also provides a valuable training resource for junior doctors who have not previously been trained in this procedure. We plan to continue to introduce the use of Entonox ('gas and air' similar to that used by expectant mothers in labour) for pain relief instead of sedation, to make further improvements to waiting times and to audit the quality of the bone marrow samples taken.
WHO surgical safety checklist	Use of the WHO surgical safety checklist was audited in our operating theatres at all our sites. We have improved our use of the three patient-focused steps (Sign In, Time Out and Sign Out). We intend to improve the use of the briefing and de-briefing stages of the WHO checklist to encourage a safety culture, improve team-working and improve efficiency in the operating theatres on all of our sites.
Perioperative blood transfusion	Blood transfusion can be a vital and life-saving intervention, but it is not without risk. We have a strong past record of minimising the requirement for blood transfusion during and after surgery. We know that correction of anaemia before surgery reduces blood transfusion requirements. We already offer a course of iron tablets before elective surgery for those who might benefit but this option is not available for patients admitted to hospital in an emergency. We will explore alternative suitable options for these patients, for example the use of intravenous iron.
Inflammatory arthritis	Since February 2014 the trust has been contributing to the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis run by the British Society for Rheumatology. This combines an organisational audit looking at staffing and other resources, with an audit of clinical care, clinical outcomes and patient experience in the important first three months after symptom onset for patients with new-onset inflammatory arthritis. The first annual report will not be published until summer 2015, but we are already finding the discipline of data collection useful. We intend to establish a co-ordinated patient education programme for patients with a new diagnosis of inflammatory arthritis across all our sites, something which has been highlighted by the audit.
Bone mineral density in patients with cirrhosis	We have looked at bone thinning in our patients with cirrhosis and will be making changes to the bone protection treatment we offer our patients.
Epilepsy in adults	Working with colleagues in Camden, we plan to establish community clinics with multidisciplinary team input to improve patient satisfaction, epilepsy severity scores and reduce emergency department attendances. We also intend to establish "patient passports" for frequent emergency department attenders who have "blackouts" (episodes of transient loss of consciousness). This will provide fast-track services when warning signs of decompensation are identified. We plan to offer a telephone or clinic appointment as an alternative and to agree clear individualised action plans

	for emergency treatment.
Physiotherapy Joint Replacement Clinic – Barnet and Chase Farm Sites	The physiotherapy clinic for patients who have undergone hip or knee replacements has demonstrated improvements in pain levels and function over an average of 4 sessions. Some difficulties with the referral process were identified and the action plan has included establishing an electronic referral process to reduce delays and improve the standard of information communicated to the clinicians.
Intravenous fluid for adult inpatients – Royal Free Hospital site	An audit against NICE guidance for Intravenous fluid therapy in adults in hospital was undertaken during 2014/15. To assist with supporting improvements in intravenous fluid prescribing and documentation, the design of the fluid prescribing chart will be changed. Implementation of the updated chart and NICE guidance will be supported by a teaching programme for medical students and junior doctors. The impact of these actions will be measured by a re-audit during 2015/16.
Safe use of syringe pumps in palliative care	Separate similar audits were carried out on all our sites. At the Hampstead site we found that consent and other discussions with patients are not documented as consistently as we would like. We also identified that records of staff competency were not well kept on some wards. Our Barnet and Chase Farm sites found that prescribing was accurate but that there was room to improve the monitoring of patients treated with this continuous medicine-delivery system. We intend to make changes to our syringe driver monitoring chart at the Hampstead site to facilitate better patient monitoring, and to update and harmonise our clinical guidelines on the use of syringe drivers for palliative care medicines across all our sites.
Discharge summaries	Following a Patient Safety Alert in August 2014 regarding the quality and timeliness of communication with patients' GPs when discharged from hospital, a local audit identified that 30% of discharge summaries contained some incorrect information regarding the patient's medication list. On most occasions, any errors that are identified are corrected before a patient is discharged. However, these corrections, which are first corrected on the paper prescription, are sometimes not corrected on the electronic system, which is sent directly to GPs. There is therefore a potential risk of the incorrect information being sent. An improvement plan is being put in place that will reduce the likelihood of the electronic system being different from the paper version, therefore reducing the risk of incorrect information being shared with the patient's GP.

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 5313.

Additional information

The above figure includes 2,952 patients recruited into studies on the NIHR portfolio and 2,361 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year.

The Trust is supporting a large research portfolio of nearly 800 studies, including both commercial and academic research. 187 new studies were approved in 2014/2015.

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

Information on use of CQUIN payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for quality and innovation (CQUIN) payment framework.

Further details of the agreed goals for 2014/15 and for the following 12-month period is available electronically at https://www.royalfree.nhs.uk/about-us/corporate-information-and-accountability/cquin-scheme-priorities/

Additional information

In 2013/14 a total of £8,833,805 of the trust's income was conditional upon achieving quality improvement and innovation goals, and for 2014/15 this figure was £14,552,000.

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

CQUIN scheme priorities 2014/2015	Objective rationale
Friends and family test	This national initiative will provide timely, detailed feedback from patients about their experience in order to improve services for the user. There is significant room for improving the level of feedback received from patients across England.
Dementia	A quarter of beds in the NHS are occupied by people with dementia. Their length of stay is longer than people without dementia and they often receive suboptimal care. Half of those admitted have never been diagnosed before admission and referral to appropriate specialist community services is often poor. Improvement in assessment and referral will give significant improvements in the quality of care and substantial savings.
NHS safety thermometer	Participation in data collection is an important step in reducing harm in four areas of concern highlighted nationally. A particular focus is on reducing incidents of pressure ulcers in hospital and the local community.
Prevention – stop cessation, alcohol screening and domestic violence	Helping patients to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer patients. Simple advice from a clinician, during routine patient contact, can have a small but significant effect on smoking cessation. Alcohol-related problems represent a significant share of potentially preventable attendances to accident and emergency departments and urgent care centres, as well as emergency admissions. Screening for alcohol risk has

	been shown to reduce subsequent attendances and alcohol consumption. Finally, to introduce and develop existing measures that will help identify, assess and advise patients where there is evidence of domestic violence.
Integrated care	There are a significant number of frail older people admitted to hospital. Identification and assessment of these patients, sharing information with GPs and participating in multidisciplinary meetings help to improve care and reduce the cost of treating these patients.
Value Based Commissioning	The hospital acknowledges that a radical long term change in managing patient care is required to ensure that there will be sufficient resources to meet future demands locally for healthcare. This CQUIN is based upon the service transformation programme regarding development of the redesigned patient pathways.
Admission avoidance for frail elderly	To reduce the number of unnecessary emergency admissions to ensure only patients who are actually require admission are admitted and to provide ambulatory or same day care as an alternative to admission for elderly patients.
Making every contact count – quality of discharge information to primary care	The hospital will ensure that discharge documentation sent to primary care following a patient's admission effectively details all relevant data and clinical information obtained and recorded during the patient's stay in hospital with a specific focus on patients with chronic conditions.
Making every contact count – increasing the stop smoking offer for patients in contact with health services	Introducing an implementation plan specifically across Barnet and Chase Farm sites to improve the recording of smoking status and increase the access to effective support and treatment to stop smoking.
Workforce	The hospital will work to ensure that their workforce has the capacity and capability to deliver compassionate and safe care. This is in support of the publication by NHS England of "How to ensure the right people, with the right skills, are in the right place at the right time."
National quality dashboard	Implement clinical dashboards for specialised services. The dashboards provide information on outcomes for specialised services and assurance on the quality of care.
Highly specialised services	For Amyloidosis, Lysosomal Storage Disorders, Liver Transplant and Islet Transplant services participate in an annual workshop to encourage learning and the spread of best practice.
Endocrinology	Identify specialised endocrinology activity in our out-patient departments.
Haemodialysis	To encourage patient involvement in elements of the

	tasks of in-centre and satellite haemodialysis.
HIV telemedicine	Introduce telemedicine care for clinically appropriate patients diagnosed with HIV.
Patient and public engagement	Improve patient and public engagement within the Trust. Areas targeted in 2014/15 include renal & liver transplantation, pulmonary hypertension and cancer services.
Vascular service transformation	Improve patient experience by developing service transformation in vascular services resulting in admission avoidance.
AAA screening	Increase the uptake rates for Abdominal Aortic Aneurysm screening.
NICU	To achieve an increase in retinopathy of prematurity screening for babies whilst still an in-patient.
Breast screening	Increase the uptake rates for breast screening.
Dental	Complete the dental dashboard. The dashboard provides information on outcomes for dental services and assurance on the quality of care.

Information on Care Quality Commission statement of assurance

The Royal Free London NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with the Care Quality Commission

The Royal Free London NHS Foundation Trust has no conditions attached to registration.

The Care Quality Commission has not taken enforcement action against the Royal Free London NHS Foundation Trust during 2014/15.

The Royal Free London NHS Foundation Trust has not subject to periodic reviews by the Care Quality Commission.

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

Additional information

This year we had an announced responsive inspection on 5 and 6 September 2014 at our Barnet hospital site.

The trust was found not to be meeting the following three specific essential standards for which we have been issued compliance actions in relation to:

• **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010. Care and Welfare**.

• **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010. Cleanliness and Infection Control**

• **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of Medicines.**

An action plan was submitted to the Care Quality Commission 16 January 2015 outlining how the trust will address these concerns. The action plan progress is monitored by the trust executive committee.

Information on data quality

The Royal Free London NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 98.8% admitted-patient care;
- 99.2% for outpatient care; and
- 92.6% for accident and emergency care;

which included the patient's valid General Medical Practice Code was:

- 99.8% for admitted patient care;
- 99.9% for outpatient care; and
- 99.9% for accident and emergency care.

Additional information

The figures above are aggregates of the Royal Free London NHS Foundation Trust and Barnet & Chase Farm Hospitals NHS Trust entries taken directly from the SUS data quality dashboard provider view, which is based on the provisional April 2013 to January 2014 SUS data at the month 10 inclusion date.

Information governance toolkit attainment levels

The Royal London NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 70% and was graded green from IGT Grading Scheme.

Additional information

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

Our score on the information governance toolkit was a slight improvement on last year due in part to improved information governance training compliance. During the 2014-15 financial year information governance across the Royal Free and Barnet and Chase Farm Hospitals were merged to reflect the expanded organisation.

Payment by results clinical coding audit

The Royal Free London NHS Foundation trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

Additional information

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into standard, recognised codes in a computer system.

Actions to improve data quality

The Royal London NHS Foundation Trust will be taking the following actions to improve data quality:

- Review and revision of data quality strategies from the two former trusts to form a new strategy for the organisation.

- Continue and build on the operational data quality improvement initiatives started in 2014/15.

- Further enhance and develop on line support tools for operational staff.

- Enhance and refine data quality reporting and performance management.

Our quality performance indicators

(The data in this section will be updated for the final accounts with year-end data where appropriate) As a foundation trust we are required to report against the following core set of indicators in 2013

Indicator	Royal Free Performance Jul 12 - Jun 13	Royal Free Performance Jul 13 - Jun 14	National Average Performance Jul 13 - Jun 14	Highest Performing NHS Trust Performance Jul 13 - Jun 14	Lowest Performing NHS Trust Performance Jul 13 - Jun 14	Actions to be taken to improve performance
The value and banding of the summary hospital-level mortality indicator for the trust	80.66 (8)	88.69 (15)	101.13 (69)	54.07 (1)	119.82 (137)	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre. SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. The latest data available covers the 12 months to June 2014. During this period the Royal Free had a mortality risk score of 88.69, which represents a risk of mortality 11.31% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked 15 out of 137 non-specialist acute trusts. The Royal Free London NHS Foundation Trust has taken the following actions to improve the mortality risk score and so the quality of its services: A monthly SHMI report is presented to the trust Board and a quarterly report to the Clinical Performance Committee. Any statistically significant variations in the mortality risk rate are investigated, appropriate action taken and a feedback report provided to the trust Board and the Clinical Performance Committee at their next meetings.
Indicator	Royal Free Performance Jul 12 - Jun 13	Royal Free Performance Jul 13 - Jun 14	National Average Performance Jul 13 - Jun 14	Highest Performing NHS Trust Performance Jul 13 - Jun 14	Lowest Performing NHS Trust Performance Jul 13 - Jun 14	Actions to be taken to improve performance
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	24.8%	28.4%	24.6%	49.0%	0.0%	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level is included as a contextual indicator to the SHMI indicator. This is on the basis that other methods of calculating the relative risk of mortality make allowances for palliative care whereas the SHMI does not take palliative care into account. The Royal Free London NHS Foundation Trust intends to take the following actions to improve the mortality risk score and so the quality of its services: Presenting a monthly report to the trust board and a quarterly report to the clinical performance committee detailing the percentage of patient deaths with palliative care coding. Any statistically significantly variations in percentage of palliative care coded deaths will be investigated with a feedback report provided to the trust board and the clinical performance committee at their next meetings.

Indicator	Royal Free Performance 2012/13	Royal Free Performance2013/2014	National Average Performance 2013/2014	Highest Performing NHS Trust Performance 2013/2014	Lowest Performing NHS Trust Performance 2013/2014	Actions to be taken to improve performance
Patient reported outcome measures scores for:						The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data. The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps hospitals measure and improve the quality of care provided. A negative score indicates that health and quality of life has not improved whereas a positive score suggests there has been improvement. For two of the indicators, groin hernia and varicose vein surgery national data has not been made available. This is on the basis that the sample size is so small there is a potential risk that individual patients could be identified, the "low numbers rule" exclusion therefore applies. While the trust is not receiving a negative score against any of the outcome measures hip replacement surgery has been identified as an outlier by the Care Quality Commission (CQC) based on the 2013/14 data. The CQC produce a quarterly Intelligent Monitoring Report for all NHS Trusts. The CQC has developed the system to monitor a range of key indicators for NHS acute and specialist hospitals. The most recent report (December 2014) has identified patient feedback following hip replacement surgery as a Risk. The Royal Free London NHS Foundation Trust intends to take the following actions to improve the patient reported outcome measure scores and so the quality of its services: Reviewing the initial consultation process to ensure that expected outcomes are clear and patient expectations are realistic, improving patient information to ensure that risks and benefits are outlined clearly and reviewing information provided at discharge to help patients achieve good outcomes post operatively.
(i) groin hernia surgery	0.07	Low Number rule Applies	0.09	0.14	0.01	
(ii) varicose vein surgery	0.08	Low Number rule Applies	0.09	0.17	0.02	
(iii) hip replacement surgery	0.38	0.38	0.44	0.55	0.34	
(iv) knee replacement surgery	0.26	0.30	0.31	0.42	0.22	
Indicator	Royal Free Performance 2012/2013	Royal Free Performance2013/2014	National Average Performance 2013/2014	Highest Performing NHS Trust Performance 2013/2014	Lowest Performing NHS Trust Performance 2013/2014	Actions to be taken to improve performance
The percentage of patients readmitted to the trust within 28 days of discharge for patients aged:						The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from Dr Foster, a leading provider of healthcare variation analysis and clinical benchmarking, and compared to internal trust data. The Dr Foster data-set used in this table presents Royal Free London NHS Foundation Trust performance against the Dr Foster University Hospitals peer group. The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good
(i) 0 to 15	4.31	4.03	7.49	4.03	14.77	
(ii) 16 or over	8.21	7.52	7.76	2.52	13.67	

Note: Trusts with zero readmissions have been excluded from the data						quality care. The rate of readmissions at the Royal Free for children is the lowest (best) in the peer group. In relation to adults the re-admission rate is lower (better) than the peer group average. The trust has undertaken detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's, identifying the underlying causes of readmissions. This is supporting the introduction of new clinical strategies designed to improve the quality of care provided and reduce the incidence of readmissions. In addition the trust has identified a number of data quality issues affecting the readmission rate, including the incorrect recording of planned admissions. The trust is working with its staff to improve data quality in this area.
Indicator	Royal Free Performance 2012/2013	Royal Free Performance2013/2014	National Average Performance 2013/2014	Highest Performing NHS Trust Performance 2013/2014	Lowest Performing NHS Trust Performance 2013/2014	Actions to be taken to improve performance
The trust's Commissioning for Quality and Innovation indicator score with regard to its responsiveness to the personal needs of its patients during the reporting period.	65.6	67.4	68.7	84.2	54.4	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results. The NHS has prioritised, through its commissioning strategy, an improvement in hospitals responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is below (worse than) the national average. The Royal Free London NHS Foundation Trust intends to take the following actions to improve its responsiveness to the personal needs of its patients: The trust has a comprehensive patient experience improvement plan overseen by the Patient and Staff Experience Committee, a sub-committee of the trust board. During February 2014 the trust received an unannounced inspection by the Care Quality Commission. The inspection was designed to assess the trusts performance against the following standards: 1) Consent to care and treatment 2) Care and welfare of people who use services 3) Meeting nutritional needs 4) Cleanliness and infection control 5) Staffing 6) Supporting workers 7) Complaints The inspection report found that all standards had been met. While the trust is considered to be meeting Care Quality Commission standards the Patient and Staff Experience Committee will oversee targeted action to improve its responsiveness to the personal needs of patients.
Indicator	Royal Free Performance 2013	Royal Free Performance 2014	National Average Performance 2014	Highest Performing NHS Trust Performance 2014	Lowest Performing NHS Trust Performance 2014	Actions to be taken to improve performance

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	72.6%	71%	67%	93%	33%	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results. Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. The trust performs significantly better than the national average on this measure. The Royal Free London NHS Foundation Trust activities to enhance engagement of staff have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends: The trust has implemented world class care programme embodying the core values of welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our world class care programme anticipates even greater clinical and staff engagement.
Indicator	Royal Free PerformanceJul 14 - Sep 14	Royal Free PerformanceOct 14 - Dec 14	National Average Performance Apr 14 - Jun 14	Highest Performing NHS Trust Performance Apr 14 - Jun 14	Lowest Performing NHS Trust Performance Apr 14 - Jun 14	Actions to be taken to improve performance
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	97.0%	96.1%	95.1%	100.0%	81.2%	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data. The Venous Thromboembolism (VTE) data presented in this report is for the period July to September 2014 and October to December 2014. On 1 July 2014 the Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust. Therefore the period reported includes VTE data for all trust sites including the Royal Free, Barnet and Chase Farm hospitals. Many deaths in hospital result each year from Venous Thromboembolism (VTE), these deaths are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE. The Royal Free performed better than the 95% national target and performed better than the national average. The Royal Free London NHS Foundation Trust intends to take the following actions to improve its VTE risk assessment rate: The trust reports its rate of hospital acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings. In addition the Thrombosis Unit conduct a detailed clinical audit into each reported case of HAT with finding shared with the wider clinical community.
Indicator	Royal Free Performance 2012/2013	Royal Free Performance2013/2014	National Average Performance 2013/2014	Highest Performing NHS Trust Performance 2013/2014	Lowest Performing NHS Trust Performance 2013/2014	Actions to be taken to improve performance

The rate per 100,000 bed days of cases of Difficile infection that have occurred within the trust amongst patients aged 2 or over.	30.5	22.2	13.9	0	37.1	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre, compared to internal trust data, and data hosted by the Health Protection Agency. Clostridium Difficile can cause severe diarrhoea and vomiting, the infection has been known to spread within hospitals particularly during the winter months. Reducing the rate of Clostridium Difficile infections is a key government target. Royal Free performance was significantly higher (worse) than the national average during 2012/13. While the rate has reduced significantly it remains above the national average during 2013/14. More recent internal trust data for the period 2014/15 demonstrates that for the period April 2014 to February 15 the Royal Free hospital site had recorded 25 infections against a plan of 35 and was therefore compliant with its national trajectory. However it should be noted that during this period the Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm hospitals NHS Trust, with those sites included the trust had recorded more infections that its annual plan. The Royal Free London NHS Foundation Trust intends to take the following actions to reduce the rate of C. difficile infections: In order to demonstrate robust governance and ensure performance improvement during 2013/14 the trust asked for independent scrutiny, by a national expert of our infection control processes. The trust also invited two other national experts to review adherence to infection control policy. The action plan arising from the reviews has been considered and fully implemented. In addition the trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code.
Indicator	Royal Free Performance Apr 13 - Sept 13	Royal Free PerformanceOct 13 - Mar 14	National Average Performance Oct 13 - Mar 14	Highest Performing NHS Trust Performance Oct 13 - Mar 14	Lowest Performing NHS Trust Performance Oct 13 - Mar 14	Actions to be taken to improve performance
The number and rate of patient safety incidents that occurred within the trust during the reporting period	2,422 (6.92)	2,422 (6.92)	6,184 (8.72)	8,841 (14.91)	4,758 (4.63)	The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS). The National Patient Safety Agency regard the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported significantly less incidents than the national average during October to 13 to March 14. The Royal Free London NHS Foundation Trust has taken the following actions to improve its reporting rate: 1) The trust purchased a web-based reporting tool with the aim of simplifying the process for staff to report incidents and to export data to NRLS. Experience from other trusts has indicated that the introduction of a web-based tool significantly increases the volume of forms submitted by staff. The web based system went live during February 2013. 2) In addition the trust has developed a patient safety campaign with the aim of focusing on improving the patient safety culture, including encouraging staff to report incidents and providing timely feedback to staff on the outcomes and learning resulting from incident investigations.

The number and percentage of such patient safety incidents that resulted in severe harm or death.	13 (1%)	22 (0.91%)	22.7 (0.37%)	1 (0.03%)	36 (0.3%)	We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts. There is also clinical judgement in the classification of an incident as 'severe harm' as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change from that shown here due to this review process

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PART THREE

OTHER INFORMATION

Quality performance indicators

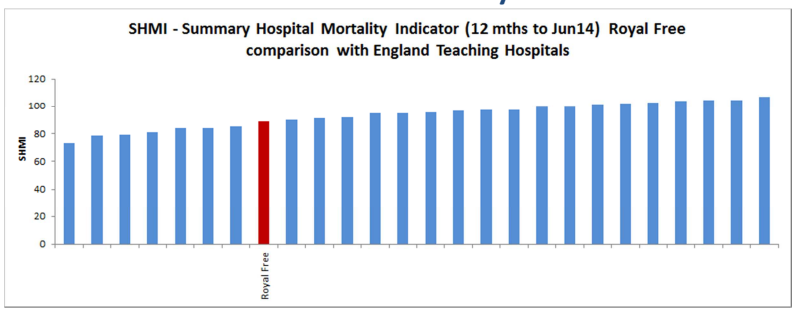
An overview of the quality of care based on performance against key national indicator priorities is detailed within our annual report.

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

- Patient safety
- Clinical effectiveness
- Patient experience.

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. The data in the graphs and commentary below aggregates performance to present a view of combined trust performance for quarters two to four, excluding quarter one, the period prior to acquisition. During quarter one the Royal Free London NHS Foundation trust was not accountable for the performance of Barnet and Chase Farm Hospitals NHS Trust.

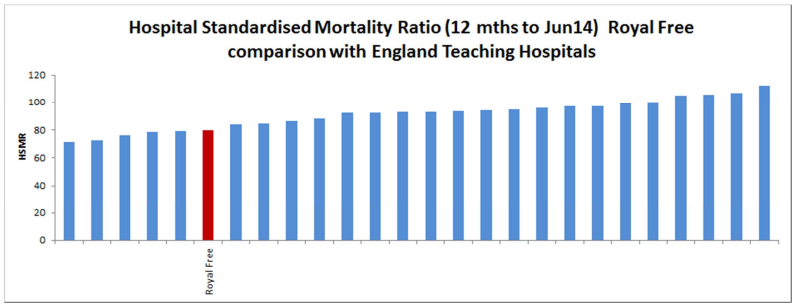
Patient safety indicators



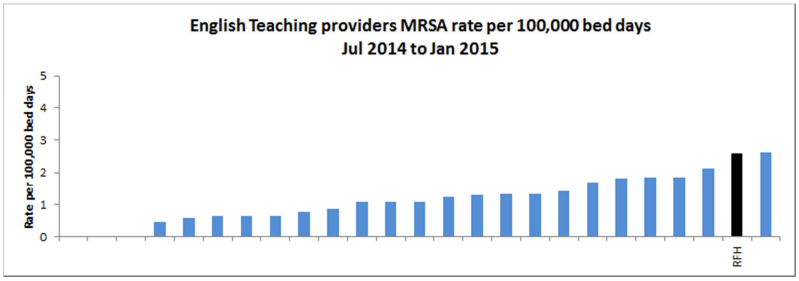
SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected.

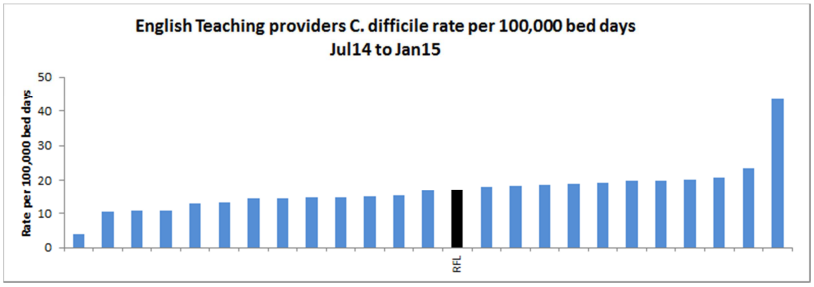
The observed volume of deaths is shown alongside the expected number (casemix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better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

The most recent SHMI data available is for the twelve month period ending June 2014, the month prior to the acquisition of Barnet and Chase Farm hospitals NHS Trust. For this period the Royal Free London NHS Foundation Trust SHMI ratio was 88.7 or 11.3% better than expected. For this period the Royal Free had the 15th lowest rate of any English Teaching Trust.



The HSMR (Hospital Standardised Mortality Ratio) data shows that for the 12 months to the end of June 2014, the month prior to the acquisition of Barnet and Chase Farm Hospitals NHS Trust, the Royal Free London NHS Foundation Trust recorded the 6th lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 79.7, which is 20.3% below (statistically significantly better than expected).





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

Reducing the rate of MRSA infections is a key government target and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.

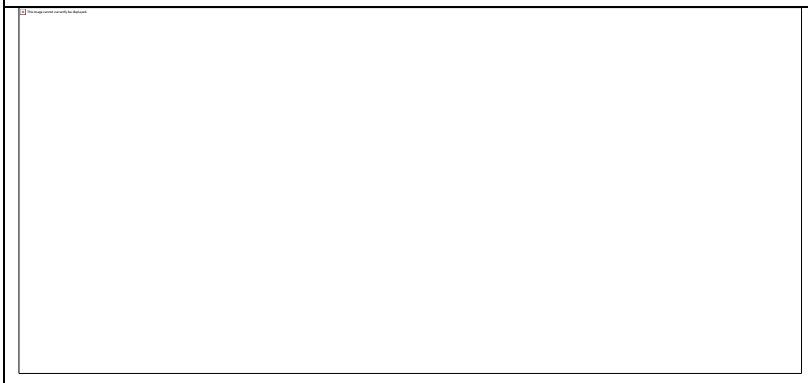
In the seven months to the end of January 2015 the Royal Free reported 5 MRSA bacteraemias, 4 of these were recorded at Barnet and Chase Farm hospital sites. The bacteraemia recorded at the Royal Free site was the first case for 27 consecutive months.

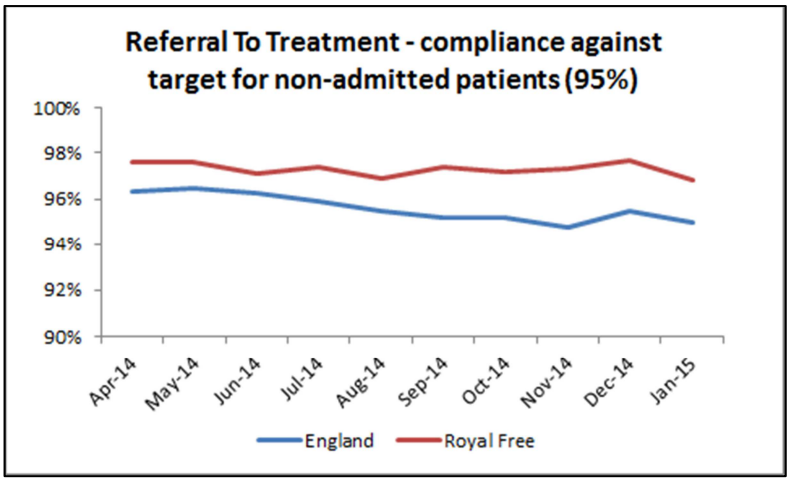
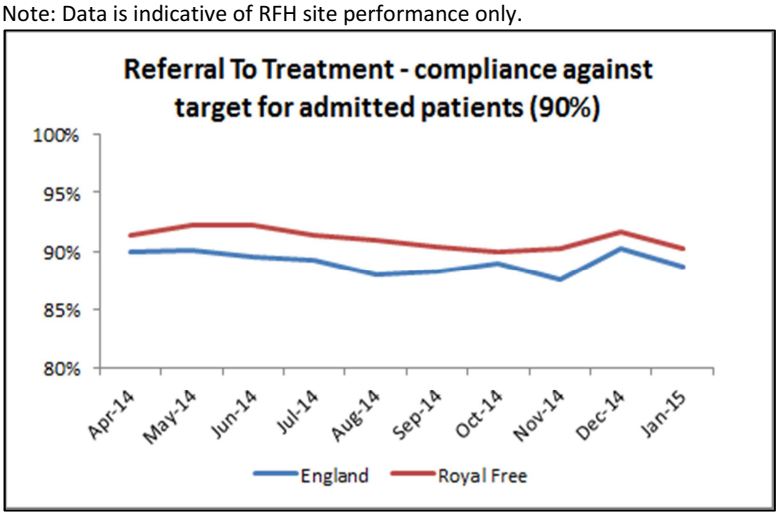
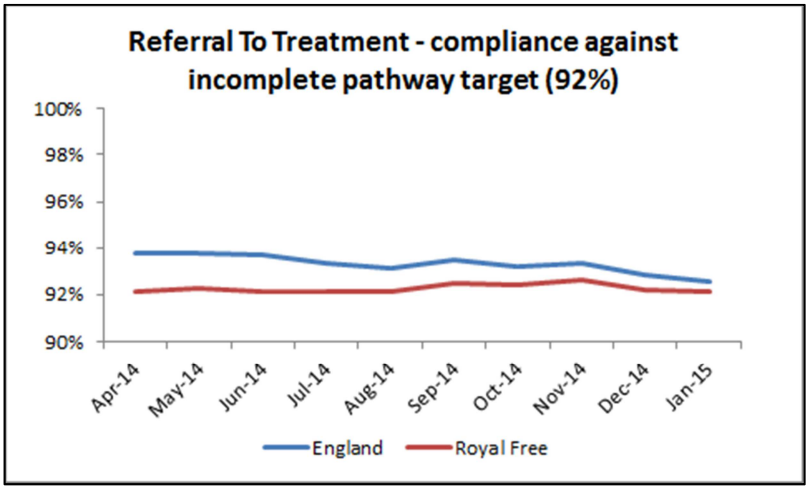
This results in the Royal Free London NHS Foundation Trust being the joint second worst performing out 25 English Teaching Hospitals during this period.

In relation to C. difficile the Royal Free London NHS Foundation Trust is ranked 14 out of 25 English Teaching Hospitals for the period July 2014 to January 2015.

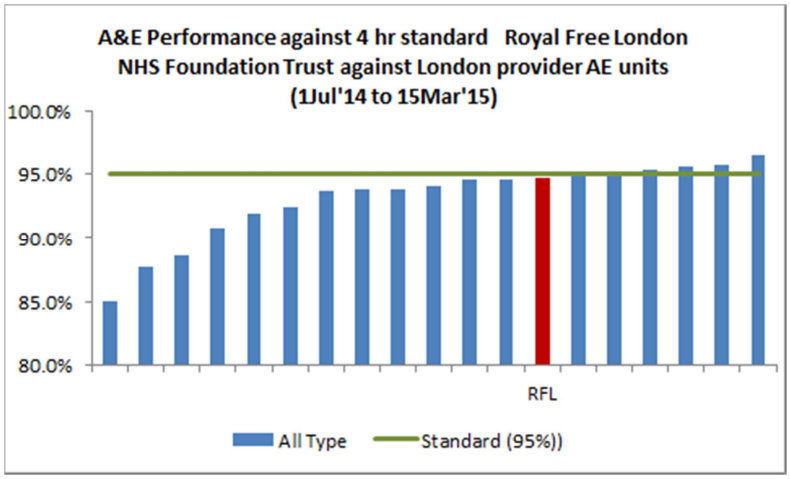
Internal trust data demonstrates that for the period April 2014 to February 2015 the Royal Free hospital site recorded 25 infections against a plan of 35 and was therefore compliant with its national trajectory. However Barnet and Chase Farm hospital sites recorded 33 infections over this period against a trajectory of 15.

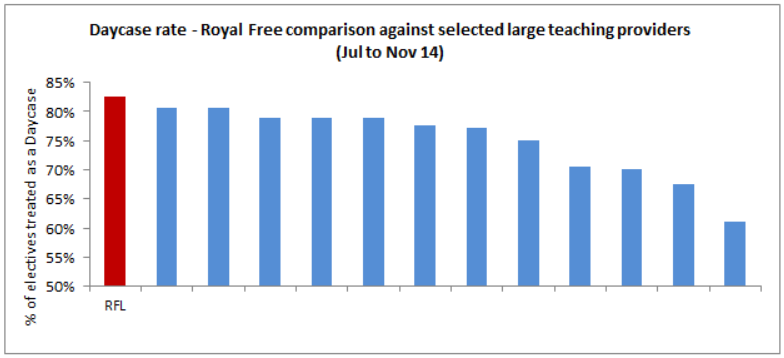
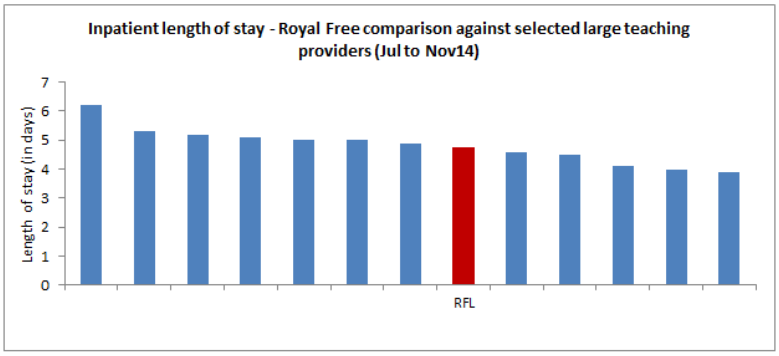
The trust is working with the Barnet and Chase Farm sites to identify the root cause of each MRSA bacteraemia and C. difficile infection and will also apply the same rigour to the Royal Free hospital site. The trust will be

	prioritising a significant reduction in the rate and volume of bacteraemias and infections during 2015/16. This will be achieved by undertaking a root cause analysis behind every case and ensuring all staff consistently apply the trusts infection control policies, with emphasis on ongoing training and monitoring across all levels of the organisation and ensuring best practice is shared across the trust. Specific high risk areas are continuously monitored by infection control staff.
	Many deaths in hospital result each year from Hospital Acquired Thromboembolism (HAT), these deaths are potentially preventable. In 2010 The National Institute of Clinical Excellence (NICE) provided unified national guidance on the prevention of HATs, together with a risk assessment tool issued by the then Department of Health. The government has set hospitals a target requiring 95% of patients to be assessed in relation to risk of VTE. In relation to the incidence of HAT the trust recorded 48 cases in 2014/15 to February 15. However, current data limitations mean that rates of thromboembolism are not differentiated between those that are hospital acquired only. Internal audits show that the trust is performing well against the national target. The trust reports its rate of hospital acquired thromboembolism to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings. Going forwards the trust is keen to

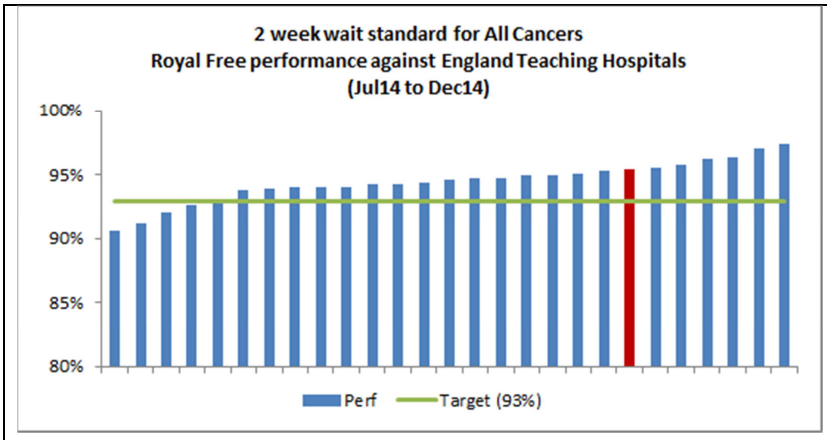
	share good practice across all its sites and ensure that there is a consistent approach to risk assessment and auditing.
## Clinical effectiveness indicators  Note: Data is indicative of RFH site performance only.  Note: Data is indicative of RFH site performance only.  Note: Data is indicative of RFH site performance only.	The 18-weeks RTT data in this section exclude the performance of the former Barnet and Chase Farm trust's services because the waiting times of patients for those services could not be accurately calculated in 2014/15. During September 2013 the Barnet and Chase Farm Hospitals NHS Trust ceased national reporting due to significant concerns relating to the accuracy of the data. The Royal Free London NHS Foundation Trust is working with its Barnet and Chase Farm sites to correct the reporting issues with a view to resuming national reporting during 2015/16. A maximum waiting of 18-weeks from referral to treatment is a key government access target with the NHS Constitution guaranteeing every citizen the right to treatment within 18-weeks. Recognising that not all patients can be treated within 18 weeks (e.g. due to clinical need, highly specialised surgery or patient unavailability) the government has set thresholds for admitted and non-admitted patients stipulating that 90% and 95% of patients respectively must start definitive treatment in 18 weeks The Royal Free London NHS Foundation Trust outperformed the wider English NHS throughout the year in relation to both the non admitted and admitted targets. In relation to the admitted standard the reduced performance visible during the summer and autumn months is the result of a national initiative designed to reduce the number of patients waiting for treatment by admitting additional breach backlog patients.

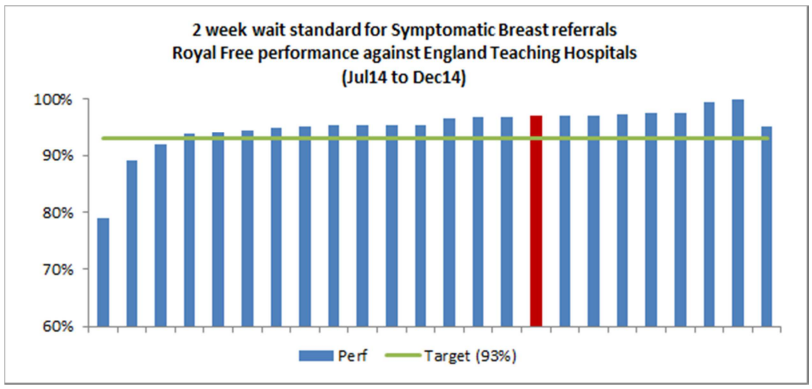
	Longer waits for treatment for patients with incomplete pathways suggest that some patients may be actively waiting for treatment for longer than the 18-weeks target. The Government set an additional target requiring 92% of patients actively waiting for treatment to have waited less than 18-weeks. The Trust has achieved this standard each month throughout the period, however has not performed as well as other English acute trusts. This is mainly due to longer waits for surgical treatment in a small number of specialties. Following the 1st July acquisition of Barnet and Chase Farm Hospitals NHS Trust, an 18 week Referral to Treatment Recovery and Improvement Programme was established within the enlarged organisation. The Programme's aim is to return to compliance at trust level with national 18 week RTT standards and to embed the necessary improvements required to sustain this level of performance. Key principles underpinning how the RTT Programme operates include keeping the overriding focus not on numbers, targets and rules, but how to ensure patients receive the best possible care with the shortest possible waits; as well as prioritising the identification of patients who may have suffered harm as a result of long waits through the clinical harm review; and also working as quickly as possible to clear the backlog based on worst case estimates, whilst closely managing the validation process to enable national reporting to resume. Ensuring all staff are effectively engaged in the programme whilst also making sure that there is open and transparent reporting to key stakeholders are core trust values supporting these principles.

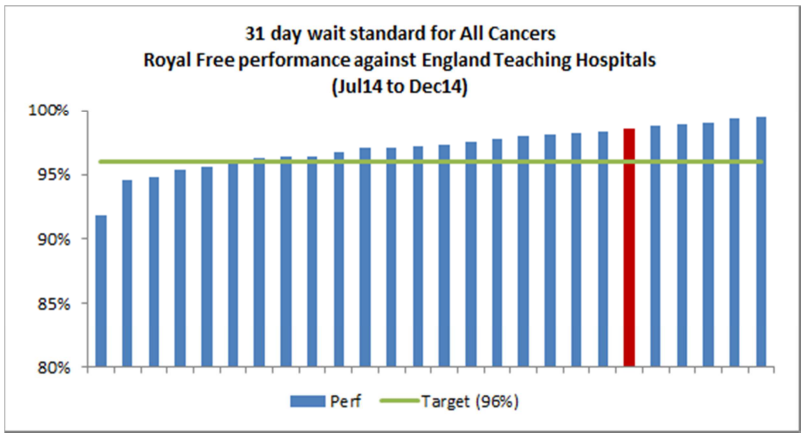
	The Royal Free will continue to prioritise waiting list reductions across the board in 2015/16. This will ensure that performance improves and patients have shorter waits for admission and treatment.
	The Accident and Emergency Department is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment. Historically, patients often had to wait a long time from arrival in A&E to be assessed and treated. The graph summarises the Royal Free's performance in relation to meeting the 4-hour maximum wait time standard compared to performance across London. A higher percentage is good as it reflects short waiting-times. During the most recent period for which data is available, July 2014 to March 2015, the Royal Free was the 7th best performing out of a total of 19 London trusts. However during this period the trust underperformed against the required 95% standard. The late summer, autumn and winter of 2014/15 has been an extremely challenging period with the majority of trusts across England and London failing the standard. Pressure on A&Es has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare. It is recognised that there are a number of trigger points which affect A&E performance including number of attendances, ambulance flows, total number of patients within the A&E at any time and bed flow. The trust has an A&E performance improvement

	plan, which includes internal plans and collaborative plans that are reviewed at a weekly summit with our care delivery partners. There is a strong focus on admissions avoidance to reduce unnecessary admissions and on reducing factors which cause delays in discharge. In addition, the trust is working with its Commissioners to better understand patient flows and offer community based alternatives to hospital care. In addition the trust has invested heavily in modernising and extending its emergency service, this included completely rebuilding its A&E department with work having already started.
 	Day cases are procedures that allow you to come to hospital, have your treatment and go home, all on the same day. From the patients' perspective day case surgery provides minimal disruptions to their daily routine as compared with an inpatient stay. In addition, there is less likelihood of their procedures being cancelled and risk of hospital acquired infection is also reduced due to less time being spent in hospital. A high day case rate is therefore seen as good practice both from a patient's perspective and in terms of efficient use of resources, allowing more patients to be treated. The trust is treating approximately 85% of elective patients as day cases. We have achieved this by constant challenge of practice: • All new procedures are challenged against international best practice for day surgery. • Overnight stays must always be justified clinically. • Overnight accommodation is provided where patients have to

	travel a long distance and have an early start for surgery. • Use of a surgical assessment unit to bring in patients on the day of their surgery. • Pre-assessment checks are re-validated where necessary to prevent admission prior to day of surgery. The graph compares the Royal Free's performance to 13 large teaching providers which Dr Foster regards as the trusts peer group. During the period July to November 14 the Royal Free was the best performing trust against this peer group. Going forwards the trust will continue to work on integrating pathways and implementing best practice to move to a higher day case rate where possible, whilst recognising that this has to be balanced against highly specialised complex surgery that requires an inpatient stay. New methods of working and technology will allow some day case surgery to be carried out in an outpatient environment. Length of stay is also an important efficiency indicator with, in most cases, a shorter length of stay being indicative of well organised and effective care. Between July and November 14 the Royal Free was the 8th best performing trust against the peer group of 13 large teaching providers referenced above.







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

National targets require 93% of patients urgently referred by their GP to be seen within 2 weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

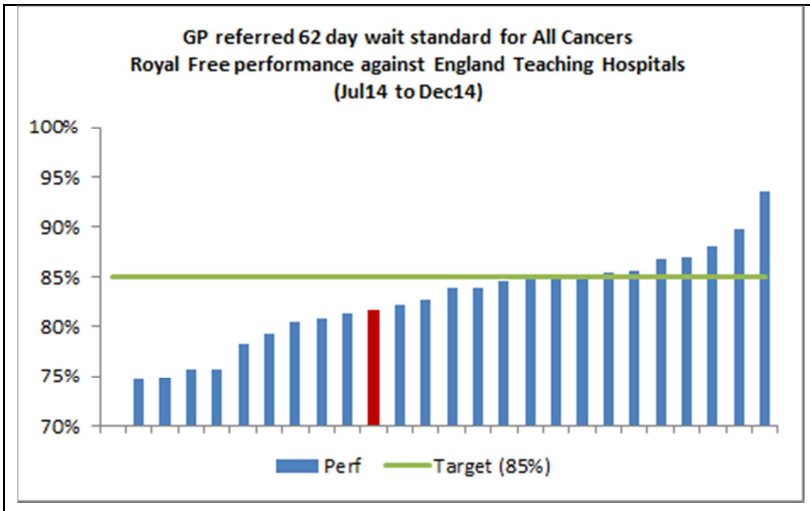
For the most recent period for which national data is available, July 14 to December 14 the Royal Free performed better than the national targets in relation to the two week wait and 31 day standards.

However the Royal Free underperformed against the 62 day standard. This is primarily due to long waits for Urology cancer pathway diagnostics, specifically TRUS biopsy, as well as long waits for prostate cancer treatments at external trusts.

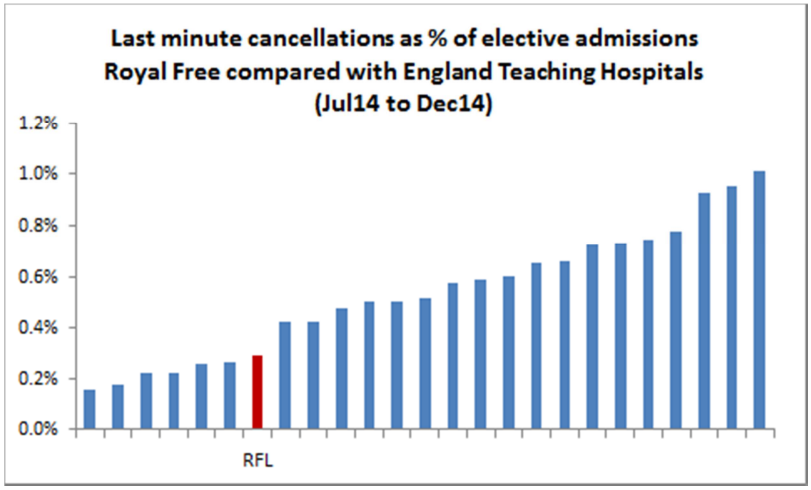
The trust is committed to putting patients at the heart of its services, ensuring all indicators are closely monitored and that all targets are met.

The trust has set out a detailed recovery plan requiring a return to national target compliance by June 2015. The plan is supported by a series of improvements across outpatients, diagnostics as well as reducing waiting times for treatment.

The graphs present the Royal Free's performance relative to English teaching trust performance and the relevant national target.



	The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. The hospital is working with Commissioners, GPs and local authorities to provide reablement and post discharge support in order to reduce the rate of readmissions. A low, or reducing, rate of readmission is seen as evidence of good quality care. The chart presents the Royal Free hospital site and Barnet and Chase Farm hospital site performance relative to 13 large teaching providers which Dr Foster regards as the trusts peer group. For the period July 14 to November 14, the Royal Free hospital site had the 13th lowest relative risk of emergency readmission within 28 days of discharge compared to the 25 English Teaching hospitals. The risk at the Royal Free was deemed to be slightly higher than the expected level, but still within the expected range of values. The services provided at Barnet and Chase Farm hospital sites are shown on the same chart for comparative purposes.

	The readmission rate at Barnet and Chase Farm is 3.7% below (better than) expected however this is within the limits expected by random variation.
Patient experience indicators 	Last minute cancellations contributes to poor patient experience and inevitably results in patients having to wait longer to have their treatment. During November 2013 the Royal Free prioritised the reduction of cancellations in order to improve patient experience. The impact was immediate and sustained, resulting in an improvement in the rate of elective activity cancelled at the last minute for non-clinical reasons. During the six month period from July to December 2014, the Royal Free NHS Foundation Trust cancelled 0.3% of elective activity at the last minute for non-clinical reasons resulting in it being the 7th best performing of the 25 teaching trusts.
	Delayed transfers occur when patients no longer need the specialist care provided in hospital but instead require rehabilitation or longer term care in the community. A delayed transfer is when a patient is occupying a hospital bed due to the lack of appropriate facilities in the community or because the hospital has not properly organised the patients transfer. This results in the waste of hospital

	resources and inappropriate care for the patient, the aim therefore is to reduce the rate of delayed transfers. Through more effective working with our community partners and better internal organisation the rate of delayed transfers of care had reduced significantly since 2009. However more recently there has been an increase, particularly in the winter months when the pressure on services is at its greatest. The trust is committed to taking an integrated care approach and is working with its partners, including social care and local authorities as well as commissioning agencies to improve the position for 2015/16.
	The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the trust to friends and family, based on the care they received. The test was introduced in April 2012. Its purpose is to improve patient experience of care and identify the best performing hospitals in England. FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services. The trust is committed to actively seeking feedback from patients and is keen to demonstrate implementation of change projects as a result. From April 2014 the Staff FFT was introduced and the trust aims to triangulate the findings with that of the patient FFT going forwards, ensuring that response rates and implementation are uniform across the trust and where the need for change is identified; it is driven by both patients and staff alike.

Monitoring of local audit quality improvement actions from 2013/14 quality accounts

Over the next few pages we will provide examples of how we have continually improved the quality of service we provided over the past year.

For several years, we have embraced national audits as a means of benchmarking ourselves against others in the UK. There are now over 50 national audits in which we regularly participate. In several, we are able to show improvements over successive audit cycles. We have benefited from the insights they give us into how we can improve care for our patients.

Through these national audits we regularly evaluate our performance in over 200 audit indicators of quality in clinical care. These include detailed measures of care, such as surgery within 36 hours after a hip fracture, or ideal sugar control in children with diabetes.

For nearly 25% of these metrics, compared to 10% in 2011, care at the Royal Free now appears to lie among the best in the UK as a result of improvements we have made to clinical care over successive years. These improvements have made an important contribution to patient safety, clinical effectiveness and patient experience.

Following the acquisition of Barnet & Chase Farm Hospitals, we have taken a similar systematic approach to evaluation of the findings relating to care at these hospitals and have found a similar distribution of performance to that at the Royal Free Hospital. Areas of relative strength and weakness differ, however, and provide a useful opportunity for us to learn from each other within the new enlarged organisation.

The next section describes some of the improvements we have made in 2014/15 as a result of our clinical audit activities and includes updates on plans we announced in our Quality Report last year:

Local Audit priorities reported in our 2013/14 Quality Accounts to improve the clinical effectiveness of our services	Actions we have undertaken to date
Pain relief in our Emergency Departments after fractured hip	At our Barnet site, a local audit showed that 80% of patients who had suffered a fractured hip were still in pain after receiving painkillers, including morphine, demonstrating the need to improve pain relief for these patients. By raising awareness of NICE guidelines on hip fractures, improving assessment of pain, and providing training to our doctors through a practical workshop, we promoted the use of 'nerve blocks' and significantly improved the quality of pain relief. We have greatly improved pain relief for patients who are admitted through our Hampstead Emergency Department with fractured hips, and our performance now lies in the upper quartile when compared nationally. All eligible patients were treated with an advanced pain technique, known as a 'nerve block', for pain relief during our last audit period.
Epilepsy in adults presenting to our Royal Free Hospital Emergency Department	Published results from the National Audit of Seizure Management indicate that we now perform in the top quartile nationally for assessing neurological observations. We have also become more consistent in measuring the patient's temperature after a seizure.
Pain relief for children in our Royal Free Hospital Emergency Department	Following the College of Emergency Medicine national audit last year, we have designed patient and parent leaflets with information on pain relief and pain scoring in children. We will soon be distributing these to

	all parents who accompany children with pain. We expect to see an improvement in pain scoring and timely use of analgesics at home to children, as suggested by the results of an earlier pilot study.
Severe sepsis - management in our Royal Free Hospital Emergency Department	We continue to perform in the top quartile nationally for seven of the eight metrics evaluated in this audit, including the six steps of our Sepsis 6 programme.
Feverish children in our Royal Free Hospital Emergency Department	We are doing much better at recording all observations on children. Our performance lies between the median and upper quartile nationally.
Patients with alcohol disorders in our Royal Free Hospital Emergency Department	When assessing and managing alcohol withdrawal at our Royal Free site we use the CIWA score. However, the score continues to be inconsistently applied. We plan to train staff about the CIWA score in our local induction programme.
CT scan after head injury presenting to the Royal Free Hospital Emergency Department	In our most recent audit, 60% of CT scans for suspected head injury were performed within 1 hour of request.
Heart attacks (Non-ST elevation Myocardial Infarction).	Across Royal Free and Barnet sites, we have developed a pathway for managing patients with Acute Coronary Syndrome. Together with service transformation, this will help us achieve the best possible care, in accordance with revised NICE guidance, at both our acute hospitals.
Elective cardioversion for atrial fibrillation	Prior to elective cardioversion for atrial fibrillation, patients need to be established on blood thinning therapy to reduce the risk of a stroke. When warfarin is used, it takes at least 4 weeks to establish a stable dose. We have changed our blood thinning therapy from warfarin to one of the newer anti-coagulants for patients at our Barnet site. This has permitted the elective cardioversion to be scheduled sooner as there are fewer delays while establishing the correct dose. We will be extending this revised pathway to the Royal Free site.
Continence plans after stroke	Most recent data indicates we have improved our continence planning and currently assess 95% of patients, who have suffered a stroke, for their continence needs.
Intra-operative assessment of tumour spread (one-step nucleic acid molecular assay of sentinel lymph nodes)	We now offer this as standard for all suitable patients having sentinel lymph node biopsy. Introduction of this technology has led to a reduction in the need for patients to undergo complete clearance of the axillary lymph nodes.
Aortic disease	We have restructured our Aortic Team at the Royal Free Hampstead to become a more patient-centred service. The appointment of two substantive consultants and a Clinical Lead since July 2014 has meant that the team's mission and mandate have become more focused. Early efforts have focused on improving the patient experience for our patients with aortic disease. We have introduced a 'one-stop-shop' approach to assessment. Patients now make one visit to hospital before surgery, meet the surgical team and have all necessary investigations and preoperative assessment on the same day. The introduction of an 'Aortic Hotline', as well as our new Royal Free Aortic Referral Service, has ensured that the team are responsive to both patients and referring physicians. This coordination has meant that patients and family members have less disruption to their schedules, and have their concerns addressed as quickly as possible. We have developed evidence-based protocols for pre-operative assessment and preparation prior to aortic surgery to enable information and treatment-planning (designed by our multidisciplinary team of surgeons, anaesthetists, cardiologists and nephrologists) for

	every patient, tailored to their individual clinical circumstances. Clinically, we have made radiation dose reduction a priority. Fusion imaging has been introduced in our Vascular Hybrid Theatre, allowing the team to use virtual images superimposed on fluoroscopic images to guide the placement of stent grafts. This has led to a significant reduction in radiation dose to both patient and clinical team.
Platelet transfusion	Platelet transfusion can be a life-saving intervention when a patient has severe bleeding or profound platelet deficiency due to chemotherapy or bone marrow transplantation. However, it is expensive and carries the risk of transfusion-associated reactions. We audited the use of platelet transfusion in the hospital and introduced a new role of platelet coordinator to guide optimal use of platelet transfusion through better use of testing at the point of care, improved platelet increment testing to guide the use of platelet transfusion, and appropriate use of double dosing. This new role has so far proved effective in safely reducing our use of platelet transfusions to patients with cancer. We intend to extend this improvement to other clinical areas where platelet transfusions are often required.
Referrals to palliative care	At the Royal Free site, an audit of in-patient referrals to the Palliative Care Team showed that most referrals arose from our Care of the Elderly teams. To avoid any delay in referral, the Monday morning Care of the Elderly ward round is now attended twice a month by a Palliative Medicine Registrar who can give specialist advice and identify patients needing referral to the service at an earlier stage
Opioid prescribing in palliative care	We have updated our guidelines on the use of this therapy and have developed information for patients.
Organ donation	We have established a joint Organ Donation Committee across our two legacy organisations.
Pain relief for in-patients	We have made improvements to our pain management training programme for staff, with a particular focus on pain assessment and documentation. We will be launching credit-card-sized 'Pain Prompters' for ward staff, to facilitate easy reference to pain assessment tools and safety checks.
Nutritional screening tool for elderly patients	A new nutritional screening tool for elderly patients has been in use for much of the last year, which encourages prescription of nutritional supplements to patients who may benefit from them.
Early mobilisation after Caesarean section	Early mobilisation is included in our Enhanced Recovery programme which has commenced at our Barnet Maternity unit.
Breastfeeding facilities on our neonatal unit	The Baby Charter national audit, run by the charity Bliss, looks at all areas of neonatal care. As a result of the audit in 2013, we have improved our facilities for breast feeding.
Missed medication doses	Daily data collection and immediate feedback to ward staff continues. Recent data shows a reduction in missed doses after the implementation of a Safety Cross programme on one of our wards. This is now being implemented on a further ward.
Patient experience for women with breast cancer	Having reviewed the patient experience survey responses from women who use our breast cancer service, we have appointed a new Clinical Nurse Specialist to support patients with breast cancer. We have updated and improved our patient information leaflets and improved our processes for ensuring patients receive the information most relevant to their condition.

NORTH·LONDON
HOSPICE

Outpatient & Therapies Service
BARNET **Bereavement Support** Patient
Community ENFIELD
Haringey **EDUCATION** **CARE**
Triage Service
North London Hospice
PALLIATIVE CARE SUPPORT SERVICES
24-hour advice line for NLH patients and professionals

OVER **90%**
SUPPORTED AT HOME

1756 **individual patients**
cared for by all NLH services this year

QUALITY ACCOUNT 2014-15

CONTENTS

OUTPATIENT AND THERAPIES SERVICE PATIENT STORY

"Everyone is lovely and very caring. "A" (nurse) is marvellous. My lung nurse, B, suggested that I come to the Hospice. I had heard of the Hospice. She knows I don't like hospitals. I don't like male nurses seeing to you when you are a woman – it's not right for someone of my generation.

I'm deaf so I don't have a lot to talk about so I was a bit worried about mixing with other people. From my first visit, "A" has been very kind.

I felt like the Queen when I first arrived – lots of people waiting around to greet me. I had my hair washed, a pedicure and a manicure. I was really pampered and couldn't get over it. The volunteers are all lovely and I've played dominos.

It would be nice if there were some magazines in the Open Space. Sometimes you are left on your own between appointments or waiting for your driver. Hospice drivers pick me up and drop me off.

I finish here in 3 weeks and I'm really choked about that. I've got used to coming. I really look forward to it and it makes me feel better. I was getting tearful and depressed at home. The best thing about coming is being able to get out. I don't get out much; my son just takes me shopping once a fortnight for an hour. I hate having to ask people to do things for me. Any problems, I have to sort them out for myself and I get very tired of having to keep struggling to get them sorted.

I would recommend the Hospice and am treated with respect and dignity."

North London Hospice (NLH) Response to this User Feedback:

Patients attend for a planned 12 week therapies programme. Following review, this is extended where appropriate. Patients are helped to move to other services prior to their discharge date. Following discharge all patients are welcome to attend on a drop-in basis.

Drop-in clients can access the following: a volunteer led activity e.g. quizzes, games, crafts etc; meditation; hair & beauty therapy; yoga. They can stay for lunch or enjoy some conviviality with volunteers. The drop-in service was instigated in July 2014 and all ex-patients were informed of this in writing and invited to attend.

NLH has a large team of volunteers and it is very unusual for a patient to be unattended at any point. NLH have reminded volunteers to be aware of patient's whereabouts at all times. In addition there is now a system of dedicated link volunteers who are assigned to individual patients attending the social programme.

EXECUTIVE SUMMARY

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

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

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

The following three priorities for improvement projects for 2015-16 are proposed:

Patient Experience Project: To pilot the use of real time user feedback in *order to seek their views whilst experiencing NLH care in order to be responsive to improve the individual's care experience.*

Patient Safety Project: To introduce a bespoke risk management database

Clinical Effectiveness Project: to scope the service provision for those living with and beyond chronic illness in North London Hospice Outpatients & Therapies Service

The 2014-15 priorities for improvement projects are reported and may have contributed in the following ways: a more social environment for IPU patients and visitors in the Living Room at Finchley; a 17% reduction in falls and a decrease in grade 3 and 4 pressure ulcers developed on the IPU; a 3% increase in dementia patients cared for by NLH and the introduction of palliative care outcome tools to enable us to better review the effectiveness of addressing patient's problems and concerns.

Key service developments are described. The extension and development of community service provision in Haringey following a partnership with 5 local palliative care providers. The collaborative project with Macmillan Cancer Support looking at greater choice and flexibility in provision of care to people at home. The provision of a flexible time limited individual programme for patients attending Outpatients and Therapies Service (formerly Day Services). Refreshed and upgraded patient rooms with improved clinical rooms and the creation of an 18th bedroom on IPU as part of the IPU refurbishment.

Service data is highlighted and discussed. IPU had 295 admissions this year and their average length of stay was 13.6 days. Bed occupancy increased this year to 81 %. 19% patients were discharged from IPU. The Outpatients and Therapies Service cared for a total of 243 patients. The community teams cared for a total of 1299 patients in their own homes and supported 59% of these patients to die at home where this was their preferred place of care. Palliative Care Support Service cared for 279 patients and provided a total of 14, 985 hours of one-to-one nursing care to people in their own homes.

NLH's user surveys revealed that 99% patients were satisfied with our service and 98% would recommend service to families and friends.

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

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

I am pleased to present North London Hospice's (NLH) fourth Quality Account which details the level of quality of care we have achieved in 2014-15 for 1756 patients and their families from our local communities of Barnet, Enfield and Haringey.

I am pleased to report that 98% of patients and 99% relatives who answered our user survey this year would recommend NLH service to a friend. Despite such excellent feedback we are always seeking ways to engage with users and see how we can improve their experience. Our Living Room project has focused this year on addressing social isolation reported by some of our Inpatients last year. The experience is now an*: "Enjoyable time spent with volunteer and enjoyed the music & table games & greatly enjoyed the courtyard."(*User quote).

We are very excited that in 2015-16, a new project will start that will involve trained volunteers interviewing our patients and relatives to see what changes we can make for them then and there to improve their experience. This will reflect two of our 8 core values "Focusing on the individual" and "Being Adaptive and Creative".

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

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

All staff work towards meeting this vision through NLH's strategic plan, linked individual staff reviews and department objectives.

This year has seen NLH extend its reach by delivering its day services (now called Outpatients and Therapies) closer to home with the delivery of services at two sites (Enfield and now Finchley). In response to commissioner feedback the service has broadened its referral criteria to include people experiencing challenges as a consequence of having had treatment and or survived a life threatening illness. This year, a new project with users will map existing service provision for our users and, if any gaps are identified, will consider how North London Hospice may be able to address this need.

This year has also seen NLH join a newly formed partnership to provide specialist palliative care services to people living in Haringey. As part of this we now employ the Haringey Community Specialist Palliative Care Team based in Haringey and provide a triage service for referrals.

NLH's education department have trained 223 staff of external organisations like Care Homes, Community Nursing Services, and trainee doctors. This year it has provided new training in communications skills and as part of NLH's Dementia Care Project has delivered dementia training to 83 staff.

NLH as an independent charity makes no charge to patients or their families for care given. It is a testimony to our local community that they continue to support the £6.2 million annual care costs. NLH receives 40% from NHS grants.

NLH Board of Trustees reviewed and approved this Quality Account on ....I, Pam Mc Clinton, confirm that to the best of my knowledge the information set out in the Quality Account is accurate. I welcome any suggestions or comments on this Quality Account and on our care.

Pam McClinton

INTRODUCTION

Quality Accounts provide information about the quality of the Hospice's clinical care and initiatives to the public, Local Authority Scrutiny Boards and NHS Commissioners. Some sections and statements are mandatory for inclusion. These are italicised to help identify them.

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

OUR CLINICAL SERVICES

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

1. Community Specialist Palliative Care Team (CSPCT)
2. An Out-of-Hours Telephone Advice Service
3. Outpatients & Therapies (OP&T), formerly Day Services
4. Inpatient Unit (IPU)
5. Palliative Care Support Service (PCSS) - NLH's Hospice at Home service
6. Loss and Transition Service (including Bereavement Service)
7. Triage Service

For a full description of our services please see Appendix One.

PART 2:

PRIORITIES FOR IMPROVEMENT PROJECTS 2015-16

The following Priority For Improvement Projects for 2015-16 were identified by the clinical teams and endorsed by the Quality, Safety and Risk Group, Board of Trustees and local commissioners and Health and Overview Scrutiny Committees.

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

Patient Experience-Project 1: Listening and responding to current individual user feedback

NLH would like to pilot real time user feedback to identify what of their current service experience could be improve and act promptly to improve the individual's care experience. Trained volunteers will be used to interact (face to face or telephone) with users during the User Survey completion. The feasibility of using this method of user surveying was reviewed by Hospice UK with Marie Curie Cancer Care and NHS Improving Quality in 2014. Unexpected learning from this study highlighted:

- the value made through the volunteer-patient interaction;
- increasing patient reporting of concerns and wishes;
- the enjoyment of the social interaction.

Baseline:

We currently carry out a user postal survey each year over a 6 month period. Feedback is entered manually into a spreadsheet, analysed after collation of all the survey results, and action taken to develop and improve services where required. In 2014, NLH only received 16 completed surveys from IPU patients with the support of one volunteer. NLH would hope to increase both the number of volunteers involved and completed IPU patient surveys.

Outcome:

Users will be enabled to provide feedback on treatment, care and preferences relating to their current needs. Staff will receive prompt patient feedback so changes can be made to care delivered. Patients will be empowered by volunteers to raise concerns or requests. Patient's social/personal interaction time with volunteers is increased.

Timescale:

A pilot of IPU and OP&TS patients will inform initially potential prospective surveying to these patient groups and then progress to telephone surveying of community patients.

Patient Safety-Project 2: To introduce a bespoke risk management database

NLH is committed to improving the safety of all users of its services, including patients, carers and relatives, as well as all members of staff and volunteers. To support this plan we are working towards introducing a bespoke risk management database which will be developed for the Hospice by Sentinel. The database will provide:

1. A robust, accessible reporting and management system for incidents and complaints
2. A central register of compliments
3. A centralised service specific and organisational risk register
4. Triggers to manage Duty of Candour incidents

Baseline:

At the present time the Hospice has a number of in-house developed Excel spreadsheets which are used to capture the information within the four areas above. Whilst this provides the information needed to manage within these areas, it is a time-consuming process. On 1st April 2015, new regulations relating to "Duty of Candour' came into effect (Health and Social Care Act 2008 (Regulated Activities) Regulation 20. These require health services to notify any persons involved in a notifiable incident which has resulted in death, severe or moderate physical harm or prolonged psychological harm. NLH will carry out a staff questionnaire asking about their experience of incident reporting and whether they are aware of outcomes and learnings.

Outcome:

The new system will enable the Hospice to build on the progress we have made over the last few years in the management of incidents, complaints/compliments and risks, to improve the reporting of these at all levels as well as the monitoring of outcomes and learnings.

Timescale:

The new database is under construction with final amendments being made by the end of May 2015. All data from 1st April will be uploaded centrally by either Service Managers or members of the Quality Team who have been trained on the system by the end of the first quarter. Also during this quarter, individual members of staff will be trained and the system will be rolled out to all Services and staff.

Clinical Effectiveness-Project 3: Developing provision for those living with and beyond chronic illness in North London Hospice Outpatients & Therapies Service

NLH's Outpatients & Therapies Service (OP&T) is considering broadening its reach to include patients who continue to experience challenges as a consequence of having had treatment, and those who continue to live alongside a potentially life-limiting illness – 'survivors'.

Baseline:

Following the broadening of NLH's referral criteria to include the patient group above, NLH have been providing one to one support. NLH have recognised the need to consider other ways of delivering this support through group work or in partnership with other providers. This scoping exercise will map the local services that currently exist in the boroughs of Barnet, Enfield and Haringey, to understand the local resources, requirements and opportunities for service development.

Outcome:

Implement recommendations of Project. If a need is established, develop a service to enable patients to utilize their own coping strategies and self-management techniques, to improve their quality of life. Alternatively, establish a database of local services.

Timescale:

Recommendations will be made by April 2016

STATEMENTS OF ASSURANCE FROM THE BOARD

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

Review of services

During 2014-15, NLH provided and/or sub-contracted 1 service where the direct care was NHS funded and 3 services that were part NHS funded through a grant.

NLH has reviewed all the data available to them on the quality of care in these NHS services.

The NHS grant income received for these services reviewed in 2014-15 represents 29 per cent of the total operational income generated by NLH for the reporting period 2014-15.

Participation in clinical audits

During 2014-2015, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that NLH provides. During that period NLH did not participate in any national clinical audits or national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that NLH was eligible to participate in during 2014-15 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2014-15, 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 2014-15 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).

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

The provider reviewed the reports of 4 local clinical audits in 2014-15 and NLH undertook the following actions to improve the quality of healthcare provided.

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

Summary of completed Internal Audits 2014-15:

Audit Topics	Key Findings	Actions
Audit of anticipatory EOLC drug prescribing in community palliative care patients	44/ 45 (98%) patients prescribed anticipatory EOLC drugs. 35/ 44 (80%) patients prescribed anticipatory EOLC drugs by CSPCT. 2/44 (5%) patients received emergency out-of-hours (OOH) prescriptions. Of note the total cost of anticipatory EOLC drugs as per local guidelines is £26.23 versus the cost of an emergency OOH GP (BarnDoc) home visit which costs approximately £500. <u>Conclusion</u> Excellent results that reflect good prescribing both in terms of timeliness and adherence to guidelines.	Disseminate results to celebrate good practice Community Team to share results at GP Gold Standards Framework (GSF) meetings (all Community Team – ongoing 2014/15) Education Team and Consultants to disseminate results via external teaching sessions (ongoing 2014/15)
Blood Transfusion re-audit	Re-audit of the transfusion pathway documentation RESULTS: good New audit looking at the assessment of effectiveness of transfusion documentation- 7/23 pathways were fully completed. 2/23 were because the patients had died before the evaluations were due to be completed. The results indicate we need to identify why these new sections are not being completed despite training and make changes to improve practice in this area.	Share results and hold session on the blood transfusion assessment for IPU and Community Team Update the training tracker e-learning session to emphasise the assessment sections and to agree if blood transfusion e- learning module should be mandatory for Community Team Modify pathway - to provide clarity of who is responsible for the assessment documentation. -insert a section re transfer of ownership from IPU to named Community Team member Ensure blood transfusion is early part of junior doctors' induction both training tracker and face to face session with auditor.

Hand washing audit	Completed at Finchley and Enfield sites. **<u>Finchley Site Audit</u>** IPU self monitoring - 97% compliance *Kitchen and sluice– This part of observation needs to be extended to provide robust data.* **<u>Enfield Site Audit</u>** Self monitoring - 77% compliance <u>Discussion</u> This was considered a good result given it was the first audit of hand hygiene at this site. It revealed there was variable knowledge amongst the team regarding hand hygiene.	Share results to raise awareness - highlight good and poor practice and reminder of 5 moments of hand hygiene. Signs in kitchen to remind staff and volunteers to wash hands Ensure Uniform and Workwear policy reflect IPC requirements Re-audit at Enfield with observational data collection
CQC (against proposed Fundamental Standards)internal audit of services	49/55 standards met. 6/55 standards partially met.	<u>IPU:</u> Care plans to be integrated with iCare. Draft consent form to be completed Controlled Drugs and infection control audits to be completed. Staff competences adapted and introduced Staff PDRs completion. Recruit to establishment. Introduce outcome measures <u>OP&T:</u> Governance standing item to be introduced at operational meeting.- complete

Research

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2014-15, that were recruited during that period to participate in research

approved by a research ethics committee was 0.

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

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2014-15 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

What others say about us

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

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

The Care Quality Commission has not taken any enforcement action NLH during 2014-15.

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

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

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

DATA QUALITY

NLH did not submit records during 2014-2015 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as it is not applicable to independent hospices.

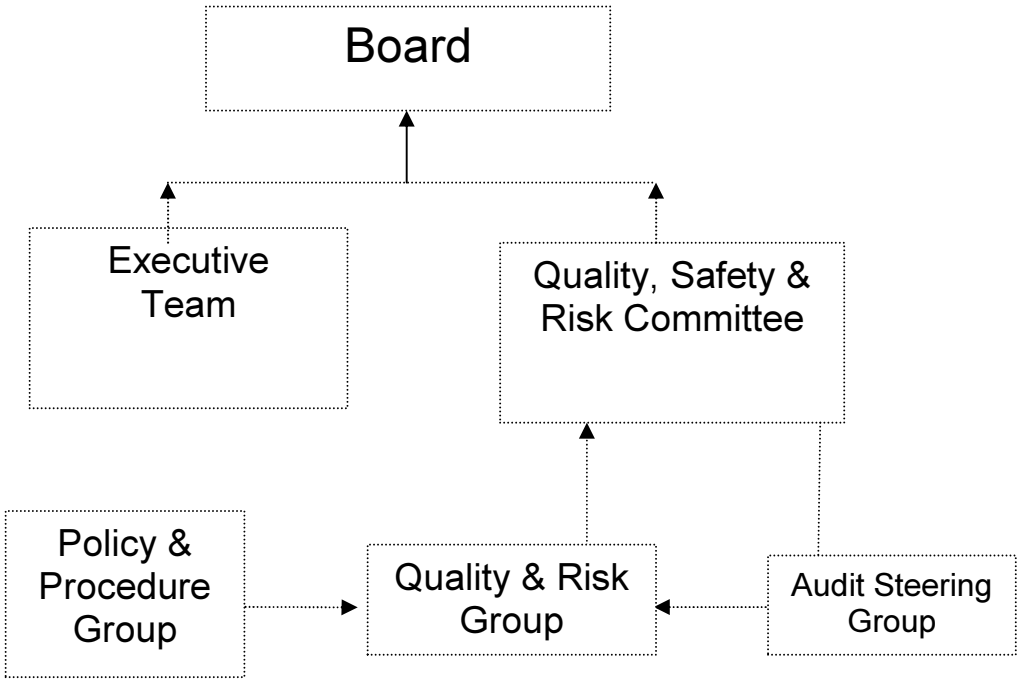
Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner. As part of the monitoring of the IG Standards within the Hospice NLH completed the annual IG Toolkit in March 2015 and received a score of 98%. In April 2015, NLH received confirmation that our assessment has been reviewed by the Health and Social Care Information Centre (HSCIC) and has been confirmed as Satisfactory.

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

PART 3: QUALITY OVERVIEW

QUALITY SYSTEMS

NLH has quality at the centre of its agenda. The Executive Team identified "Working together to make a difference to palliative and end of life care in our communities" as its overall strategic aim for 2015-18. There are specific aims and objectives around sustaining and ensuring quality outcomes.



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

KEY SERVICE DEVELOPMENTS OF 2014-15:

Extension and development of community service provision in Haringey

Palliative Care services in Haringey have undergone a period of significant change. Haringey Clinical Commissioning Group worked in collaboration with 5 local palliative care providers to develop a joint proposal for an Integrated End of Life Care system in Haringey that built on good existing palliative care practice in Haringey.

The rationale for joint integration of palliative care services has been advocated for a long time as an answer to meet patients' needs, reduce hospital admissions and also to reduce overall healthcare costs

The range of services commissioned are from one lead NHS provider North Middlesex University Hospital who is accountable for the delivery of all services and holds subcontracts with the other providers for specific parts of the pathway. The other four organisations working together with North Middlesex are as follows; NLH, Whittington Health, Marie Curie, and St Joseph's Hospice.

NLH's role in this partnership is the provision of a Community Specialist Palliative Care Service, an out-of-hours (OOH) advice line for Health care professionals and the development of an integrated Triage service with a single point of access for Haringey referrals. Following recruitment of additional Community Clinical Nurse Specialists the vision is to provide a responsive 7 day a week service and an OOH advice line for patients in Haringey and deliver a similar Community service as we do in the other two boroughs.

Haringey Community staff are now employed by the North London Hospice and are settling into new accommodation at the George Marsh Centre, St Anne's Hospital in Haringey. There is now a new Community Team Leader for the Haringey Community Team and this will support the on-going integration of staff within the organisation yet developing collaborative working with the other palliative care providers.

Enhanced community care provision in Barnet and Enfield

NLH is working in partnership with Macmillan Cancer Support to pilot a model of care that provides greater choice and flexibility following out of hospital care; a rapid response service that supports patients in a crisis; a service that has the ability to support patients earlier on in their pathway and the development of a befriending and good neighbour volunteer service that reaches out into the community

The Rapid Response Health Care Assistants for End of Life care who are part of the Macmillan Specialist Care at Home project have already made a significant impact on caring for patients and their families in the Community. Since August they have been called out to over 70 visits which range from sitting with dying patients for a number of hours or providing urgent hands-on care when patients and families are in a crisis, or being asked to take urgent 'bloods' for patients who have acute symptoms. This is a positive start and although it is in the early stages of evaluation, it is already demonstrating the need for a rapid response service for those patients who are in the unstable or dying phase of their illness in the Community.

Outpatients and Therapies Service (formerly known as Day Services) developments

NLH opened a new and different model of Day Services in Enfield in 2012 to provide a bespoke programme of care for patients with specialist palliative care needs and their carers. On referral following an assessment of need, a flexible time limited individual programme is agreed. Opportunity is provided for those who have completed their planned programme and have been clinically discharged from the service, to attend social drop in sessions.

In 2014 - 2015 in response to stakeholder feedback, the referral criteria were broadened to include those who continue to experience challenges (physical, psychological, emotional, spiritual), as a consequence of having had treatment and those continuing to live alongside a potentially life-limiting illness, 'Survivors'.

In addition, in June 2014 Day Services also reopened at the North London Hospice in North Finchley. Following a review of the service, the name changed to Outpatients & Therapies Service (OP&T) to better describe the service.

Cessation of use of Liverpool Care Pathway

NLH's adapted IPU version of the Liverpool Care Pathway (LCP) and its use in the community was stopped in the summer of 2014 following the recommendation of More Care Less Pathway (2013). The Five Priorities for Care of the Dying recommended in One Chance to Get it Right (Leadership for the Care of Dying People, 2014) are the basis of good palliative care and have always been central to NLH's care. On the IPU the adapted LCP has been replaced by the adapted Intentional Care Rounding tool which includes a minimum 2 hourly review and documentation of dying patients' needs which includes assisting with nutritional and hydration needs or the giving of mouth care if more appropriate. A new Care After Death document which was redrafted from the After Death Care section of the LCP has been introduced to ensure effective administrative tasks are completed, for example that involved professionals are notified of the death. These are linked to new Verification of Death and Care After Death of a Patient on the IPU policies. NLH's Practice Educators, through their work with over 40 care homes across six boroughs undertaking the Gold Standards Framework (GSF) Care Homes Programme, promote individualised care planning using the GSF Minimum Protocol as a guide.

Triage Service

From December 2014, the management of referrals was reviewed. All referrals for all services offered by NLH now come through Triage Service. Triage developed a direct contact with referrers, patients and/or their carers. Patients are receiving more timely and effective care from appropriate services through more integrated NLH service provision and improved signposting of referrals to other services.

Compassion in Practice

Compassion in Practice, the national strategy for nurses launched in 2012, is reviewed regularly by NLH's nursing and facilities group. It has led NLH to benchmark itself against national nursing and quality improvement initiatives. The following are some examples. The NHS Institute for Innovation and Improvement's Fifteen Step Challenge led to improvements in front of house volunteer training, as well as in presentation of areas on view to users and the public. A bid was made to Nursing Technology Fund. Though unsuccessful, this process highlighted NLH's clinical IT development needs which will be sought from other fundraising streams. User information boards introduced in front of house area. Comment cards were amended to include prompts for suggestions. Patient case studies are now presented at each

Board meeting.

Catering provision

NLH undertook a catering review which included a patient survey. Findings indicated a need to review the patients' menu (especially the supper menu) and the visitors' menu to increase variety. There had been a need to use some external agency staff which did not provide a consistent provision. It was therefore decided to outsource the catering service. In November 2014, Valeside, a specialist Hospice Catering provider working within 7 other Hospice environments, took over the catering provision at NLH. This action has enabled us to benefit from Valeside's experience gained over several hospice settings and has enabled us to improve the catering offer to our specialist client group.

IPU refurbishment

Patients and families have enjoyed the benefits of our newly refurbished Inpatient Unit (IPU), with patient rooms refreshed and upgraded to include improved lighting. Staff are finding the enlarged and re-fitted clinical rooms provide a more efficient working environment. The new hard flooring enables the Housekeeping team to ensure rooms are patient ready in a reduced amount of time. The creation of therapy rooms in our OP&T suite enabled us to convert an existing therapy room into an additional ensuite patient bedroom increasing our number of rooms to 18, allowing us to care for a greater number of patients and their families on the IPU

Nursing Workforce Competencies

The Education Department has been working with the IPU, Community Teams and OP&T Departments to develop nursing competencies for all NLH nursing and care staff. The purpose of the competencies is to aid the development of high quality nursing care. The competency model will be used alongside the nurses' Personal Development Reviews.

PARTNERSHIP WORKING

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

1. NLH is actively involved in local End of Life Boards which work in partnership to achieve local end of life strategies and share best practice.
2. Clinicians attend General Practice Gold Standard Framework meetings which review the care of end of life patients being cared for by individual practice teams.
3. NLH is part of PallE8 a specialist palliative and end of life care expert group for North Central and North East London.
4. NLH is a member of Enfield Dementia Action Alliance
5. NLH is providing specialist palliative care input into Barnet Clinical Commissioning Group (CCG) 'Frail Elderly Multi Disciplinary Team (MDT)'. The initial pilot demonstrated

effectiveness at reducing unnecessary admissions and improving coordination and quality of care. NLH's involvement is to continue.

6. NLH participates in London Cancer's Psychosocial Forum and is involved in the Carers stream. NLH facilitated an event in February on "Illness and Its Meaning" for forum professionals.

7. NLH User Involvement Lead is a member of Enfield Healthwatch's Reference Group

8. In 2013, NLH embarked on some early work with local hospices to benchmark IPU incident data for falls, pressure ulcers and medicine errors. Challenges identified at this stage were around consistency between hospices of how such data is collected and the lack of data analysis resources within small independent hospice organisations. This inter hospice group has however proved invaluable in sharing good practice. Hospice UK (previously Help The Hospices), the national organisation for hospices, has initiated a national benchmarking exercise which NLH joined and has been sharing data in 2014-15. Similar data challenges remain to our local early benchmarking as well as a new challenge of how to interpret differences with small individual hospices' data. NLH plan to employ a new post of data analyst to support this and similar work.

9. NLH's Assistant Director-Quality is working with the Royal College of Nursing (RCN) on two streams: on a Task and Finish Group developing a national nutritional and hydration care resource for nurses and health care assistants (following the recommendation of More Care Less Pathway) and representing the RCN in the Royal College of Physician's review of the National End of Life Audit for Hospitals.

10. NLH is part of the Barnet Integrated Locality Group which aims to deliver care using an Integrated multi-disciplinary approach. Currently, NLH is there in a specialist advisory role to help shape the needs of the model.

11. NLH is working in partnership with Macmillan Cancer Support in its community care provision as detailed.

12. NLH is working with North Middlesex University Hospital, Whittington Health, Marie Curie Cancer Care and St Joseph's Hospice in provision of services in Haringey, also detailed previously.

13. OP&T has developed links in Enfield with two local primary schools, Firs Farm and Highfield. Choirs from both schools have sung to patients at OP&T for the last two years in the run-up to Christmas. Pupils and staff from both schools have also participated in two very successful Art Projects with OP&T patients, facilitated by our Art Therapist and a Volunteer. The project enabled Year 5 and 6 pupils to gain an understanding of different people's lives and experiences, helped dispel anxiety or fears they may have about death and dying and gained an understanding of the services provided by a hospice. NLH patients reported thoroughly enjoying working with the children and found the project 'energizing'. Schoolchildren have raised funds for the Hospice, e.g. running a cake stall at school. Parents have also raised funds and some have expressed an interest in volunteering.The Schools' Art programme continues with a new project in Finchley in April 2015. This will be a collaboration between NLH and our neighbour, the Dwight School.

14. The NLH Education Department works with the University of Hertfordshire, providing placements for their student nurses. One of our Practice Educators sits on the University's Fitness to Practice panel, which assists the university when a student nurse's fitness to practice is called into question e.g. if their behaviour or health raises a serious or persistent concern.

15. Involvement in Pan London End of Life Network meetings. There are several strands to the Network and NLH has particularly been involved in the London Social Care Partnership and have contributed to the development of a charter that local authorities are being asked to sign up to - to deliver standards around commissioning, training and service content around end of life. Skills for Care are also part of the Network and NLH are on the Volunteer Sector Executive Group. The purpose of this group is to identify how there could be a useful and coherent contribution by the very large and diverse voluntary sector around end of life. Initially, it has tasked itself to influence the response to bereavement in the work place across all sectors.

16. The Enfield Community Team Social Worker is now the secretary of the Association of Palliative Care Social Workers and NLH organised a session on the subject of "Mediation in End of Life Work".

EDUCATION AND TRAINING

NLH delivers for external professionals

- A bi-annual 'Introduction to Palliative Care' course aimed at trained nurses and allied health professionals and runs over four days.
- A bi-annual 'Introduction to Palliative Care' course aimed at Health Care Assistants and Support Workers and runs over two days.
- Monthly syringe driver training, assisting nursing homes and district nurses to become familiar with the new CME T34 syringe driver.
- Three times a year we run a session for King's College Medical students, providing them with an insight into palliative care and the role of the hospice.
- As a Gold Standards Framework regional centre for end of life training for care homes, the Hospice has completed three training programmes for over 50 care homes in the boroughs of Barnet, Enfield, Haringey, Tower Hamlets, Hackney, Newham, Camden and Islington. For the homes in the three boroughs we serve, we are now providing facilitation to help them become accredited GSF homes.
- Bespoke training for care homes.

New this year:

- We have run a new course this year, 'End of Life Care and Dementia' that has been attended by 30 internal and 53 external delegates.
- The Hospice now runs Sage & Thyme, foundation level communication training that has been attended by 28 internal and 47 external delegates, held on alternate months.

NLH provides a variety of training placements for:

- Speciality Registrars from Local Educational and Training Board (LETB) - Health Education North Central and East London and Senior House Officers from Barnet General Practitioner Vocational Training Scheme
- Student nurses with the University of Hertfordshire
- Social work student placements with London South Bank University

- Half & one day hospice placements for final year medical students
- Chaplaincy placements
- Work experience for 16 and 17 year-olds wishing to apply for nursing, medical or allied health professional training.
- Erasmus students (European students), one of which said:
  "I feel very privileged to have been given this opportunity to work at the Hospice. For me, it's about the personal relationship between a medical professional and a patient, providing care at a hospice you really feel that personal link ... I now know that palliative nursing is what I want to do with my life."

Induction and Mandatory Training for NLH Staff and Volunteers:

NLH provides an induction programme for NLH new staff and volunteers as well as annual mandatory training. To make this training more accessible and flexible, much of it is now done by e-learning. Additional internal training is also provided for staff.

CARE ENVIRONMENT

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

SERVICE ACTIVITY DATA

NLH sets itself annual targets on activity, some of which are included in the following tables in brackets e.g. first table IPU admissions (NLH target 330). The targets relate to 2014-15 activity only.

In Patient Unit (IPU)

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

ALL ADMISSIONS	2011 TO 2012	2012 TO 2013	2013 TO 2014	APRIL 2014 TO MARCH 15			
				BARNET	ENFIELD	HARINGEY	TOTAL
Admissions to the IPU:							
Patient Admissions (NLH target 330)	304	313	314	166	108	21	295
% Patients with cancer	90%	89%	86%	91%	97%	100%	93%
% Patients with non cancer	10%	11%	14%	9%	3%	0%	7%
Completed in patient stays:							
Total of Completed Stays	327	357	345	162	99	27	288
Total number discharged home (inc care home)	82	89	82	23	24	8	55
Discharged to acute	12	4	7	2	0	1	3
% patients returning home	25%	25%	24%	14.2%	2432%	29.6%	19.1%
Total number of patients who died	233	264	256	139	75	20	234
% patients who died	72%	74%	73%	85.8%	79.8%	70.4%	80.9%

Average length of stay (NLH target 14)	14	12.6	13.3	14.6	15.1	12.3	14.(13.6*)
Day Cases	4	9	8	1	1	0	2

*Average length of stay includes one patient who was in the Hospice for 120 days who died in April 2014 and another patient who stayed for 130 days and died in January 2015. If these patients are excluded from the figures the average length of stay is 13.6

Analysis:

There were slightly fewer admissions this year with 295 versus 314 in 2013-14. Of these admitted patients there was an increase in patients cared for with a cancer diagnosis (86% in 2013-14 to this year's 93%) versus those with a non cancer diagnosis. There was an increase in the percentage of patients who died during their admission to the IPU with 80.9% of completed stays ending in the death of the patient. However nearly 1 in 4 (19.1%) patients was discharged home. The average length of stay remains fairly constant when adjusted as discussed above.

Comment:

The fewer admissions this year (versus previous years) and not reaching NLH's target of 330 IPU admissions, could be attributed to a decrease in available bed days due to IPU refurbishment, more patients staying longer including two patients staying 120 days and 130 days.

The increase in patients dying during their admission may be attributable to an ongoing trend of patients referred being sicker and fewer patients admitted for respite care.

Bed Usage

ALL ADMISSIONS	2011 TO 2012	2012 TO 2013	2013 TO 2014	APRIL 2014 TO MARCH 2015			
				BARNET	ENFIELD	HARINGEY	TOTAL
Bed Occupancy (NLH target 75%)	73%	73%	73%	45.5%	29.4%	6.3%	81.3%
Closed bed days: Refurbishment							596
Closed bed days	156	85	116				75

9% of beds were closed for refurbishment during the twelve months

Analysis:

Bed occupancy percentage has increased from 73% in the last three years to 81.3% this year. As described under Key Service Developments of 2014-15, the IPU underwent a

significant refurbishment which involved all rooms and in patient areas. This accounted for 596 closed bed days. In addition this year there were 75 closed bed days which is less than in 2013-14 and 2011-12 but the same as 2012-13.

Comment:

The bed occupancy increase may be due to the newly refurbished rooms being easier to clean, the hygiene technician's spread of hours of work having been increased and taking more planned admissions at the weekend.

The reason for closed bed days prior to the refurbishment (between April-September 2014) were deep cleaning requirements of rooms where patients with MRSA have been cared for. Other issues included electrical and plumbing issues and electric hospital bed equipment failures.

Outpatients & Therapies Service

	2013 TO 2014	APRIL 2014 TO MARCH 2015			TOTAL
	ALL PATIENTS	BARNET	ENFIELD	HARINGEY	TOTAL
Total number of Patients	184	115	108	20	243
Patient Attendances (NLH target 1665*)	927	490	721	105	1316
Patient Did not Attend		280	513	97	890
% patients with cancer	88%	75.3%	90.9%	95.75%	82.9%
% patients with non cancer	12%	24.7%	9.1%	4.25%	17.1%
Nursing and Therapies session (NLH Target 3300)	621	280	477	62	819
Complementary Therapy session-patient	1638	386	594	116	1096

Description of Data Fields:

Nursing and Therapies activities are any other care provided by Hospice staff and volunteers including Physiotherapy, Spiritual Care, and Nursing; Psychological Therapy (includes Psychology, Art Therapy and Music Therapy).

Analysis:

There has been an increase in total number of patients seen in OP&Ts from 184 in 2013-14 to 243 and a similar increase in patient attendances. More patients were cared for with a non cancer diagnosis 17.1% compared to 12% last year. There has been an increase in Nursing

and Therapies sessions and a decrease in number of complementary therapy patient sessions compared to last year.

Comment:

The number of patient attendances (1316) did not reach its NLH target of 1665 despite a OP&TS Service Promotion programme amongst health professionals. The service wanted to offer more complementary therapy sessions than the existing volunteer complementary therapist model could offer so the Board agreed to appoint a new funded Complementary Therapy Coordinator. The post holder took up post in February 2015 and will enable the organisation to develop the service through amending the level of post registration experience that Complementary Therapy volunteers require as the post holder will provide mentoring, training and supervision of the volunteers. The coordinator will also maintain a caseload, providing a sustained level of service availability.

Community Teams Highlight information

	2011 TO 2012	2012 TO 2013	2013 TO 2014	APRIL 2014 TO MARCH 2015			
				BARNET	ENFIELD	HARINGEY	TOTAL
Total number of Patients	1237	1265	1251	588	517	194	1299
% Patients with cancer	79%	76%	80%	81%	83%	85%	83.5%
% Patients with non cancer	21%	24%	20%	19%	17%	15%	16.5%
Completed periods of Care	864	930	851	525	447	84	1056
Patients discharged from the Service	147 17%	158 17%	179 21%	93 18%	102 23%	20 24%	215 21.5%
Number of Patients who died within the Service	717 83%	772 83%	672 79%	432 82%	345 72%	64 76%	841 79%
Died (%) at home (care home)	56%	55%	58%	56%	64%	59%	59%
Died (%) hospice	24%	22%	21%	22%	14%	9%	18%
Died (%) hospital	19%	20%	20%	17%	21%	23%	19%

Died (%) other	1%	3%	1%	5%	1%	8%	4%
Average number of Visits and Telephone Calls made by the Community Team to each patient during office hours							
Visits	5	5	5.1	5.2	6.	3.2	5.2
Phone calls to Patient/Family	16	12	12	14.6	16.5	8.8	14.9
Phone calls to other professionals	9	12	8	10.8	10.4	5.5	9
Average number of Telephone Calls made out of hours and at weekends to each patient							
Phone calls to Patient/Family	0.5	3	2	0.4	0.3	0.1	0.3
Phone calls to other professionals	0.6	1	1	0.3	0.5	0.1	0.4

Analysis:

The total number of patients cared for by the community team has increased to 1299 from 1251 in 2013-14. There has been a similar percentage of cancer patients (83.5% v 80%) versus non cancer this year compared to last year. The home death rate of patients cared for by the community team is 59%. The average number of visits per patient has remained fairly constant at 5.2 with a higher percentage of phone calls to the patient/family (14.9 versus 12) and professionals (9.8% v 8.5) than in the previous two years.

Comments:

This shows demand for the service continues to increase. The improvements in activity have been achieved despite significant vacancies. It is recognised that community staff prioritise patient care need over the other components of the specialist role e.g. audit and teaching. As vacancies are recruited to, this will be readdressed. Staff have worked smarter with the use of a first assessment pro-forma and experienced administrators are working more proactively to support the Community Nurse Specialists (CNS). The home death rate is increasing year on year and may be attributed to the PCSS and increased awareness of the team and external partners of advanced care planning.

Palliative Care Support Service (PCSS)

	2011 TO	2012 TO	2013 TO	APRIL 2014 TO MARCH 2015

	2012	2013	2014	BARNET	ENFIELD	TOTAL
Total number of Patients (NLH target 400)	188	241	278 (277)	134	145	279
% Patients with cancer	82%	83%	81%	81%	82.4%	82%
% Patients with non cancer	18%	17%	1 (19%)	19%	17.6%	18%
Total hours direct care (NLH target 14589)	8339	9497	16244 (14278)	6286	8699	14985
Home death rate						97.5%
Average hours direct care per patient	44	39.25	58.4 (51.55)	47	60	53.7

Please note in 2013-14 the difference in figures provided in brackets and out of brackets demonstrates the influence of one complex patient cared for on the |PU that also required PCSS nursing care hours. Total year figures are provided out of brackets.

PCSS CARE PROVIDED FOR EACH BOROUGH APRIL 2014 TO MARCH 2015			
	BARNET	ENFIELD	TOTAL
Total hours of care	6286	8699	14985
Health Care Assistants	5813	7578	13391
Registered Nurses	473	1121	1594

Analysis:

It is noted that similar number of patients (279 v 278) were cared for by PCSS this year compared to 2013-14 but more hours of direct care were given (14985 v 14278)

Comment:

This service is delivered within separate NHS commissioned budgets from Barnet and Enfield. It is considered that the complexity of patients referred and the realisation of the volume of

hours of care required to support a patient at home is increasing. This explains the decrease in numbers cared for but the increase in total hours. The high home death rate of 97.5 % (n=158) demonstrates the impact that funds allocated for hands on nursing service contributes to enabling patients to die in their preferred place of death where that is home. The community district nursing services appear to have embedded the use of the service for palliative care crisis and end of life care in their practice.

Supportive Care Team

	APRIL 2014 TO MARCH 2015			
1. Spiritual Care Team (IPU)	BARNET	ENFIELD	HARINGEY	TOTAL
Number of clients in the In Patient Unit	166	108	21	295
Number of clients seen by the Spiritual care Coordinator	123	77	22	222
Number of contacts by Spiritual Care Coordinator	330	215	45	590
Average number of contacts by Spiritual Care Co-ordinator	2.7	2.8	2.0	2.65
Number of clients seen by the Spiritual Care chaplains	101	85	22	208
Number of contacts by volunteer IPU chaplains	696	549	135	1380
Average number of contacts by volunteer IPU chaplains	6.9	6.5	6.1	6.6

	APRIL 2014 TO MARCH 2015			
2. Social Workers Team (IPU and Community)	BARNET	ENFIELD	HARINGEY	TOTAL

Number of clients seen by Social Workers	290	209	58	557
Number of face to face visits by Social Workers	624	352	126	1102
Number of Telephone Contacts by Social Workers	1803	872	194	2869
Average number of contacts by Social Workers	8.4	5.9	5.5	7.1

3. Loss and Transition Service (including Crimson Volunteers)	APRIL 2014 TO MARCH 2015			
	BARNET	ENFIELD	HARINGEY	TOTAL
Number of clients seen by Staff	206	167	26	399
Number of visits made by Staff	505	375	62	942
Average number of visits by staff per client	2.5	2.25	2.4	2.4
Number of clients seen by Volunteers	61	48	12	121
Number of Volunteer Sessions	571	499	83	1153
Average number of sessions by Volunteers per client	9.4	10.4	6.9	9.5

Client=patient or significant others

Analysis:

This is the first year that full data is available so comparison is not possible with previous years.

Comment:

This data shows the significant contribution the Supportive Care Team make to the multidisciplinary care provided by NLH to its users. This ranges from specialist professional support provided by the Spiritual Care Coordinator, Specialist Social Work staff as well as Loss and Transition Staff who offer bereavement support for more complex situations. The team has the expertise to provide more complex psychosocial interventions to patients and families; this includes young people and children in the patient's family. The Social Work Team saw 557 clients with an average of 7.1 contacts. The Spiritual Care Team provides a safe space for patients and family members to explore many of the deep and difficult

questions associated with dying. They make no assumptions about a person and there is no expectation that a person is or ought to be religious. The key question is: how does this person make sense of their illness? What do they need in terms of support? The team never provides 'ready made' answers, but accompanies each person on their journey to find their own answers. Respect, compassion and genuineness are key to this person-centred expression of Hospice care. 295 clients were seen and received on average 2.65 contacts by the Spiritual Care Coordinator and 6.6 by the volunteer IPU chaplains. The Loss and Transition service (see appendix 1 for service role description) saw 399 clients with an average of 2.4 visits by staff and 9.5 sessions by trained volunteers.

SERVICE USER EXPERIENCE:

NLH remains committed to listening to the views of patients, relatives, carers and friends across all of its services. Since 2011 NLH has been sending out Annual User Surveys. Comments cards remain in use. In the autumn of 2014, NLH started to log compliments making data available to meet CQC pre inspection requests. Since 2012 NLH has been gathering patient stories to add richer narrative data to our user feedback. These have enabled us to gain more up to date feedback and as they are not anonymised and enables us to take immediate positive action where needed. This is known as real time reporting and is an area we plan to develop further in 2014-15 with new external funding for real time reporting software and devices.

The following are key performance measures NLH rates itself against.

QUALITY AND PERFORMANCE INDICATORS	QUALITY AND PERFORMANCE INDICATOR(S)	THRESHOLD	OUTCOME 2012-13	OUTCOME 2013-14	OUTCOME 2014-15
Service User Experience	% of patient/carers satisfied with the service	80%	100% (n=87) rated care as satisfactory and above	99% (n=102) rated care as satisfactory and above	99% (n=117) rated care as satisfactory and above
Service User Experience	% who would recommend service to friends & family	80%	98% (n=85) would recommend service to friends & family	98% (n=103) would recommend service to friends & family	98% (n=119) would recommend service to friends & family
Relatives Experience	% of patient/carers satisfied with the	80%	100% (n=138) rated care as	99% (n=116) rated care as satisfactory	98% (n=107) rated care as satisfactory

	service		satisfactory and above	and above	and above
Relatives Experience	% who would recommend service to friends & family	80%	99% (n=216) would recommend service to friends & family	98% (n=119) would recommend service to friends & family	99% (n=104) would recommend service to friends & family

Surveys:

239 (31%) survey responses (similar to previous years) were received from the total of 761 sent to:

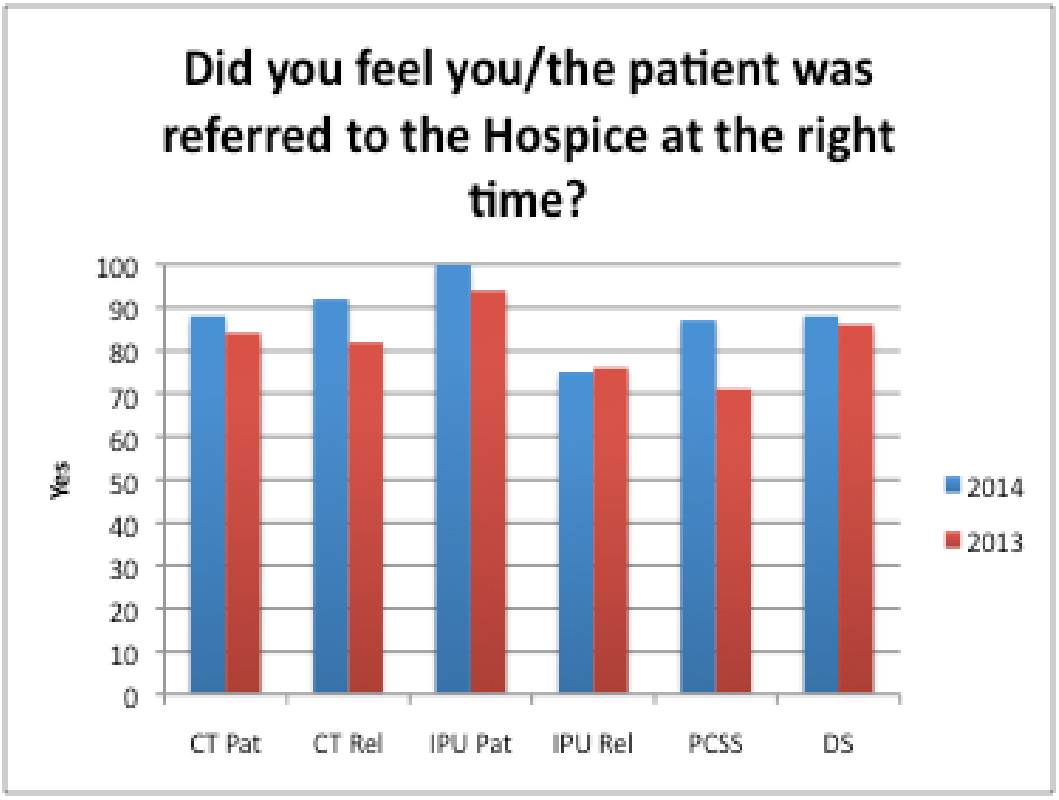
- Community Team patients (CT)
- Relatives/carers of Community Team patients (CT Rel)
- Inpatient Unit patients (IPU)
- Relatives/carers of Inpatient Unit patients (IPU Rel)
- Relatives/carers of patients who used the Palliative Care Support Service (PCSS)
- Day Services (DS) patients

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

Key Performance Indicators

The following three Key Performance Indicators are measured in our annual surveys:

Key Performance Indicator 1


Did you feel you/the patient was referred to the Hospice at the right time?
Yes
100
90
80
70
60
50
40
30
20
10
0
CT Pat
CT Rel
IPU Pat
IPU Rel
PCSS
DS
2014
2013

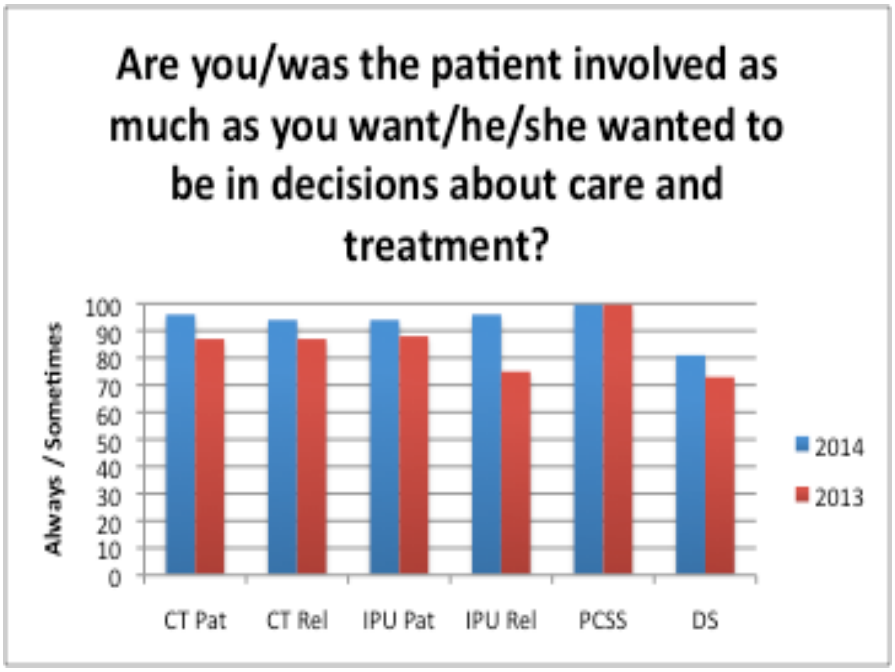
2014

CT Pat	88%	N=64
CT Rel	92%	N=47
IPU Pat	100%	N=16
IPU Rel	75%	N=21
PCSS	87%	N=26
DS	88%	N=30

Analysis:
100% of IPU patients felt they were admitted at the right time, whereas 75% of IPU Relatives felt the admission came at the right time. The remaining 25% all felt that their relative had not been admitted soon enough. 2 Community patients and 2 Community relatives felt that they/the patient had been referred too soon.

Comment:
An improvement in these results is shown in all groups compared to 2013 results, except for IPU Relatives where this is slightly lower at 75%, (n=21). The relatively low IPU Relative response has been raised with the community and hospital teams that refer patients to NLH to try and improve this and also highlighted to NLH's own triage department.

Key Performance Indicator 2



2014

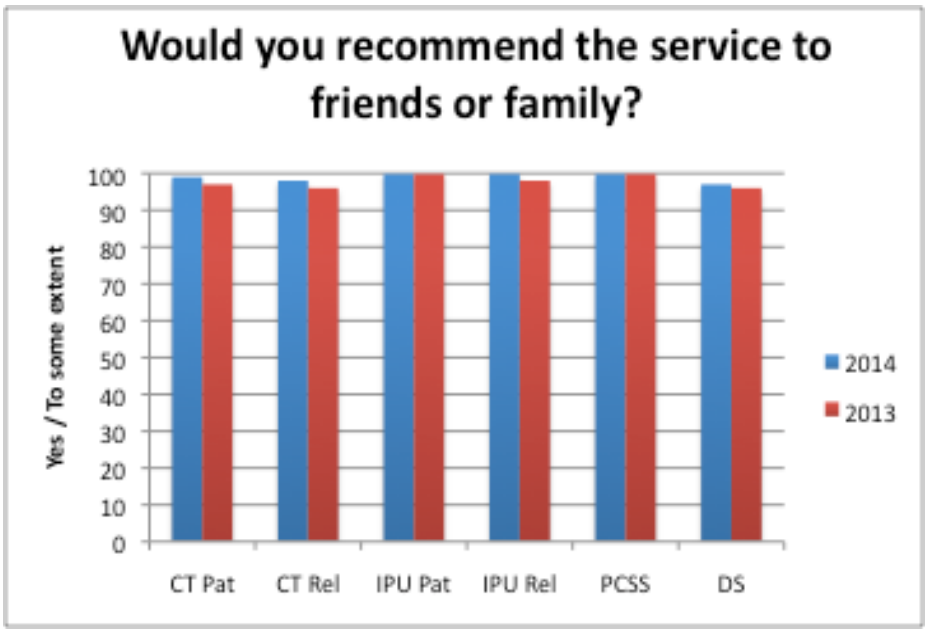
CT Pat	96%	N=67
CT Rel	94%	N=51
IPU Pat	94%	N=15
IPU Rel	96%	N=26
PCSS	100%	N=31
DS	81%	N=25

Analysis and Comment:
2014 has seen an increase in positive responses. One DS patient and one CT relative responded 'Never', however we cannot determine if they felt they wanted to be more or less involved.

The Day Services' team expected their result of 81% to be higher as all patients are informed about what is on offer on their first visit. There is currently no specific leaflet available as it is being updated to reflect the change to Outpatient and Therapies. The team will improve collaborative decision making around planned programme relating to goals.

Key Performance Indicator 3 - NHS Family and Friends test

This question is for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E. The Hospice has included this question to all services since the first surveys in 2011.



	CT Pats	CT Rels	IPU Pats	IPU Rels	PCSS	DS
2014 n=	74	49	15	26	29	30

Analysis and Comment:
The average of all services has increased from 98% in 2013 to 99% this year. CT Patients, CT Relatives and DS Patients all had one reply of 'Not Sure' to this question.

Survey Comments:

"I was never in this situation before so I would not have a clue how to go about it without help; I could have written pages about the help we got. But I

am not in the right state now, but thanks for everything that the PCSS has done for us: we value every minute of it and appreciate much."

"Patients' food needed a greater variety and improved quality and presentation. Closer monitoring of agency staff, regarding drug rounds, e.g. I found on a couple of occasions, tablets trying to be given when patient had just woken up, and wasn't quite with it. This was unsuccessful and distressing. This was not the norm. It only happened twice while I was there"

North London Hospice (NLH) Response to this User Feedback:
Catering provision is now provided by Valeside, a specialist Hospice Catering provider. Only 19 hours of agency nursing staff were used in 2014-15. NLH has recruited additional nursing bank staff in order to mitigate the use of agency staff.

"The volunteers are highly motivated, caring and outstanding!"

"It has felt very important to find the Hospice. - I now feel I have somewhere "I" not just my cancer is being taken care of. Sadly hospitals don't really understand the importance to feel emotionally held."

"I didn't know what to expect because I didn't know they [Community Team] existed until about 2 weeks ago. I am very impressed & I think they do an amazing job and I am very grateful."

Comment Cards & Emails:

Total received 101

Finchley based services: 80

Themes: High quality of care, kindness of staff, suggestions for fundraising, 2 separate comments about noisy relatives.

"Thank you for all your help with my dad. You made us all welcome. Thank you for making us feel that it was a home from home. Thank you all for the care you showed my dad and my family."

"Families of 10-25 at a time, taking over, being loud, rude and inconsiderate, eating fish and chips and generally encroaching upon the grief of others are really upsetting and all but negate the otherwise excellent service of the Hospice (patient visitor)."

North London Hospice (NLH) Response to this User Feedback:
All visitors can use the space provided - Front of House (FOH) Volunteers /FOH Co-ordinator will manage the area. This is a scenario we use in the FOH training and volunteers should be able to take steps to manage this situation. It will be discussed in the next FOH meeting.

Enfield based Services: 21

Themes: Good welcome, friendly, kind, negative comment about meditation session, positive comments about the Ceremony of Remembrance

"To all the wonderful and caring people who since my coming to the Day Service Unit at Enfield. I was made so welcome by all of you, smiling all of the time, making me feel so good from day one. Thank you is so small a comment to you all on my visits, you will always be very special to me. For all that you wonderful people did during my time with you, your kindness, and wonderful way you have treated me. Thank you Joe, John for bringing me from door to door, not forgetting Peter."

"I went to the meditation group a few times which I quite enjoyed but the last time I went, there was quite a lot of religion involved which I didn't like so I'm trying the art instead"

North London Hospice (NLH) Response to this User Feedback:
Review meeting held with meditation group lead.

"I have had an excellent time. I was grateful to attend the physiotherapy and art therapy sessions. Thank you."

"Last week, before I came here, I just wanted to end it all – there was no point in carrying on. I told my CNS and she thought I should come in here – thank goodness she did."

Example: My wife had been in Chase Farm and came home. It was the weekend and she was in pain. …Everywhere was shut… I was so worked up and then rang NLH. The lady there said I sounded so stressed that she was coming straight out to see me, which she did. You assessed the situation and set up the syringe driver for my wife – the weekend service was brilliant. You made a real difference even though you were only involved for an hour or two – my wife died later that night. I can't tell you how much I appreciate what you did. I could only have called an ambulance and my wife didn't want to go back to hospital."

The comments are passed to Service Management Teams (SMTs) at the end of every quarter for responses and actions.

Case Studies

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

Total number of case studies collected in 2014-15 is 22

IPU: Case Study 9 – *"Lovely building, nice food but always cold, relaxing, nice staff, fantastic care, new rooms less cosy and more clinical: reassuring: if I want something I only have to ask: Staff are excellent, volunteers lovely: The cleaners are so nice, they say "Good morning, how are you, did you sleep well?"*

Day Services: Case Study 8 – From patients: *"caring, nice to chat and meet other people instead of looking at 4 walls, lovely volunteers, From a carer : nice to have time to get my eyes tested, go to the bank etc, knowing patient is well looked after."*

Community Team: Case Study 11 – *"Lack of information given, both oral and written*

Care is good from everyone, whoever we speak to. CNS does all the leg work and knows what we need before we do!

She (CNS) does her role with a constant compassion, professionalism and with a huge heart. She always treated us like people she was interested in rather than patients she looked after."

Day Services & IPU Case Study: 1 – *"Lovely volunteers, have some live music, like to sit in the courtyard."*

The case studies are given to SMTS at least at the end of every quarter for responses and actions.

North London Hospice (NLH) Response to this User Feedback:
CT Case Study 11: Staff to be reminded of the Information Policy and Procedure which defines the information to be given out at specific events in the patient's pathway. The admin team are to ensure that packs of leaflets are available for staff to access.

See Appendix… for IPU Case Study example

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

COMPLAINTS

Quality Performance Indicator	Threshold	Outcome 2011-12	Outcome 2012-13	Outcome 2013-14	Outcome 2014-15
Number of Complaints (NLH targets less than 30)	25	31	19	34	18

Quality Performance Indicator	Outcome 2011-12	Outcome 2012-13	Outcome 2013-14	Outcome 2014-15
Investigations completed, complaint upheld/partially upheld	21	13	18	12
Investigations completed, complaint not upheld	4	1	7	0

Analysis:

18 complaints were received in 2014-15. No complaints were referred to The Parliamentary and Health Service Ombudsman. 14 related to clinical care given and 4 related to our charity shops. Of the 14 clinical care complaints, the common themes were:

- communication (2)
- managing expectation (2)
- care quality (10).

The following are some examples of actions taken following completed investigations (12) this year:

- The scope of the out-of-hours service provision is to be clarified in the Community Team Leaflet.
- Additional training for IPU volunteers, specifically around boundaries

In light of the complaints about communication received in 2013-14, the Learning and Development Steering Group have reviewed the communication training needs of NLH staff and recommended that all staff should undertake Sage & Thyme training and all nursing staff Band 6 and above should undertake Advanced Communication Skills training. 28 NLH clinicians have received Sage and Thyme training this year.

This year we have separated critical feedback from Formal Complaints.

PATIENT SAFETY

Incidents

	2011-12	2012-13	2013-14	2014-15
Total number of Incidents	207	279	250	216
Total Number of Clinical Incidents	147	168	173	152
Clinical Incidents as a percentage of total number of incidents	71%	60%	69%	70%

Analysis:

- There is a decrease in the total number of incidents for 14-15 (n=216) data compared to 13-14 (n=250) and 2012-13 (n=279).
- There are a similar number of percentage of clinical incidents of total number of incidents of 70% for 14-15 () data compared to 69% in 2013-14.

- Comparison of patient related incidents:
    - Increases noted in
        - contact with a hazard from 0 to 1
        - premises and estates from 0 to 1
        - confidentiality from 1 to 2
    - Decreases noted in
        - Admission/discharge and transfer to 3 from 5
        - drug errors reduced to 19 from 25
        - 10 errors were missed administrations
        - 1 error involved giving a prescribed medication that was not needed at the time
        - 1 wrong medication to wrong patient
        - 1 anticipatory prescription not done so delay arose when medication needed
        - 4 right drug but wrong preparation
        - 1 wrong drug administered but immediately noted and changed
        - 1 under dose of right medication given
    - Patient information reduced to 2 from 4
    - slips/trips and falls reduced to 49 from 61

A new "safeguarding" category was introduced into the incident categories this year to aid closer monitoring through governance where learning from individual cases is examined and shared. There were 6 such cases. All cases were discussed with NLH's safeguarding lead (or deputy in absence) and NLH and statutory processes were followed.

Comparison of category of clinical incidents

	2013-14	2014-15
Major	6	5
Moderate	60	53
Minor	62	68
No effect	45	26

Of the five major clinical incidents:
1 missing clinical notes of a patient.

1 RN in a care home refused to repeat a prescribed medication for a patient distressed in last few hours of life
1 patient admitted to IPU with a grade 3 pressure sore
1 patient admitted to IPU with a grade 4 pressure sore
1 patient disclosure of safeguarding issues

Falls:

	2011-12		2012-13		2013-14		2014-15	
Number of Patient related Slips/Trips/Falls (% of all incidents) (NLH target less than 65)	57	28%	60		61	24.4%	49	22.7%
Falls per 1,000 occupied bed days	12.9		13.45		13.7		9.75	

Analysis:

The number of falls per 1000 occupied bed days this year has fallen compared to previous years. This is despite having one patient who fell 9 times in quarter 1 of 2014-15 (18 % of all falls).

Comment:

Higher incidences of falls in hospices are recognised due to the deteriorating condition of hospice patients. Confusion, unsteady walking, deteriorating continence and patient's personal struggle to accept the limitations of their illness are common contributory factors. NLH has safety measures in place to prevent and minimize the impact and frequency of these and is committed to ensuring best practice. This year the introduction of Care Rounding reported on page… may have contributed to a reduction in falls. NLH's Falls Policy and Procedure and Bedrails Policy were reviewed this year alongside a new assessment process combining manual handling and bed rails assessment and an amended falls assessment tool and patient information leaflet. NLH's physiotherapist now reviews all falls incidents. This ensures a consistent objective review of falls incidents, monitoring of adherence to policy and procedure and ensures patients reviewed by physiotherapy service.

Pressure sore monitoring and reporting

Summary of pressure sores reported April 2014 to end of March 2015

	2013/14		2014/15	
	UNAVOIDABLE	AVOIDABLE	UNAVOIDABLE	AVOIDABLE
Developed Grade 3 more than 72 hours of admission	9	0	6	0
Pressure Sores developed Grade 3 more than 72 hours of admission per 1000 Occupied Bed Days*	2.02	0	1.3	0

*Occupied bed Days April to March= 4727

Explanation:

NLH's services and governance systems scrutinise pressure sores that develop 72 hours after admission to NLH IPU. It is agreed nationally that the most likely cause of such pressure sores relates to care provided within the healthcare setting the patient is in i.e. NLH. The identification of such sores is reported through NLH's incident process as well as externally to local tissue viability nurses and Safeguarding teams. NLH has introduced in-depth case review called "Root Cause Analysis" or abbreviated commonly to "RCA" which are undertaken in house and scrutinised by NLH's governance systems described in Part 3-Quality Systems and Appendix Three. A judgement was made by the investigator leading the RCA as to whether the pressure sore development was considered avoidable or not. Please see Appendix 4 for definition of avoidable and unavoidable pressure sores.

Analysis:

There have been less grade 3 or 4 pressure ulcers this year compared to 2013-14. 5 of the above were grade 3 pressure sores. 1 was a grade 4 pressure sore. All were reviewed and deemed "unavoidable". This could be equated to a decrease in admissions however there has also been an increase in IPU bed occupancy.

Comment:

This year, through the Hospice UK In Patient Unit Quality Metrics work, we have been able to benchmark acquired grade 2 and above pressure sores incidence with other similar size hospice IPUs. The available data for the first three quarters show NLH IPU population has a lower incidence of avoidable pressure ulcers (0 vs 3.8, 6.9 & 9.9 per 1000 OBDs) in Quarters 1/2/3 when compared to similar size hospice IPUs. However, NLH has a higher incidence of total pressure ulcers per 1000 OBDs of hospice acquired grade 2 and above pressure ulcers (4.5 compared to 2.7 in quarter 3). NLH are not able to ascertain why this is so but will continue to monitor and ask the question 'why?'

Infection Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2011-12	NUMBER 2012-13	NUMBER 2013 -14	NUMBER 2014-15
The number of patients known to be infected with MRSA on admission to the IPU	2	4	3	7
The number of patients known to be infected with Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission to the IPU	0	0	2 with known Clostridium Difficile	1 patient known to have Vancomycin Resistant Enterococci
Patients who contracted these infections whilst on the IPU (NLH target 0)	0	0	0	0

NLH notes patient's infective status on admission and tests where clinically indicated. The clinical team agrees, on an individual basis, what is the most appropriate treatment plan, if any, depending on the patient's condition. During 2014-15 there were no cases noted where patients contracted reportable infections whilst on the IPU.

PRIORITIES FOR IMPROVEMENT PROJECTS 2014-15

The following priorities for improvement for 2014-2015 were identified by the clinical teams and were endorsed by our internal governance structures.

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

Priority One: Patient Experience: "The Living Room Project"

Initial Plan:

IPU Patient A: *"The worst bit is being stuck in my room but I do get taken out for walks around the grounds in a wheelchair and I do have lots of contact with staff and volunteers."*

IPU Patient B: "I have previously been in another hospice where there was a Day Centre in the building and I could join in. It makes the place seem more lively and better than being in my room all day. It takes my mind off the pain. If I sit up I'm in pain so I can't sit and read or type for very long but if I was interacting with others I'd be more distracted and not thinking so much about how I'm feeling. I'd like to play board games. I feel a bit isolated in my room although I am used to being on my own."

We received feedback from a number of IPU patients, indicating that patients who were active and mobile were feeling isolated, lonely and bored. People staying in the IPU could previously attend the Day Centre during their stay but this service was moved to the Hospice site in Enfield during 2012. Inpatients said they would like more interaction with other patients/visitors which was reiterated by patients who attended Day Services at our Enfield site. They said that they found great benefit from meeting and being able to chat with other people in a similar position.

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

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

This was our original project plan:

TIME	ACTION PLANNED	STATUS
March 2014	Log of events in place. 6 in office hours events planned by steering group. Staff informed of project & engaged	Achieved
June 2014	6 in office hours events held and user feedback gained to develop future events programme	Achieved
September 2014	Regular events delivered according to user feedback need. Physiotherapy exercise/class started. 3 community groups to have visited and discussed how they can work collaboratively with the hospice and its users in the Living Room	Partly Achieved
December 2014	Plan for out of hours events agreed	Not Achieved
March 2015	7 further community groups to have visited. Community groups interacting with users in Living Room	Not Achieved

March-June 2014 Actions:

Steering group cascaded project plan to staff and users

Log of events commenced

Communal dining of IPU and OP&T patients and visitors with volunteers and staff commenced.

Daily (weekdays) Tea at 3pm started

Other events held:

- 8 x singers
- 1 x Magician
- Television brought out for Wimbledon/ World Cup.
- 2x Comedy DVDs played

Feedback:

"Didn't know you had events like this: lovely, a nice diversion, surprising"

"Should have more light music"

"Something to take our minds of the stress"

July-September 2014 Actions:

Tea at 3pm continued

OP&T commences social group on Thursdays

Events – 1 singer

4 Community Groups visited the Living Room

- Hornsey Girls School
- Chase Community School
- Barnet Lions
- Heroes for Helen

During this period the Inpatient Unit was undergoing refurbishment with a number of bedrooms closed. Therefore there were less visitors and access was often difficult. Because of this we offered fewer entertainment events but we continued with the weekday Tea at 3pm.

Feedback: "*Enjoyable time spent with volunteer and enjoyed the music & table games & greatly enjoyed the courtyard*."

October - December 2014 actions:

Weekend Tea at 3 commenced.

Events: - 2 music events

4 Community Groups visited the Living Room

- Sainsbury's (Head Office)
- Sainsbury's (Golders Green branch)
- Metaswitch
- Local Cubs

Feedback: "*So unexpected - didn't know something was going on. Just came out for the tea. I love this space - love to come out here."*

January-March 2015 actions:

Daily Tea at 3

Events – weekly informal harp/xylophone/piano music provided by OP&T volunteer

2 Groups visited the Living Room

- St James (Corporate Supporters)
- Representatives from Fortismere School

Feedback: "*The Living Space is nicely laid out with comfy chairs – there's no need to spend lots of money making it any better."*

End of Project Review:

Tea at 3. This gives patients and visitors an opportunity to come out of their rooms and mix with others in the Living Room space, with a complimentary hot drink and a tasty morsel. A dining table is laid out with a lace tablecloth, pretty china and homemade cakes. If there is no entertainment scheduled, volunteers will sometimes put the radio on for background noise, following positive user feedback. Tea at 3 is now firmly established and happens every day. On most days there are family members and visitors present, often along with the patient. The event is well publicised and volunteers make sure that visitors are aware of it.

"*Tea at 3 is a good idea. When I went home after my first stay here, I was thinking about coming back sometimes to have the Tea at 3."*

"The tea is very much appreciated. Lovely cake and company."

Entertainment. Music events and other entertainment are well received and we will continue to provide this. Sometimes the number of people in the audience is very low or even non-existent (depending on the patients we have at the Hospice), which we have to bear in mind when inviting artists. Following user feedback we have been trying to increase activity in the area. We have also received feedback that some people would prefer quieter spaces and not everyone wants to be 'entertained'. We are now more mindful when organising events that we also need to provide quiet places for those who require them.

"*We weren't ready for a magic show or anything similar really. We opted not to watch."*

OP&T. Volunteers encourage patients in the IPU to join in the social activities that happen every Thursday. There is a meditation group, informal art group and informal music group. We now also have a few patients that come on a Wednesday for social interaction although it is not as busy as Thursday. Patients and carers are interacting with others which encourages inpatients and their families to join in when they are able. Because of this, people from the Inpatient Unit are now using the Living Room throughout the week, not just when OP&T are operating.

"*You get fed up sitting in your room, you need something else as stimulation. I like to talk, not to play scrabble or games, just to mingle with other people. The more you mingle, you hear about other people's ailments, sometimes worse than yours and that makes you feel that things perhaps aren't that bad."*

Community Groups. We have yet to see these groups engaging with

patients and families although they are encouraged to use the area whilst these events are happening. When a school or other group is providing entertainment, then the interaction is more obvious.

Exercise class. Due to staff changes, the planned exercise class has been postponed until a new permanent member of staff has been appointed.

Challenges:

- Providing a variety of events
- Providing events out of office hours
- Facilitating IPU patients to eat together in the Living Space
- Encouraging groups to use the area and engage with patients and families

Unfortunately, despite requests via Twitter and Facebook, it is proving difficult to provide regular entertainment. We will continue to look for suitable entertainment as it is so popular.

We are currently providing entertainment on weekdays only. We made one attempt on a Sunday but as only Front of House volunteers are on duty at weekends, they have no-one to liaise with, apart from IPU staff who are busy with patient care. Despite our best efforts to ensure the event ran smoothly, it caused many problems so it was decided that we would not pursue weekend entertainment for the moment. We will look at this again at a later date. Tea at 3 is popular at the weekend.

For inpatients, outpatients and visitors, having lunch together remains popular. We had hoped to be able to offer this throughout the week, not just on the two social activity days, but currently there is still only one volunteer who seems to be able to facilitate this. This is an area that will continue to be looked at.

Conclusion:

The Living Room Space is now becoming much busier and during the day it is rare to find it empty. OP&T have brought more people and activities into the space. The two days when the OP&T Social programme is running have brought about the most change.

Because they are now meeting in the Living Space, patients from the IPU are getting to know each other and socialising, sometimes in their rooms.

We have seen many instances of patients being taken in their beds into the Living Space and the courtyard, sometimes more than one at a time, with interaction between the families.

The Living Room offers much more than space for patients and their family members to access hospice services. It allows them to offer support, care and help to one another. Many patients have commented on the positive emotional and human impact of being with others, sharing ordinary non-health-care related activities which, even for a short while, expands their world beyond sickness, back into something they want and recognise.

The work that has developed over the year will be sustained by the Front of House Co-ordinator and User Involvement Lead. We will now focus on the user experience within our open spaces at our Enfield site.

The Living Room project certainly seems to have fulfilled its mission of giving IPU patients a chance to socialise and alleviate isolation. In addition to this, other visitors are enjoying the space and using it as they wish.

"This place is lovely and the staff are all wonderful. I'm so amazed with the room and the open space. When you first come in, it's so comforting."

Patient Story: Patient has been staying in the Inpatient Unit for a couple of weeks and likes to spend time socialising in the reception/living room area.

"When I was in the Royal Free Hospital and they told me that I could come to the Hospice, I imagined that there would be dark, little cubicles there, religious statues and candles.
I got out of the ambulance and thought to myself, ' Heavens, this cannot be' – I was so surprised. I wondered what my room would be like – everywhere looked so comfortable. The staff were so friendly. You never see a nurse here with a long face. I'd not been in 5 minutes when someone came in and said "Hello". How did they know who I was so quickly?

I came out into the open area to have a look round and someone explained the outside area. The staff were very helpful and understanding. I was very hesitant and apprehensive and feeling quite 'down'. I had a few tears and said some prayers – my faith is pretty strong. After 3 or 4 days I began to relax and my spirits lifted. Being at the Hospice has given me my confidence back and I feel able to face tomorrow, when I have an appointment at the hospital.

When I first came in, the doctors took all my tablets from me. I have to take my medication on the dot or some of my symptoms start up so I rang the bell and asked for my pills that were due. Someone came along and said that they were looking at my medication now and it would be along in a moment. 10 minutes went by and still no tablets so I rang again. I got the same answer and I said that I wasn't asking for anything I shouldn't be having.

Eventually after another 10 minutes my tablets were brought to me. Luckily that hasn't happened again as I need to keep my symptoms under control.

Once I was in reception and thought I'd better go back to my room as it was time for my pills. Someone said that I should stay where I was and the nurses would come and find me and they did!

One day I went into the Room of Quiet to pray but there was a group of people talking outside so it wasn't quiet and I could hear every word. I gave up and went back to my room – that was disappointing.

When people are on their mobiles in the rooms and the door is open, it is very disturbing. Sometimes bereaved families congregate outside my room and there are children running up and down the corridor.

I like coming out into reception and talking to the receptionists.
I saw some nurses sitting at the tables, having their lunch and I thought that was a good idea and something I could do. The food is nice but never hot. The soup is always cold. I've had a cooked breakfast twice and both times it was cold.

The volunteers are very nice, even if they give me a soup spoon to eat my porridge with or forget my tea! And no-one tells me off for keep ringing the bell.

I enjoyed the harpist the other day. Would like to see a string orchestra and a film – perhaps a history of the Hospice. I wasn't going to come out for the afternoon tea today as there was a film starting on the telly, but I decided to after all.

In the open space the chairs are too close together for private conversations but it's a good idea to be able to wheel beds out into the garden.

I find it very relaxing at the Hospice and want to stay a little bit longer."

North London Hospice (NLH) Response to this User Feedback:

The following actions have been taken to address some of the points raised in this case study:

- teaching regarding importance of timing of Parkinson's medication incorporated into the ward rounds and MDTs
- continue working with the living room group to develop activities in the living room space
- New catering company engaged
- Re: Noise outside the Room of Quiet – the reception volunteers are

given training which includes scenarios about how to assess the impact excess noise might be having on other users and offering them alternative, quieter places to sit.
- Chairs too close together – We have now purchased some high back furniture which improves privacy in the area. Also the furniture can be moved around or meeting rooms can be made available for private conversations.

Priority Two: Patient Safety: To ensure fundamental care needs are met and evidenced through structured intentional care rounding and improved documentation on IPU.

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

NLH wanted to introduce this initiative to:

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

* Occupied bed days: bed is occupied by a patient at midnight

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

<u>How we hope to achieve this</u>

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

In 2014-15, NLH adapted IC checklist was to be piloted in one of two teams

on the IPU. The use of the checklist in achieving the above stated objectives was to be monitored and the value of IC for all patients on IPU evaluated in the spring of 2015.

TIME	ACTION
April 2014	Adapted tool introduced to IPU staff and planned Red Team (9 beds) three month pilot
May 2014	Pilot commences with quarterly review
August 2014	Review of pilot. The IPU was refurbished June-September 2014. This required beds to be closed in rotation; this meant that a full pilot was not achieved for the Red Side of the Unit Beds 9-17. However the Care Rounding Tool continued to be used for patients assessed as a high risk of falls or Waterlow greater than 10. The Care Rounding Tool was adapted to include assessment of agitation on 01/07/2014 and the Unit is now using Version 2.1. A review was completed in October 2014 that showed a reduction in falls comparing reported fall for Q1 and Q2 2013 but an increase in reported Grade 2 pressure ulcers, that were a combination of patients admitted with the ulcer, acquired prior to 72 hours of admission and those acquired on the unit. All have been identified as unavoidable.
October 2014	The Pilot has commenced on the Red Side of the Unit Beds 10-18, with patients at risk on the Blue Side also included. The Care Rounding Tool version 2.1 will be kept in the patient's room for completion
December 2014	Review of Pilot. Introduction of Care Rounding tool for every patient admitted to the unit from January 2015
March 2015	Final Review

Final Pilot Review.

A selection of patient records where reviewed as part of the final review of the introduction of Intentional Care Rounding on the Inpatient Unit. Each patient record that was reviewed had IC documentation in place for each day

of the patient's stay on the unit. The intended review areas including the patient's access to food and drink and mouth care showed adherence to completion of all tool prompts. However, the review of the documentation identified that not all records were 100% complete. The review highlighted that during the late shift between 8pm and 10pm completion of the documentation was more sporadic. Staffing requirements on the IPU for the late shift are now being reviewed.

Slips, Trips and Falls

In 2013/14 there were 61 patient related slips, trips and falls on the Inpatient Unit, representing 13.2 falls per 1000 occupied bed days. This figure has reduced in 2014/15 to 49 patient related slips, trips and falls equating to 9.75% falls per occupied bed days. 2014/15 has seen a 19.7% reduction in falls compared to 2013-14 data. In the first quarter of the year one patient had 9 repeated falls recorded throughout the admission despite close monitoring.

Pressure Care

There has been a decrease in Grade 3 pressure sores developed after 72 hours of admission to IPU from 10 in 2013/14 to 5 in 2014/15. However, there has been an increase in Grade 2 pressure sores developed after 72 hours of admission from 4 in 2013/14 to 5 in 2014/15.

Following the final review the IC document will be further amended so that it is documented whether the patient was in bed or sitting in a chair when the documentation was completed in order to monitor the length of time patients are sitting out of bed.

It appears that the Intentional Care Rounding is having a positive impact on the incident of slip, trips and falls and there has been a decrease in the number of grade three acquired pressure ulcers. The IC documentation will be updated and its use will continue on the IPU with ongoing monitoring of its use by the IPU Nurse Management Team.

Priority Three: Clinical Effectiveness:

Project One: Dementia care

At NLH we want to make a real difference to the lives of people with dementia and their carers by building on the National Dementia Strategy (2009) and the Prime Minister's challenge on dementia (2012).

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

Baseline:
Currently we accept referrals for patients with dementia as their primary diagnosis in addition to those with dementia as a non primary disease. Up until now, there has been no NLH Strategy in relation to meeting/responding to the increasing needs of this patient group. One of NLH's palliative care consultants has been funded to attend Barnet CCGs frail and elderly MDT pilot where a significant number of patients have dementia.

A review of NLH patient primary disease activity has revealed that in 2013-14, 60 patients, out of a total of 1409 patients seen across the Hospice, had dementia. This represents 4% of patients. Across the services, 11 of the 60 patients were seen by two services. Below is the breakdown of patients cared for by each service:

- IPU 5
- Day Services 0
- Enfield CNS 28
- Finchley CNS 26
- PCSS 12

It can be seen that the majority of patients with a dementia diagnosis are cared for by our community services.

We hope to achieve this by doing the following:

- Providing dementia awareness sessions for all staff and volunteers.
- Providing different levels of dementia training for staff according to identified needs.
- Training key NLH staff to become Dementia trainers who can then deliver further training.
- Delivering external dementia training to care homes and district nurses.
- Working in partnership with the Enfield Dementia Action Alliance initiative.
- Using the Kings Fund Dementia Friendly Assessment Tool to enable us to assess our current environment and help identify areas that need modification. We will then use this information to inform the IPU refurbishment plan. The assessment tool can then be repeated to ensure we have addressed the issues relevant to our care setting.
- Trialing a clinical assessment tool on the IPU for monitoring dementia the symptoms of dementia patients on the IPU who are unable to communicate verbally.

TIME	ACTION	April 2014 - March 2015

April 2014	Commence development of programme of 3 levels of dementia training for staff	Two of the three levels of dementia training for staff have been delivered in February & May 2014. These sessions are to be repeated in February & March 2015. Level 3 training completed in March 2015.
	NLH Dementia Group to attend Dementia Awareness Train the Trainers Course	Dementia group have now attended Train the Trainer Course
	NLH develop partnership with local and national cross sector dementia initiatives e.g. Enfield Dementia Action Alliance	NLH attend meetings of Enfield Dementia Action Alliance on a regular basis - meetings have not been attended this quarter due to clashing with other events. NLH have kept up to date with the minutes of meetings and hope attendance will be possible in the coming quarter
	NLH consultant to become Dementia Champion and attend Dementia Champion Training	Achieved and 2 practice educators have now trained as Dementia Champions and ways to incorporate Dementia Friends into existing training are being explored
	IPU Team to use Dementia Friendly Site Assessment Tool to self assess IPU and develop action plan	Completed
September 2014	NLH consultant to deliverer teaching on IPU Assessment Tool for people with dementia prior	Delayed as below, but due to commence in March/April 2015

	to trial of tool	
October 2014	Trial of IPU Symptom Assessment Tool for people with dementia	This pilot has been delayed due to staff changes on IPU, but is due to commence with new IPU leads in March/April 2015
January 2014	Effectiveness of Assessment Tool evaluated	Delayed, as above
March 2015	NLH Dementia Group to have delivered Awareness Training Sessions at 3 levels to staff and volunteers	Achieved Dementia training has been attended by 43 internal & external delegates over this year Additional and new Dementia Friends Sessions to run from April 2015 for internal and external delegates including local lay community

Of NLH's 1756 individual patients cared for in 2014-15, 122 patients' primary diagnosis was dementia. This is 7% of the total number of patients cared for. This is an increase from last year of 3%. Perhaps if this is an early outcome of raised awareness of the needs of EOL dementia patients for specialist palliative care services. NLH remains committed to responding to the needs of dementia patients. NLH's Dementia Champions will continue to review and develop the organisations approach. It will continue with its dementia training and are persuing funding opportunity from Hospice UK around Hospice Enabled Dementia Care

Project Two: Introduction of a suite of outcome tools

Project Two was amended from the introduction of the Holistic Needs Assessment (HNA) Priority for Improvement in light of two factors that are influencing the approach that the Hospice needs to take to the use and introduction of a patient outcome tool.

In June 2014, Hospice UK in collaboration with The Dame Cecily Saunders Institute introduced the Outcome Assessment and Complexity Collaborative Suite of Outcome Measures. The measures have been identified in order to support hospices in the commissioning environment and to provide opportunities for benchmarking hospice services.

NLH commenced the Specialist Palliative Care at Home project in conjunction with Macmillan on April 2014. As part of the project the service is being evaluated by Nottingham University. A number of outcome tools form part of the evaluation of the project, which will take place between January and December 2015.

It is believed the introduction of the primary alternative outcome tool, The Integrated Palliative Care Outcome Scale (IPOS), will still enable the organisation to achieve:

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

The organisation will now implement, rather than pilot, the following tools across all services/teams:

- Integrated Palliative Care Outcome Scale (IPOS)
- Phase of Illness
- Palliative Performance Scale (PPS)

Revised Action Plan:

COMPLETED BY	ACTION
September 2014	• Meeting of the Priority for Improvement Project Group to discuss the rationale for the change • Evaluation work stream for the Specialist Care at Home Project Established

October 2014	• Meeting to ascertain the IT requirements for implementation of the outcome tools
November 2014	• Commence briefing and training with staff • Commence IT development
December 2014	• Continue training and use of tools
January 2015	• Commence use of tools across the organisation • Training completed with the Barnet and Enfield Teams and the Macmillan Project as planned. • The Haringey Team joined the organisation in December and they are continuing to familiarise themselves with iCare, will look to introduce to them from April 2015 • Due to the current staffing issues on IPU, IPOS was not rolled out in January - aim to be training IPU in April/May 2015
March 2015	• Review progress with implementation • Provide final report

The outcome tools have been introduced with patients receiving care within OP&T and from the Barnet and Enfield Community Teams. The multidisciplinary staff training ensured that both clinical staff and supportive care staff were able to contribute to how the tools would influence practice and benefit patient care. Systems for administering the tools and recording have been established. The IPOS is recorded on the electronic patient database so the Multi Disciplinary Team has the ability to review patient goals and monitor if appropriate internal referrals have been made.

The roll out of the Outcome Tools within the IPU has been delayed, it is anticipated implementation will commence in May 2015. Also at this time, the Haringey Community Team will commence use of the Tools.

The next steps is to start to evaluate/analyse the data that has been captured in relation to our effectiveness at addressing patients' problems and concerns and keeping pace with best practice guidance from the Outcome Assessment and Complexity Collaborative .

NLH STAFFING

NLH employs a total of 172 regular staff and 45 bank staff. It benefits from the efforts of approximately 750 volunteers who are used as required in clinical and non-clinical roles. The Hospice has many staff working part time or flexible hours.

	2011-12	2012-13	2013-14	2014-15 April-March
Staff joined	17	38	52	54
Staff left	21	16	30	50

Comment:

Of the 54 starters this year, 33 have been clinical staff and 21 non clinical. Of the leavers 28 have been clinical and 22 non clinical.

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

- Staff Performance Development Review process and documentation continue to be rolled out across the whole Hospice, with a revised 'short form' version for certain roles (e.g. Shop Manager). Both the process and the documentation are being revised in light of user feedback.
- Embedding Staff Care, the new HR MIS, across NLH departments and activities.
- NLH's Management Development Programme (MDP4) continued (Year 4) to concentrate on specific skills. A survey of managers will be conducted to gather views on possible content for MDP5 in 2015.
- Review of all Human Resources policies and procedures.
- Information and Consultation Forum formed and involved as the consultative body in two cases of staff transfer under "Transfer of Undertakings (Protection of Employment) Regulations 2006" (TUPE) provisions; efforts are now underway to establish the Forum as a self-managing body meeting on a regular basis.
- NLH staff satisfaction survey (not undertaken since 2012)
- Staff Handbook revised and re-issued.
- Recruitment, Induction & Probation Handbook (guide for managers) compiled (nearing completion).

- The Bradford Score system adopted and sickness absence closely monitored/managed to try and improve attendance.

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

NLH Board of Trustees Quality Account Comment

The Board of Trustees of the North London Hospice warmly welcomes the fourth Quality Account. The report reflects the continued commitment to ensuring that everyone who requires access to Hospice services experiences skilled, respectful and effective care.

The year has seen a number of achievements in terms of service developments and capacity to extend the reach and impact of high quality care delivered by experienced and dedicated staff in our inpatient, day and community services. We are delighted to have extended our model of service to reach more service users in Haringey and also to have developed a productive partnership with Macmillan Cancer Support.

Once again, the Board is assured by the progress made against the priorities identified for this year. The Living Room Project in particular has had a positive impact on the experience of patients in the Inpatient Unit at the Finchley site, creating a comfortable, welcoming space that is increasingly used by patients, their families and friends. Focussing on safety, Intentional Care Rounding has introduced even more effective and systematic approaches to ensuring that patient needs are met in a timely, effective and responsive manner in the inpatient unit. This is reinforced by the introduction of consistent Outcomes Measures, that will assess service effectiveness at meeting patient's problems and concerns.

The Board welcomes the priorities identified for 2015/16 covering the domains of user feedback, improving risk management and extending the reach of services in our Outpatients and Therapies Service in Enfield and in Finchley. Volunteers will be central to the real time user feedback pilot, that seeks to be more responsive to the needs of users, and thus improving their overall experience of care. The risk management database will provide a more robust reporting system that will facilitate improved learning and responsiveness around issues of quality, safety and risk. The Board is especially supportive of the developments proposed in relation to the

Outpatient and Therapies services, welcoming approaches that will extend access to high quality services to a wider client group.

This report illustrates that the Hospice continues to serve the local community that supports its work so generously and consistently. It also illustrates the Hospice's commitment to extend its services to more people who can benefit from the high quality of care provided in all of its settings.

John Bryce
Chair
North London Hospice Board of Trustees

STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

Barnet Health and Overview Scrutiny Committee

APPENDIX ONE: OUR CLINICAL SERVICES

1. Community Specialist Palliative Care Teams (CSPCT)

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

The service emphasis is based on:

- Care closer to home
- The facilitation of timely and high quality palliative care

This is achieved by providing:

- Specialist advice to patients and Health Care Professionals on symptom control issues
- Specialist advice and support on the physical, psychological, emotional and financial needs of the patients and their carers.
- An out of hours telephone advice service

Community patients are given the out of hours (OOH) number for telephone 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 IPU. At weekends and bank holidays, a community Clinical Nurse Specialist deals with calls between 0900-1700 hours. Currently this level of OOH care is only provided in Enfield and Barnet (see plans to develop in Key Service Developments section).

2. Outpatients and Therapies -OP&T (formerly Day Services)

The service offers a planned bespoke programme for patients and their carers as follows:

- Nurse-led assessments and clinics; clinical interventions such as

transfusions;

- Psychological Therapies (Psychology, Art Therapy and Music Therapy);
- Physiotherapy;
- a range of Complementary Therapies (Acupuncture, Massage, Reflexology, Reiki);
- Informal Art and Music groups;
- Meditation and a Carers' Group;
- Hairdressing and Beauty Therapy.
- Macmillan CAB service available. Patients and carers can informally attend for volunteer-led social support, following assessment. Nutritious, low cost lunches and snacks are on offer on both sites.

OP&T is offered on both Finchley and Enfield sites and currently open four days a week. North London Hospice aims to eventually offer a five-day a week service to include an expanded Outpatient Clinic Service, as well as developing the therapeutic activities and interventions on offer.

3. Inpatient Unit (IPU)

NLH has 18 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons including symptom control or end-of-life care. As the unit is a specialist palliative care facility, it is unable to provide long-term care.

4. Palliative Care Support Service (PCSS)

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

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

The service works in partnership with the District Nurses and Clinical Nurse Specialists providing additional hands-on care at home for patients.

5. Loss and Transition Service (including Bereavement Service)

The Loss and Transition Support Service supports:

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

The support is provided by volunteers who we have trained in support skills on our Oyster Training Programme or who are qualified counsellors. This

service is in addition to that provided by our Specialist Palliative Care Staff (nurses, social workers and doctors) and is offered pre-bereavement and for up to 14 months after bereavement. This service will be developing a range of support groups on both sites. Regular Ceremonies of Remembrance and the annual Light Up A Life event commemorate those who have died.

6. Triage Service

The Triage Service comprises a team of Specialist Nurses and administrators and is the first point of access for all referrals to NLH.

The Triage Service works in partnership with other hospice services, other Primary and Secondary Care Teams and other Health and Social Care Providers.

The team provides specialist palliative care to referrers and patients with any potentially life limiting illness. Haringey are a signposting service for patients in the last year of life.

APPENDIX TWO: INFORMATION GOVERNANCE

Information Governance

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

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

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

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

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

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

The last assessment was completed in March 2015 with a score of 98%. In April we received confirmation that our assessment has been reviewed by the HSCIC and has been confirmed as satisfactory.

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

Hospice Board

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

Executive Team (ET)

ET will review NLH's Balance Scorecard quarterly.

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

Quality and Risk (Q&R)

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

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

Audit Steering Group (ASG)

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

Service Risk Register.

Policy and Procedure Group (PPG)

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

APPENDIX FOUR: DEFINITION OF AVOIDABLE AND UNAVOIDABLE PRESSURE SORES

Avoidable Pressure Ulcer:

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

Unavoidable Pressure Ulcer:

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

Department of Health, Patient Safety First (2014)

APPENDIX 5 PATIENT CASE STUDY

From the wife of a former Barnet Community Team patient.

"We first got involved with A..., our Community Nurse Specialist, through the hospital. Initially home visits weren't necessary but after a couple of months we needed her to visit.

My husband was happy for the Hospice to be involved but he was adamant that he didn't want to go into the Hospice. He thought that I would like the support that they could give. The support was excellent and it was so comforting to know that help was on hand 24 hours a day.

My husband found A... helpful. He was a proud man and very independent. He was glad of her help for me. Ayesha would always offer to come round and would give us the name of the person who was on duty at the weekend, should we need to call. She told us about things like an attendance allowance which we didn't have a clue about.

We were involved in all decisions – A... would say 'This is the next step' and then ask us what we thought. She weighed up my husband and gave just the right approach. I felt I could ask A... any question and always understood her answers – she was very good.

The Hospice helped a great deal with my husband's drugs. I could ring anytime and that gave me confidence. Someone would always ring me back. It was so important that my husband was not in pain.

A... was very helpful with my husband's medication, especially in getting the right dose. Once she was involved the GP took more notice and listened to her. It had been a nightmare up until then as the dose would be changing every couple of days or sometimes daily. I used to dread getting prescriptions. Faxes would go missing, prescriptions not there, that sort of thing. If my own GP wasn't there, the locum would always query the high dose and then I'd have to start all over again.
On a couple of occasions I was horrified by the GPs attitude.

My husband had a syringe driver fitted and then the District Nurses got involved – they all seemed to work well together.

We really appreciated the support from the Hospice and my husband passed away at home which is where he wanted to be. He didn't want to go to hospital.

I would totally recommend the Hospice. My husband could have come in but he chose not to. You don't have to be in the Hospice to get the great treatment.

I had such confidence in the Hospice – they met my needs and reassured me. I was delighted to have them involved.

I have been offered bereavement support and A... said that she would come and see me again if I needed her. I couldn't have been more pleased."

ACCESSING FURTHER COPIES

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

Or
ww.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/quality-accounts-2013-2013.aspx

HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

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

If you have comments contact:

Fran Deane
Director of Clinical Services

North London Hospice
47 Woodside Avenue
London N12 8TT

Tel: 020 8343 8841

Email: nlh@northlondon hospice.co.uk

Appendix 4 – Final Comments made by the Health Overview and Scrutiny Committee to NHS Trust for Quality Accounts 2013-14

Royal Free London NHS Foundation Trust:

The Committee scrutinised the Royal Free London NHS Foundation Trust Quality Account and wished to put on record the following comments:

- The Committee noted the high quality of care provided by the Royal Free London NHS Foundation Trust.
- The Committee welcomed the fact that the Royal Free London NHS Foundation Trust had met all of their targets, except the target on C. Difficile.
- The Committee welcomed the action that the Trust was taking in relation to working with partners to increase dementia awareness, and welcomed the fact that the Trust had a dementia lead.
- The Committee welcomed the actions being taken to improve quality in relation to dementia as a result of the National Clinical Auditor in 2013/14.
- The Committee noted that approximately a quarter of inpatients at the Royal Free London NHS Foundation Trust have diabetes, and welcomed the innovative work that the Trust is undertaking in relation to care of patients with diabetes.
- The Committee welcomed that there were zero attributable cases of MRSA at the Royal Free London NHS Foundation Trust during 2013/14, and are pleased to note that the various methods used to achieve the zero rate are being passed on to other Trusts as examples of best practice.
- The Committee welcomed that the percentage of staff employed by or under contract to the trust who would recommend the trust as a provider to their family or friends had increased from 72.6% in 2012 to 76.2% in 2013.
- The Committee noted that the Performance Indicator for the percentage of patients readmitted to the trust within 28 days of discharge for patients aged (i) 0 to 15 and (ii) 16 or over used old data, and requested that the final version of the Quality Account be updated with any available data from years 2012/13 onwards where possible.
- The Committee noted that other NHS Trusts tend to include references to complaints, and whilst noting that the Royal Free London NHS Foundation Trust would be limited by the regulator, advised that they would welcome a section on complaints in the Quality Accounts.

However, the Committee wished to express concern in relation to the following:

- The Committee noted that the rate per 100,000 bed days of cases of *C.Difficile* infection that have occurred among patients aged two and over had risen from 19.3 in 2011/12 to 30.5 in 2012/13, compared to the National Average Performance 2012/2013 of 16.3. The Committee were told that the Royal Free London NHS Foundation Trust had seen an improvement of those results over the last six months.

  The Committee note the Independent auditor's limited assurance report to the Council of Governors of the Royal Free London NHS Foundation Trust on the

annual quality report and expressed concern over the reporting that a significant proportion of the staff themselves felt bullied, under stress or discriminated against.

- That the number and rate of patient safety incidents that occurred during the reporting period October 2011 – March 2012 and October 2012 – March 2013 had increased from 451 to 2,528. The Committee noted that the data submitted between October 2011 and March 2012 was incomplete due to technical issues with exporting data, and that the Trust had taken actions to improve its reporting rate.

Barnet, Enfield and Haringey Mental Health NHS Trust Quality Account 2013/14

The Committee scrutinised the Barnet, Enfield and Haringey Mental Health NHS Trust Quality Account and wished to put on record the following comments:

- The Committee noted that although the Trust had worked to strengthen communication with GPs through the GP Advice Line and the Primary Care Academy, communication with GPs as a whole was still needing improvement.
- The Committee noted that the "Carer Strategy" will be launched after 2nd June 2014.
- The Committee noted the survey undertaken by the Trust in relation to GPs' satisfaction with communication and commented that it would be helpful to see the satisfaction statistics broken down by Borough.

However, the Committee wished to express concern in relation to the following:

- The Committee had expected to receive a more complete version of the report. The Committee noted that in advance of the Health Overview and Scrutiny Committee meeting, the London Borough of Barnet had been informed that updates made to the issued draft were not substantial enough to require the re-issuing of the draft provided for publication. The Committee expressed concern that when the report was presented at the meeting, the changes appeared to be much more substantial than had been initially implied. The Committee noted that if they had been aware of the magnitude of the changes, then the Committee would have wanted to have had the latest version of the document published and circulated in advance of the meeting. The Committee also wished to express their dissatisfaction that, on the evening, they were not made aware of the changes that had been made to the document.
- The Committee expressed concern that the priority for 2013-2014, "Safety - Improve communication with GPs" had not been met, and were further concerned to note that this priority would not be taken forward for 2014-2015.
- The Committee was told that the CQC had revisited The Oaks Ward on 10 April and that the Trust was now compliant. The Committee were informed that the enforcement notice had been lifted regarding the seclusion rooms.

North London Hospice Quality Account 2013/14

The Committee scrutinised the North London Hospice Quality Account 2013/14 and wished to put on record the following comments:

- The Committee welcomed the continuing improvements to the quality of care provided by the North London Hospice.
- The Committee noted the removal of the Liverpool Care Pathway and welcomed the examples of best practice undertaken by the North London Practice in end of life care following the Pathway's removal.
- The Committee welcomed the fact that the Hospice had invested in a day services Clinical Nurse.
- The Committee welcomed the action taken by the Hospice in seeking ideas for social activities and were pleased to note that activities such as musical performances in open spaces, reading and playing cards with people took place.
- The Committee welcomed the dementia facilities provided by the hospice.
- The Committee welcomed the refurbishment of bedrooms and inpatient units to improve dementia care.
- The Committee commented that the statistic for falls per occupied bed days per 1000 in 2013-14 was 13.2, compared to the national benchmark of 6.5 falls per 1000 bed days. The Committee noted that this national benchmark included hospitals and commented, that by the nature of being a hospice, a higher falls rate would be expected because of the frailty of its patients.
- The Committee welcomed the Clinical Effectiveness Project One: Dementia Care. The Committee welcomed the variety of dementia training that the Hospice would be undertaking, particularly, offering to train staff of external care homes and district nurses.
- The Committee noted that in 2012/13, the Hospice began working within a local five hospice consortium to benchmark performance. The Committee were pleased to note that the Hospice would be working with a group of 99 hospices in order to conduct benchmarking and were pleased to note that this data could be available in next year's Quality Account.
- The Committee welcome the 0-0 rate of avoidable pressure sores reported in April 2013 – March 2014.
- The Committee asked to be informed of the attendance figures of Barnet patients attending the day centre when it was located at the North Finchley site, compared to the current figures of Barnet patients attending the day centre at new Enfield site.

However, the Committee wished to express concern in relation to the following:

- The Committee noted that the Audit Steering Group Chair had highlighted the need to increase competence and the quality of audits.
- The Committee noted that there had been an increase in closed bed days in 2013/14 due to plumbing problems, deep cleaning requirements in rooms which patients with MRSA had been cared for, staff sickness and maternity cover.

Central London Community Healthcare NHS Trust

The Committee Scrutinised the Central London Community Healthcare NHS Trust Quality Account 2013/14 and wished to put on record the following comments:

- The Committee welcomed the fact that the addition on the annual complaints report.

However, the Committee wished to express concern in relation to the following:

- The Committee expressed concern that the milestone, “Reduction in paperwork for front line staff (by a third), creating time to care by introducing electronic / digital solutions to reduce paperwork” had not been achieved
- The Committee expressed concern that the milestone, “Audit of recruitment processes to demonstrate values questions asked and staff survey to show high levels of understanding and commitment to Trust values” target had not been achieved.
- The Committee expressed concern that the outstanding milestone of “Audit of dementia, mental health and learning disability and care of vulnerable adults policy” had not been achieved.
- The Committee noted that the Risk Management Strategy showed that 90% of services are using their risk registers and that service improvements can be clearly demonstrated. The Committee expressed concern that some services were unable to identify risks.
- The Committee expressed concern that there was no proof of dentistry provision in Barnet being provided by the Trust.

Barnet and Chase Farm Hospitals NHS Trust:

The Committee scrutinised the Barnet and Chase Farm Hospitals NHS Trust 2013/14 Quality Accounts and wished to put on record the following comments:

- The Committee welcomed the very recent improvement that the Trust had made in Accident and Emergency waiting times.
- The Committee welcomed the fact that following an upgrade of the telephone and call centre technology, Patient Services were handling 80% of calls within 30 seconds.
- The Committee welcomed the fact that additional staff resources had been made available to deal with complaints
- The Committee noted that it was a legal requirement of the Trust to have a “Limited Assurance” report.
- The Committee welcomed the “Home for Lunch” initiative.
- The Committee welcomed the use of the “Forget-me-Not” scheme to assist patients with dementia.
- The Committee welcomed Priority Two for 2014/15, which is to reduce the “Did Not Attend” rate. The Committee questioned what further actions were

being taken to reduce the rate of cancellations and were told that the Trust was using text reminders, reminder phone calls and were working to improve communication skills so that patients felt more able to inform the Trust that they would not be attending an appointment. The Committee requested that this be expanded upon within the Quality Accounts.

However, the Committee wished to express concern in relation to the following:

- The Committee noted that 56.1% of formal complaints were acknowledged within the first three days and suggested it would be helpful for patients to be given an estimated response time within the acknowledgement.
- The data from the last three months in the “Monthly Cardiac Arrest Run Chart” was not included. The Committee requested that this be inserted if the data is available before publishing the Quality Accounts.

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AGENDA ITEM 8

Health Overview and Scrutiny Committee

11 May 2015

Title	**Health Overview and Scrutiny Committee Work Programme**
Report of	Governance Service
Wards	All
Status	Public
Enclosures	Appendix A - Committee Forward Work Programme June 2014 - May 2015
Officer Contact Details	Anita Vukomanovic, Governance Service Email: anita.vukomanovic@barnet.gov.uk Tel: 020 8359 7034

Summary

The Committee is requested to consider and comment on the items included in the 2014/15 work programme

Recommendations

1. **That the Committee consider and comment on the items included in the 2014/15 work programme**

1. WHY THIS REPORT IS NEEDED

1.1 The Health Overview and Scrutiny Committee Work Programme 2014/15 indicates forthcoming items of business.

1.2 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.

1.3 The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

2. REASONS FOR RECOMMENDATIONS

2.1 There are no specific recommendations in the report. The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/A

4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be incorporated to the work programme and will be reflected in forthcoming agendas.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Committee Work Programme is in accordance with the Council's strategic objectives and priorities as stated in the Corporate Plan 2013-16.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 The Terms of Reference of the Health Overview and Scrutiny Committee are contained within the Constitution, Responsibility for Functions, Annex A.

5.4 **Risk Management**

5.4.1 None in the context of this report.

5.5 **Equalities and Diversity**

5.5.1 None in the context of this report.

5.6 **Consultation and Engagement**

5.6.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 None.

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London Borough of Barnet Health Overview and Scrutiny Committee Forward Work Programme April 2015 - May 2015

Contact: Anita Vukomanovic 020 8359 7034 anita.vukomanovic@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
11 May 2015			
NHS Trust Quality Accounts		NHS Trusts	
Unallocated Items			
Royal Free London NHS Foundation Trust Acquisition - Update Report (to include Ambulances)	Committee to receive an update report from the Royal Free London NHS Foundation Trust provide an update report on the topic of Ambulances.		
Liverpool Care Pathway and Hospitals	Committee to receive a report on the removal of the Liverpool Care Pathway and Hospitals.		
Dehydration in Patients Admitted to Hospitals from Care Homes	Committee to receive a report on the admission of patients with dehydration to hospital.		
Options for Unscheduled Care Services at Cricklewood GP Health Centre: Update Report	Committee to receive a further report on this matter which includes the views and concerns expressed by patient participation group.		
Public Health Commissioning Intentions		Director of Public Health (Barnet and Harrow)	

Subject	Decision requested	Report Of	Contributing Officer(s)
Tuberculosis	Following the consideration of the Annual Report of the Director of Public Health, Committee have requested to receive a report on Tuberculosis.	Director of Public Health (Barnet and Harrow)	
East Barnet Health Centre	At their meeting on 30 March 2015, the Committee considered an update on the East Barnet Health Centre. The Committee invited representatives from NHS England and NHS Property Services to present on this. Both NHS England and NHS Property Services advised that due to their Purdah regulations, they would not be able to attend the meeting on 30 March 2015. The Committee have therefore requested that they attend a future meeting on the Committee to provide a further update and respond to Member's questions.		

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