Putting the Community First

MEETING
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
MONDAY 16TH MAY, 2016
AT 7.00 PM
VENUE
HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

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

Councillors

Val Duschinsky
Arjun Mittra
Gabriel Rozenberg
Caroline Stock
Philip Cohen
Laurie Williams
Vacancy

Substitute Members: Councillors

Shimon Ryde BSc (Hons)
Daniel Thomas BA (Hons)
Anne Hutton
Maureen Braun
Kath McGuirk
Barry Rawlings

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore the deadline for public questions or comments is Wednesday 11 May 2016. Requests must be submitted to anita.vukomanovic@barnet.gov.uk

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

Andrew Charlwood – Head of Governance

Governance Services contact: Anita Vukomanovic 020 8359 7034
anita.vukomanovic@barnet.gov.uk

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 b) Whipping Arrangements (in accordance with Overview and Scrutiny Procedure Rule 17)	
4.	Report of the Monitoring Officer	
5.	Public Question Time (If Any)	
6.	Members' Items (If Any)	1 - 4
7.	Children's Mental Health and Eating Disorders	5 - 24
8.	North West London, Barnet & Brent Wheelchairs Service Redesign	25 - 32
9.	NHS Trust Quality Accounts	33 - 284
10.	Health Overview and Scrutiny Forward Work Programme	285 - 290
11.	Any Other Items that the Chairman Decides are Urgent	

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AGENDA ITEM 6

	Health Overview and Scrutiny Committee 16 May 2016
Title	**Member's Item in the name of Councillor Philip Cohen**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	None
Officer Contact Details	Anita O'Malley, Governance Team Leader Email: anita.vukomanovic@barnet.gov.uk Tel: 020 8359 7034

Summary

The report informs the Health Overview and Scrutiny Committee of a Member's Item and requests instructions from the Committee.

Recommendations

1. **That the Health Overview and Scrutiny Committee's instructions in relation to this Member's item are requested.**

1. WHY THIS REPORT IS NEEDED

1.1 Councillor Philip Cohen has requested that a Member's Item be considered on the following matter:

Community pharmacy in 2016/17 and beyond

The government has announced that funding for community pharmacy services in 2016/17 will be cut by £170m – from £2.8bn to £2.63bn, which is a reduction of more than 6 per cent in cash terms. This will clearly have an impact on local pharmacy services in Barnet, and according to Pharmacy Minister, Alistair Burt, could result in the closure of between 1,000 to 3,000 pharmacies across the country.

So far concerns have been raised by the Royal Pharmaceutical Society, Pharmacy Voice, NHS Alliance, the LGA, Association of Pharmacy Technicians UK, and the All Party Pharmacy Group.

The Department of Health has extended its consultation on the proposal until 24 May.

I request that the HOSC discuss the issue and respond to the consultation opposing the cuts.

For background:

http://psnc.org.uk/psncs-work/communications-and-lobbying/community-pharmacy-in-201617-and-beyond/

http://psnc.org.uk/psncs-work/communications-and-lobbying/community-pharmacy-in-201617-and-beyond/responses-from-other-organisations/

1. REASONS FOR RECOMMENDATIONS

1.1 No recommendations have been made. The Committee are therefore requested to give consideration and provide instruction.

2. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

2.1 Not applicable.

3. POST DECISION IMPLEMENTATION

3.1 Post decision implementation will depend on the decision taken by the Committee.

4. IMPLICATIONS OF DECISION

4.1 Corporate Priorities and Performance

4.1.1 As and when issues raised through a Member's Item are progressed, they will

need to be evaluated against the Corporate Plan and other relevant policies.

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

4.2.1 None in the context of this report.

4.3 **Legal and Constitutional References**

4.3.1 The Council's Constitution (Meeting Procedure Rules, Section 6) states that a Member, including appointed substitute Members of a Committee may have one item only on an agenda that he/she serves. Members' items must be within the term of reference of the decision making body which will consider the item.

4.3.2 The Health Overview and Scrutiny Committee terms of reference includes:

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 Chairman, Vice- Chairman, Members and substitutes to be appointed by Council which may 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.*

a. Risk Management

i. None in the context of this report.

b. Equalities and Diversity

i. Members' Items allow Members of a Committee to bring a wide range of issues to the attention of a Committee in accordance with the Council's Constitution. All of these issues must be considered for their equalities and diversity implications.

c. Consultation and Engagement

i. None in the context of this report.

2. BACKGROUND PAPERS

a. None.

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	Health Overview and Scrutiny Committee **16 May 2016**
Title	**Report on Eating Disorders - Children and Young People**
Report of	Eamann Devlin CCG - CAMHS Joint Commissioning Manager (interim) Barnet CCG
Wards	All
Status	Public
Urgent	NO
Key	NO
Enclosures	Appendix A
Officer Contact Details	Eamann Devlin, eamann.devlin@barnetccg.nhs.uk

Summary

This report is a response to Cllr Trevethan's request that the HWBB be provided with a general report on Eating Disorders issues and specific responses to eight direct questions. It was circulated to clinical and Public Health leads.

The report provides:

- The context for Eating Disorders in the wider Child and Adolescent Mental Health Agenda
- An overview of Eating Disorders as clinical condition
- An overview of the Barnet context for Eating disorders with local and national data where available
- An overview of current commissioning arrangements, provision and development works for the local CAMHS Transformation Programme
- Responses to the specific questions raised by Cllr Trevethans

Recommendations

1. **That the Committee notes the contents of this report.**

1. WHY THIS REPORT IS NEEDED

1.1. This report follows on from a request from Cllr Trevethan for a report addressing Eating Disorders in Barnet. The Joint Commissioning Unit was tasked with responding to the questions along with a more general update on the Eating Disorders Agenda.

2. REASONS FOR RECOMMENDATIONS

2.1. The report allows the Committee to be informed as to the policy context of eating disorders. The Committee may resolve to request any further actions they feel necessary upon considering the report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1. None in the context of this report.

4. POST DECISION IMPLEMENTATION

4.1. Following the consideration of this report, the Committee will be able to determine if they require any future reports or information.

5. IMLICATIONS OF DECISIONS

5.1. Corporate Priorities and Performance

5.1.1. The report provides insight into Eating Disorders, both current works and future developments in response to a Member enquiry. The report details elements of Children and Adolescent Mental Health Service (CAMHS) activity which are being addressed through the Barnet CAMHS Transformation Programme and Plan .

5.1.2. The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020

The strategic objectives set out in the 2015 – 2020 Corporate Plan are

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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6. Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

6.1. There are no financial implications for the Council in receiving this report

6.2. In October 2015 the Department of Health announced that alongside the allocations that would be made to local areas to support the general CAMHS

Transformation programme and addition, a specific allocation for Eating Disorder and or Self-Harm and Out of Hours services was being made. A degree of flexibility in allocation of spend was given to local areas to enable them to prioritise spend in line with the relative maturity of the services they commission for these vital CAMHS areas. An allocation of £198,000 was made available to Barnet, and the decision was made to place £100,000 against development of the existing service, with the remainder being invested in Out of Hours and Crisis Care related works. This reflected the level of service development in Barnet where we already commissioned a "gold Standard" Eating Disorder service

7. Social Value

7.1. The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders

7.2. There are no specific references to Social Value Act relevant issues within the report, but the wider CAMHS Transformation Plan which frames the five year delivery programme for CAMHS work in Barnet has been developed with Social Value as one aspect of the overarching commissioning principles, specifically the use of Voluntary and Community Sector agencies operatives and resources to both inform, co-produce and deliver specific strands of the CAMHS Transformation Programme

8. Legal and Constitutional References

8.1. The report outlines current and planned activity and service context and specific responses to the members item only. No decisions are being called for and all aspect of the wider CAMHS Transformation programme referred to have been assessed for impacts on Barnet legal and constitutional separately in the sign off process for the CAMHS Transformation Plan in October 2015

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

8.3. The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities

"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."

9. Risk Management

9.1. There are no risks identified within the report the report itself. Should the Committee not receive this report, there would be a risk in the Committee not being kept abreast of the issues surrounding eating disorders

10. Equalities and Diversity

10.1. The report and the services it describes are specifically designed to address key vulnerable groups including those with protected characteristics and service delivery models are specifically tailored to maximise inclusion in line with the current specification for the service. Work is under way to ensure that the service is able to meet both the waiting times standard for the service

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

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

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

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.

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."

11. Consultation and Engagement

11.1. The development of the CAMHS Transformation Plan included significant consultation and engagement. It is acknowledged that the implementation of the CAMHS Transformation necessitates effective and sustainable mechanisms to not only consult and engage service users and their families but to involve them ('co-production') in all aspects of the programme. This point has been reiterated in national guidelines and in 'Future in Mind', the original policy stimulus for this Transformation programme. Hence the CAMHS agenda in Barnet seeks to continue and extend the co-production and engagement initiatives until the completion of the work in 2020 and beyond

11.2. Insight

11.2.1. A plethora of information resources have informed this paper including local Insight resources, and national specialist data sets. See the report for a full list of references

12. BACKGROUND PAPERS

12.1. The Attached report provides the detailed response requested by item 6A discussed at the Heath Overview and Scrutiny Committee of Monday December the 7th 2015. (https://barnet.moderngov.co.uk/mgAi.aspx?ID=15067)

Appendix A

Introduction:

Barnet Eating Disorders – Response and Report to Members Item 6A HOSC Dec 7, 2015

This report is a response to Cllr Trevethans' request that the HWBB be provided with a general report on Eating Disorders issues and specific responses to eight direct questions.

The report aims to provide:

- The context for Eating Disorders in the wider Child and Adolescent Mental Health Agenda
- An overview of Eating Disorders as clinical condition
- Responses to the Members questions

Context:

In March 2015 NHS England (NHSE) and The Department of Health (DoH) published Future in Mind, promoting, protecting and improving our children's emotional health and wellbeing**.** The report sets out national transformation of child adolescent mental health services (CAMHS) over a five year period.

The Barnet CAMHS Transformation Plan has been developed in response to the letter from Sir Bruce Keogh and Richard Barker in May 2015 which calls for "…a major service transformation programme to significantly reshape the way services for children and young people with mental health needs are commissioned and delivered across all agencies over the next 5 years in line with proposals put forward in Future in Mind…."
Barnet Transformation Plan identifies five areas for priority development across all services including Eating Disorders

- Improving access to effective support
- Care for the most vulnerable
- Promoting resilience, prevention and early intervention
- Accountability and transparency
- Developing the workforce

A priority for both National and Local CAMHS is tackling Eating Disorders.

Eating Disorders and the CAMHS Transformation Plan:

Barnet currently has a high quality eating disorder service and through the Transformation Plan we will improve the service further by reducing waiting times to meet new guidance requirements (4 weeks from first contact, or 1 week for urgent cases: NICE Standards). By 2020 Barnet will have expanded the capacity of the Eating Disorders service to offer intensive community based treatment (Eating Disorder Intensive Service-EDIS)), increased the number of children able to access services. As part of the Transformation Plan Barnet will roll out training for all eating disorder staff as part of the "Improving access to Psychological Therapies for children" (CYP-IAPT), provide outreach education training for eating disorders and provide telephone support for General Practitioners. Early identification and support is known to enhance outcomes for suffers and reduce hospital admissions

Barnet's Eating Disorder service: The Royal Free London CAMHS eating disorder service has been running a highly successful and innovative eating disorder service since 2001. It is now one of the largest CAMHS eating disorder services in the country, currently covering six North London boroughs. The service aims to help young people with anorexia nervosa, bulimia nervosa or atypical variations of these disorders, to recover fully in the community. A key aim for the service is to try and help young people avoid admissions into eating disorder residential units. While eating disorder residential units should always have a place in the treatment options for young people the service operates on the assumption that that they should be for the minority and used as a last resort. CCGs are required to work collaboratively to commission a community eating disorder service for children and young people. Accordingly Barnet who are the lead commissioner for the Royal Free Hospital lead the commissioning of the Eating Disorder service for North Central London on the behalf of Enfield Haringey Camden and Islington.

Key Treatment Plan Components

Flexible appointment times

The service aims to offer flexible appointment times and can often offer young people in exam years (years 11, 12 and 13) early or late appointments, eg 9am or between 5pm and 6pm, to reduce potential impact on school.

Eating Disorder Intensive Service (EDIS): An intensive day and inpatient service offering a multi-disciplinary approach and including all of the menu of interventions below. The EDIS service is also supported by an in-house school provision.

Nursing and dietician reviews: Regular nursing and dietician reviews to monitor weight and meal plans.

Nursing key worker sessions: Young people on the ward in EDIS will have regular meetings with both of their nursing key workers. These meetings serve as a useful preparation for future individual therapy.

Psychiatry reviews: Eating disorders rarely occur in isolation, so CYP will have regular meetings with a psychiatrist, consultant and/or a trainee psychiatrist, to assess, monitor and treat any other related conditions e.g. depression, self-harm or OCD (obsessive compulsive disorder).

Family therapy: Family therapy is the most effective treatment for young people with eating disorders. Family therapy aims to discover how resources or strengths in the family can be developed to help young people recover from their eating difficulties.

Parent skills based group: Offered as a preparation for family therapy and offers parents a range of skills, techniques and knowledge to help them support their child with their eating difficulties.

Individual therapy: Individual therapy offers young people a private space to discuss their thoughts and emotions associated with their eating disorder. CYP are offered two main types of therapy: cognitive behavioural therapy (CBT) or psychodynamic psychotherapy. Both have been specially adapted to help young people with eating disorders. Both treatments are equally effective.

Groups for young people: The Royal Free currently offers a creative group to help young people use art materials to find an alternative outlet for emotional expression. There is also a 'food and me' group which seeks to use mindfulness and relaxation techniques to reduce some of the anxieties and stresses associated with eating. Other groups are being planned.

Core team reviews: CYP, Parents and carers will have regular reviews with the consultant psychiatrist coordinating the CYPs care and any other members of the team that are also involved e.g. nurse, family therapist and individual therapist. The purpose of these meetings is to review and refine treatment plans.

Eating Disorders as Clinical Conditions:

Eating disorders include a range of conditions that can affect someone physically, psychologically and socially. The most common eating disorders are:

Anorexia Nervosa – when a person tries to keep their weight as low as possible; for example, by starving themselves or exercising excessively

Bulimia Nervosa – when a person goes through periods of binge eating and is then deliberately sick or uses laxatives (medication to help empty the bowels) to try to control their weight

Binge Eating Disorder – when a person feels compelled to overeat large amounts of food in a short space of time

Some people, particularly those who are young, may be diagnosed with an eating disorder not otherwise specified (EDNOS). This means you have some, but not all, of the typical signs of eating disorders like anorexia or bulimia.

Eating disorders are a range of conditions that affect people physically, psychologically and socially. They are serious mental illnesses which affect over 725,000 people in the UK and have the highest mortality rate of any mental illness – one in five of the most seriously affected will die prematurely from the physical consequences or suicide. Moreover, it is estimated that annual cost to the NHS of treating eating disorders is £4.6 billion.

Anyone can develop an eating disorder, regardless of their age, sex or cultural background. However, figures show that 1 in 30 school children have diagnosed eating disorder and alarmingly, the number of hospital admissions across the UK for teenagers with eating disorders has nearly doubled in the last three years, from 959 in 2010/11 to 1,815 in 2013/14, a rate of increase that experts say is mirrored by a larger number of cases that don't go to hospital.

The Government has stressed its commitment to improving access to mental health services for children and young people, announcing a further £1.25 billion in 2015 to improve children's mental health services over the next 5 years. Additionally, in

December 2014, £30 million worth of extra funding was announced for eating disorder services in order to improve community provision and cut waiting times; to ensure that 95% of children and young people with eating disorders are seen within four weeks, or one week for urgent cases by 2020.

With most cases of eating disorders beginning in childhood or adolescence, increasing rates of diagnosis and mounting pressures on child and adolescent mental health services (CAMHS), there is growing awareness that a coordinated approach across sectors which promotes early intervention is now crucial for identifying, treating and preventing eating disorders among young people.

Prevalence rates, diagnoses age gender and incidence:

The number of people diagnosed with eating disorders has increased by 15 per cent since 2000, according to a study by King's College London and the UCL Institute of Child Health in 2011. The increase was more pronounced in males with incidences rising 27 per cent. The research looked at incidence of eating disorders in primary care in the UK over a ten-year period (2000-2009) and found that the largest increase was in eating disorders which meet most, but not, all of the criteria associated with anorexia or bulimia. 1

The study showed a 60 per cent increase in females with these types of eating disorders, known as Eating Disorders Not Otherwise Specified (EDNOS), and a 24 per cent increase in males. Rates of anorexia nervosa and bulimia nervosa remained stable. The researchers analysed information from 400 general practices representing approximately 5% of the general UK population, and identified 9,072 patients with a first-time diagnosis of an eating disorder. It revealed that in 2000 there were 32.3 new cases of eating disorder per 100,000 population aged between 10-49 years, which rose to 37.2 cases by 2009. It is acknowledged that eating disorders can develop at any age, with reported cases in children as young as 6 and women in their 70s.

Most eating disorders, however, develop in adolescence with those under 20 making up almost half (49%) of all those receiving inpatient treatment for an eating disorder in England. NHS guidance on eating disorders notes that anorexia nervosa commonly develops around the ages of 16-17, while bulimia nervosa develops at 18-19 and binge eating disorder appears later in life, usually between the ages of 30-40

1 Micali, N. et al "The incidence of eating disorders in the UK in 200-2009: findings from the General Practice Research Database" *BMJ Open* doi: 10.1136/bmjopen-2013-002646

Incidences of eating disorders were seen to vary by sex and age with adolescent girls aged 15-19 years having the highest incidence of eating disorders (2 per 1,000). There was a much higher overall rate of eating disorders among females of 62.6 per 100,000 in 2009 compared with a male rate of 7.1 per 100,000. The peak age of diagnosis for girls with all eating disorders was 15-19 years. Other research, however, indicates that up to 25% of sufferers are males. It is possible that because males make up the minority of sufferers, there are issues around diagnosis due to lack of awareness of the problem among men. They may also be reluctant to come forward due to the stigma attached. The peak age for diagnosis for males varied depending on the type of eating disorder: 15-19 years for anorexia; 20-29 years for bulimia; and 10-14 for EDNOS. There is still a significant late diagnoses according to the research literature. The Kings Study reference above noted a large number of late or undetected cases. [2]

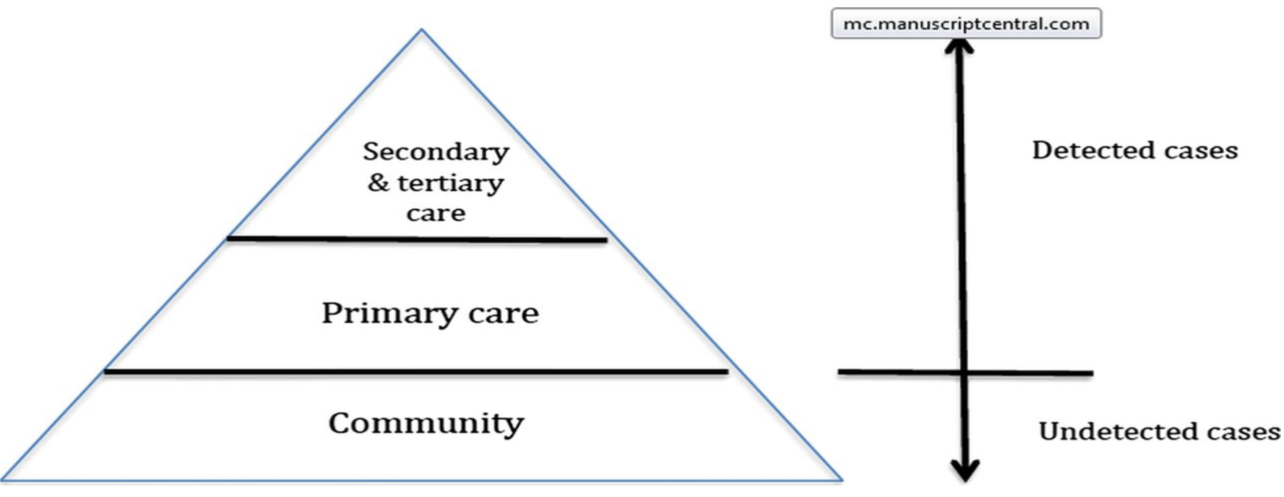

Fig 1 The incidence of eating disorders in the UK in 2000–2009: findings from the General Practice Research Database

Stigma and other societal and cultural pressures can make the task of identification hard to achieve and the evidence suggests that most sufferers wait over a year from first symptoms to seeking help. People with anorexia nervosa often differ from others with mental health problems in that the central characteristics of the illness are perceived as functional and valued by the individual. The individual can be perceived as ambivalent about recovery and resistant to intervention. In (eating disorders) treatment an emphasis is placed on developing a collaborative therapeutic

[2] http://bmjopen.bmj.com/content/3/5/e002646.full

relationship with the individual. The PWC report 2015 also indicates that 62% of sufferers develop symptoms prior to 16th birthday and a further 24% between 16-19yrs, so a total of 86% under 19 yrs. The imperative therefore to improve early identification is significant and this is a major focus of work within the Barnet Transformation Plan

Inpatient treatment [3]: In a minority of patients, admission to hospital may at times be necessary to stabilise the physical state or even save the life of severely physically impaired patients. Inpatient treatment aimed at recovery usually leads to weight gain at least where admission has been to a unit where such treatment is a regular activity. Such treatment may have lasting effects although weight loss is common after discharge. There is no unequivocal evidence that inpatient treatment confers long-term advantage except as a short-term life-saving intervention in patients at high risk. However, inpatient treatment may well be a rational option for patients who have failed to respond to apparently adequate outpatient treatment.

A decision to compulsorily treat people with eating disorders occurs infrequently. Treatment in this context refers to inpatient treatment of anorexia nervosa in adults, children and adolescents. However in the case of children and adolescents compulsory treatment can take place on an outpatient basis under parental authority, under the Mental Health Act 1983 and more rarely, with specific Court Orders.

A further aim of employing compulsion under the MHA 1983 is to offer the individual the protection that is provided for them in the Act. It is important to remember that compulsory treatment does not equate with 'feeding against the will of the person' or 'force feeding'. It is helpful to hold in mind the distinction between treatment carried out under the legislation with which the individual complies (for whatever reason) and that which the individual resists.

Responses to the Members Questions:

1. **What is the prevalence of eating disorders amongst young people (under 18 year olds) in Barnet? Is the prevalence increasing?**:

   There has been no detailed needs assessment for Eating Disorders in Children and Young People in Barnet and prevalence levels are uncertain. This gap is common across most areas of the UK. Public Health England estimates suggest that 7% of

[3] This section is taken from the NICE guidance ibid.

people of all ages [4] will have an Eating Disorder in Barnet (18,902) at some stage. No specific figures are provided for Children in PHE data but it is estimated that in Barnet 5,146 16-24 yr olds have two or more indicators of an Eating Disorder that would require further investigation ((Adult Psychiatric Morbidity Survey 2007 http://www.ic.nhs.uk/pubs/psychiatricmorbidity07).

Anorexia Nervosa commonly starts in the teenage years in the UK around 1 fifteen-year-old girl in every 150 or 1 fifteen-year-old boy in every 1000 is affected. For Bulimia approximately 4 out of 100 women will be affected but the condition at some stage in their life with typical onset at mid teenage years, with far fewer men being affected..

The introduction of the Mental Health Minimum Data Set will over the next two years significantly improve the data available regarding prevalence in Barnet. Barnet has a higher rate of referrals to the specialist unit than surrounding boroughs

Referral Rates for NCL to Specialist RFH Unit

During the period 2013/2014 there were 157 referrals to Royal Free CAMHS Eating Disorder Service.

CCG	Number of referrals received	Number of referrals accepted
Barnet	64	62
Camden	23	22
Enfield	25	23
Haringey	15	13
Islington	18	16
Other	12	12
TOTAL	157	148

[4] Barnet ADPH Report 2015

In the following year the number of referrals for Barnet had reduced by 20% but for the whole catchment area by 7%. This should not be considered a statistically significant change. We are awaiting final year figures for 2015.16 but understand these have risen slightly on last year.

2014/2015

CCG	Number of referrals received	Number of referrals accepted
Barnet	49	49
Camden	18	17
Enfield	31	29
Haringey	17	14
Islington	18	17
Other	13	8
TOTAL	146	134

2. **What are understood to be the common causes of eating disorders and what research is taking place at a local or national level to identify possible causes and/or contributory factors?**

   Eating Disorders are complex, multi-factorial in their causation and the interrelation of these issues on individuals are still to be fully understood. Factors can include genetic, biological, social and cultural influences. Eating disorders arise from a combination of personal, family, physical or genetic factors as well as life experiences that may cause someone to be both emotionally vulnerable AND sensitive about their weight and shape. Dieting has a role to play in the development of an eating disorder, in fact in most sufferers the eating disorder grew out of dieting behaviour.

3. **Information on a treatment plan/referral plan for a young person diagnosed with an eating disorder but not requiring inpatient treatment?**

Barnet CCG commissions a comprehensive Outpatient Eating Disorder service[5] from the Royal Free NHS Foundation Trust. This comprises of a combination of service offers according to the needs of the Children and Young People accessing the service. – SEE KEY TREATMENT PLAN COMPONENTS ABOVE

4. **At what stage/severity would admission to hospital be required?**

The decision to admit a patient is made on a case by case basis. Overall the key factors in admission are the severity of symptoms, the need to stabilise physical conditions or provide symptom interruption. Sometimes in extreme circumstances the provisions of the Mental Health act to detain and impose treatment are required in life threatening circumstances, but this is unusual.

- Physical Health Risks - Medical stabilisation, re-feeding or other medical complications
- Mental health Risks – e.g. suicidality
- A combination of the two: e.g. refusal to engage with a community team and an eating disorder of such severity that it is likely to cause significant harm without treatment being provided.

Some patients may require detention under the Mental Health Act when it is necessary for their health or safety. The Junior MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) guidance highlights how eating disorders risk in children and adolescents can be recognised by any clinician working with them and when hospital admission would be necessary.

5. **What are the long-term complications arising from eating disorders; and national rates of recovery and mortality?**

Long term complications do vary according to the specific Eating Disorder under consideration but can include combinations of the following: Painful swallowing,

[5] See https://www.royalfree.nhs.uk/services/services-a-z/child-and-adolescent-mental-health-services/eating-disorder-treatment/

drying up of the salivary glands, imbalance or dangerously low levels of essential minerals in the body, increased risk of heart disease, and problems with other internal organs, severe damage to the stomach, esophagus, teeth, salivary glands and bowel, poor functioning of the body: specifically the brain, heart, liver and kidneys, difficulty conceiving, infertility, osteoporosis (brittle bones), restricted growth, high blood pressure, high cholesterol, Obesity, diabetes. Research into recovery rates by condition suggests that around 46% of anorexia patients fully recover, 33% improve in their condition and 20% remain chronically ill. Similar research into bulimia suggests that 45% make a full recovery, 27% improve considerably and 23% remain chronically unwell. Individuals with eating disorders have significantly elevated mortality rates, with the highest rates occurring in those with Anorexia Nervosa (AN). The mortality rates for Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Stated (EDNOS) are similar. Studies have found age at assessment to be a significant predictor of mortality for patients with AN[6]. Eating disorders have the highest mortality rates among psychiatric disorders. Anorexia Nervosa has the highest mortality rate of any psychiatric disorder in adolescence[7]. The overall mortality in long-term studies of Eating Disorders ranges from 0–21 per cent from a combination of physical complications and suicide. The all-cause standardised mortality ratio for anorexia nervosa has been estimated at 9.6 (Nielsen 2001) which is three times higher than other psychiatric illnesses.[8] In AN, excess mortality is explained in part by the physical complications and in part by an increased rate of suicide.

6. Does evidence suggest that suffering from an eating disorder increases an individual's risk of suicide and attempted suicide?

Yes there is significant evidence to suggest the eating disorders and suicide ideation or risk of suicide are related. Across studies, approximately 20% to 40% of deaths for Anorexia Nervosa are thought to result from suicide. Individuals with eating disorders have significantly elevated mortality rates, with the highest rates occurring in those with Anorexia Nervosa. Depressed mood is a common feature, partly because of these adverse consequences and also because of the distressing nature of the central symptoms of these disorders. The adverse physical consequences of dieting,

6 http://archpsyc.jamanetwork.com/article.aspx?articleid=1107207#RESULTS

7 Arcelus J, Mitchell AJ, Wales J. et al, "Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders: A Meta Analysis of 36 Studies." Arch Gen Psychiatry 2011, 68: 724-31. Sonnenville K, Micali N et al., "Common Eating Disorders Predictive of Adverse Outcomes are Missed by the DSM-IV and DSM-5 Classifications." Paediatrics 2012; 130:e289-95

8 NICE Guidelines 2004 page 7. "Eating Disorders Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa, and Related Eating Disorders"

weight loss and purging behaviours are can sometimes prove fatal

7. **What work is taking place to improve data on eating disorder prevalence and can we have a timescale as to when up-to-date data for England and for the local area will be published?**

Overall research is continuing globally and there are specific research hubs within the UK, such as those at Kings College Hospital Eating Disorders Research Group[9] and internationally, the Academy for Eating Disorder Research[10] and UK Mental Health Research Network [11]that have a focus on improving analysis of data and assessing prevalence rates. The introduction of a national Mental Health Services Data Set (MHSDS) requirement for the NHS in January 2016 [12] will significantly improve the responsiveness of data sets addressing CAMHS conditions including Eating Disorders local data collection of the MHSDS will commence on 1st April 2016. Central data submission will commence at the end of May 2016. From July 2017 extracts from this data set will be available for review. A fuller picture of Barnet Prevalence rates will emerge from that point and be robust after a full year data has been examined at some point in 2017. In tandem with this the 2004 NICE guidance is under review with a new guideline for Eating Disorders scheduled for publication in 2017. It is anticipated that the guidance will have a fully updated section on prevalence morbidity and mortality data.

8. **How important is early diagnosis in patient outcomes and what factors would assist early and correct diagnosis?**

Early identification for Eating Disorders as for other conditions is clearly desirable. Given that evidence based therapies are available and that they are successful in meeting the needs of CYP affected by Eating disorders, and given the complexity and high levels of morbidity and mortality inherent in the field, there are clear advantages to addressing the mental health issues manifesting through Eating Disorders. Early access to specialist diagnosis and advice is difficult to encourage in Primary Care settings given that patients may be slow to self-present and many remain undetected for a significant period.

Royal Free Hospital Eating Disorder Service-Waiting Times

[9] http://www.kcl.ac.uk/ioppn/depts/pm/research/eatingdisorders/index.aspx

[10] http://www.aedweb.org/

[11] http://www.mhrn.info

[12] http://www.hscic.gov.uk/mhsds

CCG	Waiting Times to first face to face contact (weeks)	Number of patients	Percentage of patients
Barnet	0 - 3	28	48.2%
	4 - 6	25	43.1%
	7 - 9	3	5.2%
	10 - 12	2	3.4%
	13 – 18	0	0%
	18+	0	0%

To improve early identification and reduce waiting times for treatment Barnet is directing an additional £100k of Transformation Funding to Eating Disorders per-year 2015.16-2019.20. The target is to have 90% of young people seen within 4 weeks by 1st April 2018 and urgent cases under 1 week. High-risk groups within the general CYP population will be targeted for prevention support. A Public Health orientated approach that addressed the cultural issues among young people, encouraged self-efficacy support and access to help at an earlier stage would be of significant benefit within the wider School or community context. To this end the CCG CAMHS lead and Public Health are working jointly to develop programmes with professionals, targeted cohorts and the wider community.

Targeted groups will include young women 11 yrs+, patients with a low or high BMI, adolescents consulting with weight concerns, menstrual disturbances or amenorrhea, gastrointestinal disorders and psychological problems. Screening tools and simple questionnaires can be used for such high-risk groups. Questionnaires of this type may have a role for screening in very high-risk groups in special settings, e.g. in ballet schools, fitness and sports facilities. In addition there is a need to roll out prevention work across primary school age groups.

They may have occasional application in general practice, when a CYP with a probable eating disorder has already been identified. Identification of clinical presentations should also be noted for example, adolescent girls with concerns about weight, and young women consulting with menstrual disturbances, gastrointestinal or psychological symptoms.

The role of school nursing services in supporting school environments deliver healthy weight and wellbeing strategies would be essential here to augment CAMHS services within schools.

Best practice suggests most important factor in the identification of eating disorders in generalist settings is for the practitioner to consider the possibility of an eating disorder and to be prepared to inquire further in an empathic and non-judgmental manner.

AGENDA ITEM 8

	Barnet Health Overview and Scrutiny Committee **16 May 2016**
Title	North West London, Barnet & Brent Wheelchairs Service Redesign
Report of	Elizabeth James Director of Clinical Commissioning, Barnet CCG
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Muyi Adekoya Head of Joint Commissioning - Muyi.Adekoya@Barnet.gov.uk

Summary

West London, Central London, Hammersmith & Fulham, Brent, Barnet, Ealing and Hounslow NHS Clinical Commissioning Groups (CCGs) are currently mobilising contracts with new service providers following an extensive and robust procurement exercise.

AJM Healthcare won the contract to deliver Wheelchair Services in lot 2, which is made up of Ealing, Brent and Barnet, following an extensive and robust procurement process, which involved representatives from a number of areas including service users, management leads, quality, clinical, HR, Contract Management, IT and Finance. The new contract will go-live on 1st July 2016.

To ensure go-live on this date, a mobilisation board has been developed, which meets weekly, and is made up of commissioners, contract leads, incumbent providers and the new provider.

Recommendations

1. That the Committee noted the contents of the report, the proposed direction of travel in relation to awarding the contract to a new provider, and the required timescales.

1. WHY THIS REPORT IS NEEDED

1.1 In November 2014 Central London, West London, Hammersmith & Fulham, Brent, Barnet, Ealing and Hounslow NHS Clinical Commissioning Groups (CCGs) agreed to undertake a full service redesign of community wheelchair services for people of all ages who have a long-term need for mobility assistance. The priority was to ensure those with complex, long term conditions, are able to access the right wheelchair, quickly, and with appropriate support. The full service redesign of all wheelchair services covered:

- Assessment and prescribing of powered and non-powered wheelchairs
- Rehabilitation engineering facilities (RE)
- Special seating
- Wheelchair cushions and accessories
- Service and maintenance packages (AR)

1.2 **Current delivery of wheelchair services**

1.2.1 Wheelchair Services in North West London are commissioned collaboratively by the 7 NHS CCGs. The services are provided by four separate NHS Trusts and one private sector provider:

A) **Wheelchair services:** The Wheelchair Services provide the clinical mobility, postural assessment and special seating services to child and adult clients who have a long term condition affecting their mobility. Once provision of service is established, the Wheelchair Service will continue to support and reassess clients. In Barnet these services are currently provided by Central London Community Healthcare NHS Trust (CLCH).

B) **Rehabilitation engineering:** The rehabilitation engineer (RE) service provides information and advice on adaptations and modifications and technical advice on the use and maintenance of equipment. It monitors and assists in the quality management of the repair refurbishment service and ensures that technical and safety standards of the work are of a good quality.

C) **Approved repairer:** The approved repairer is responsible for the procurement, storage, delivery, collection, refurbishment, decontamination, repair and maintenance of manual and powered wheelchairs, cushions, accessories and spares. NRS Healthcare provides the approved repairer service.

1.3 **Integrated Wheelchair Service Procurement**

1.3.1 Central London, West London, Hammersmith and Fulham, Hounslow and Ealing (collectively known as CWHHE), Barnet and Brent CCGs undertook a service re-design and re-procurement for a new integrated wheelchair service. The service is designed to meet the needs of people of all ages who have a long-term need for mobility assistance in the catchment areas.

1.3.2 The priority for this redesign was to ensure those with complex, long term conditions, are able to access the right wheelchair, quickly, and with appropriate information and support. The current incumbent Rehabilitation Engineering service (covering all 7 CCG areas) has received high levels of service user and carer complains and there is little effective communication between the providers. The new service will address these areas of concern and ensure services meet the needs of our service users. The new service covers:

- Assessment, prescription and supply of powered and manual wheelchairs and associated postural seating accessories (WCS)
- Rehabilitation Engineering facilities (RE)
- Service and Maintenance Packages (AR)

1.3.3 The critical success factors outlined below were the precursors to achieving a successful tender outcome:

- Getting the right equipment at the right time, with improved outcomes;
- Involves service users and carers in shaping the service redesign, which raises satisfaction levels;
- Generating efficiencies by avoiding costlier secondary episodes of care;

- Providing quality of life for the service users by regarding social model of disability and 'whole life' needs;
- Addressing historic concerns and recommendations from previous disability equipment and wheelchair service reviews;
- Improving early years development for disabled children;
- Reducing risk and likelihood of unnecessary injuries, e.g. falls, pressure ulcers, untoward incidents and fatalities;
- Reducing unscheduled hospital admissions, and avoiding crisis admissions to high-cost services;
- Reducing length of hospital stay and 'bed-blocking'
- Enabling timely discharge from hospital and supports post-discharge recovery;
- Providing seamless care pathway for service users across different care agencies;
- Supporting independence and user autonomy
- Taking into account the needs of carers/personal assistants as part of assessment/review.

1.3.4 The service re-design was undertaken with a committed group of service users, clinical advisors, independent standards body for disability equipment and wheelchair services and NHS quality improvement programme for which we have been selected as an exemplar site. It was primarily driven by the need to improve quality and meet the needs of people of all ages who have a long-term need for mobility assistance in the catchment areas.

1.3.5 Service users have also been strongly represented on key strategic programme groups and were extensively sought during the service re-design process and were reflected in the service specification. Service users and carers representatives also evaluated the bids.

1.3.6 NHS Barnet CCG joined a contract lot with NHS Ealing CCG and NHS Brent CCG. This was a more logical decision due to shared borders making it easier for delivery of an integrated service.

1.3.7 Three bidders submitted responses for all three lots. All bidders met the maximum affordability threshold.

1.3.8 Qualitative evaluation took place between 9th February and 18th February 2016 by the Procurement Evaluation Panel. Bidder interviews/ presentations took place on the 22nd February 2016 where bidders were asked to present on two areas - service user, carer and personal assistant experience, as well as reporting and monitoring.

1.3.9 Moderation of qualitative evaluation scoring took place on 23rd February 2016. The moderation panel was Chaired by the Senior Responsible Officer (SRO) alongside a local service user (Ealing) and the wheelchairs programme lead (supported by SBS). The outcome of the moderation process was agreed consensus scores for each of the bids for each of the lots. The moderation meeting was undertaken on a lot-by-lot basis with each of the separate evaluation panels.

1.3.10 For lot 2 the winning bidder was AJM Healthcare. On 24th March 2016 the Barnet CCG Finance, Performance and Quality Committee approved the award reports' recommendation to award the contract to AJM Healthcare. There were no challenges from the other two bidders, Opcare and Central London Community Healthcare NHS Trust, during the ten-day standstill period.

1.3.11 The first mobilisation meeting between commissioners and AJM Healthcare took place on 11th April 2016. Mobilisation will take place over the coming months and be led by the Contract Mobilisation Board, which is chaired on a rotating basis by the lead commissioners from Ealing, Brent and Barnet.

2. REASONS FOR RECOMMENDATIONS

2.1 This approach is being recommended following the procurement process followed and the approval of the award report by the Finance, Performance and Quality Committee on 24th March 2016.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There is one alternative option that has been considered:

Alternative option 1: Continue service as currently provided. This option would not be feasible as the existing contract for the approved repairer expires on the 30th March 2016 (although will be extended until 30th June 2016).

4. POST DECISION IMPLEMENTATION

4.1 The Procurement Award Report went to the Barnet CCG Finance, Performance and Quality Committee on 24th March 2016 and the Committee approved the recommendation to award the contract to AJM Healthcare. After successful and unsuccessful bidders were informed, there followed a ten-day standstill period, which ended on 4th April 2016.

Barnet have elected to be the lead contracting authority for lot 2 (Ealing, Barnet and Brent). The first mobilisation meeting took place on 11th April 2016 and the contract will start on 1st July 2016.

4.2 Following the consideration of this report, the Health Overview and Scrutiny can determine if they wish to receive any future reports on this matter.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

5.1.2 The strategic objectives set out in the 2015 – 2020 Corporate Plan are:

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 There are no financial implications arising as a result of this report.

5.2.2 The benefits of this procurement are generated through 7 CCG's joining together to procure a wheelchairs service:

- Facilitate economies of scale, redirecting current monies to facilitate benefits.
- Address equality issues between CCG's, providing that all CCG's follow the same model.
- The new contract will look for Value for Money (VFM) and sustainability in the short and long term.

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 The Health Overview and Scrutiny (Responsibility for Functions, Council's Constitution) has the following responsibilities:

- 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.

- 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 affect or may affect the borough and its residents.

- To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, HealthWatch and/or other health bodies.

5.4 **Risk Management**

5.4.1 The contract mobilisation will be managed by the Wheelchair Services Contract Mobilisation Board. This will be chaired on a rotating basis by the commissioners and will include both the incumbent and new providers. Meetings will be held weekly and the suppliers will be required to provide highlight reports in advance of the meetings; the incumbent highlighting risks, issues and milestones relating to their exit plan; and, the new provider highlighting risks, issues and milestones relating to their mobilisation plan.

5.4.2 Where escalation of risks is required, they will be escalated to the Barnet CCG Finance, Performance and Quality Committee, and to similar committees in our partner CCG's.

5.5 **Equalities and Diversity**

5.5.1 An Equality Impact Assessment was carried out as part of the service redesign programme.

5.5.2 The development of a wheelchairs service would ensure that services are accessible to all who need them on a fair basis and ensure compliance with the public sector equality duty in s149 Equality Act 2010 to have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and,
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

- The protected characteristics are:
- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation; and,

No human rights or privacy issues have been identified.

5.6 **Consultation and Engagement**

5.6.1 Significant engagement has taken place to date outlined under section one.

5.7 **Insight**

5.7.1 As above.

5.8 **BACKGROUND PAPERS**

5.8.1 *North West London, Barnet & Brent Wheelchairs Service Redesign*, presented to the Barnet Health Overview and Scrutiny Committee on 13th October 2015.

AGENDA ITEM 9

	Health Overview and Scrutiny Committee **16 May 2016**
Title	**NHS Trust Quality Accounts 2015/16**
Report of	Head of Governance
Wards	All
Status	Public
Enclosures	Appendix 1 –North London Hospice Quality Account 2015/16 Appendix 2 – Community London Healthcare NHS Trust Quality Account 2015/16 Appendix 3 – Royal Free Hospital NHS Foundation Trust Quality Accounts 2015/16 Appendix 4 – Barnet Health Overview & Scrutiny Committee 2014-15 Quality Accounts Submissions Appendix 5 – Mid Year Quality Account Reviews – Minute Extract from Committee Meeting in December 2015.
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 2015/16. 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 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 2015/16, 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

The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.
The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 None in the context of this report.

5.3 Social Value

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 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

5.4.2 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.

5.4.3 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.

5.4.4 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

> *"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."*

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.

1.5.2 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.

1.5.3 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

North London Hospice
DRAFT
QUALITY ACCOUNT 2015-16

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Page Number

Executive Summary

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

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

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

The following four Priorities for Improvement Projects for 2016-17 are proposed:

Patient Experience Project 1: To create a user forum

Patient Experience Project 2: To introduce elements of the national initiative "Hello My Name Is"

Patient Safety Project: To introduce the national and international initiative Schwartz Rounds

Clinical Effectiveness Project: To improve NLHs evidence of the implementation of the national initiative "Five Priorities of Care"

The 2015-16 priorities for improvement projects are reported and have contributed in the following ways: realtime patient experience feedback has led to changes to care delivered; a bespoke risk management system has been introduced and has centralised incidents, concerns, compliments and complaints information; and a model of care for patients with ae Long Term Condition has been identified.

Key service developments are described: (i) the development of community provision in Haringey; (ii) the development of "Come and Connect" flexible model of care; (iii) the creation of an Independent Nurse Prescribing Strategy; (iv) the partnership working on local integrated care agendas; (v) the availability of a hearing aid resource on both public NLH sites; (vi) the development of dementia care and training; (vii) the installation of day and date clocks in the IPU patient room.

Service data is highlighted and discussed. The IPU had 342 admissions this year. There was an increase in admissions to the IPU of 17% with a minimal reduction in average length of stay when compared with the previous year. 30% of patients were discharged from IPU. The Outpatients Service cared for a total of 248 patients and the Therapies Service cared for 247 patients. The community teams cared for a total 1973 patients in their own homes and supported 60% of these patients to die at home. Palliative Care Support Service cared for 321 patients and provided a total of 13,062 hours of one-to-one nursing care to people in their own homes.

The Board of Trustees gives assurance to the public of the quality of NLH's clinical services.

USER FEEDBACK:

On Losing, Wondering and Tea

To the staff at North London Hospice, who impact lives every single day and will never know how amazing they are.

Thank you for always understanding the subtext, even when I didn't realise there was any. The subtext behind every "I'm fine thanks how are you?" that really meant "I don't have the words to express the way my heart is breaking and I have no way to try and cover up the cracks that are starting to show but I'll tell you I'm fine because it's far more convenient and I don't want the hassle".
You saw past me in the way I wanted you to, but the way I'd never admit to. The way that gave me permission to curl up on the hospice sofa in the same dirty jumper and tracksuit trousers I'd worn every day for the past 3 days because I didn't really see the point in taking care of myself when I was figuring out what my life was going to be like with a gaping hole in it. You allowed me to understand my own pain and you let it be about me when I needed it. Heck, you reminded me it wasn't about me at all when I needed it too, although those times are harder to admit to.

Thank you for treating him like a man with 80 years of wisdom and worldliness and not like someone who had ceased to be able to look after himself. He was hurting too, and I know that now.

Thank you for being the embrace that held my family when I didn't think I could give it to them. Thank you for letting my beautiful Nana walk around in barefoot and leave empty mugs all over reception because she was desperate to make this place that housed her dying husband feel like her home too. When she insisted that she wanted to sleep here every single night so she could take care of her love the way she had for the past 60 years you didn't try and talk her out of it. You put up the bed every night and took it down every morning and made her toast for breakfast and gave a wash bag just in case she felt like thinking about herself for a second. She never did, and you never made her feel bad about it.

When he stopped being able to hold my hand back because he didn't know what in this world was going on, you were there. You never tried to make it better, together we watched the cracks appear and we watched things get worse and you stood next to me when I wanted you to and when I thought I didn't want you to and merely your presence reminded me that sometimes it's easier to open your heart to someone you don't really know.

He chose that Thursday morning to see what it would be like to leave suffering behind. And you were there, ready and positioned to do what you do best. To catch the falls of the people whose lives have changed in a second. The people who turn their fingers into clenched fists so they can hold the anger of their hearts in their hands, the people who when they hear the words, don't know what else to do but hold their face in their raw palms and pretend they want to be alone when actually that's the last thing they need. And you know, because you always know.. Time and time again. In the moment when we think we can't find a way out, the moment that hurts the worst right in our guts, when we feel so wronged by some higher power, you give us unspoken permission to ride all those waves and when we feel like coming back to shore you have your arms held wide, and a cup of tea ready...because there's always a cup of tea ready.

And as we packed up the things that painfully reminded us of the last 3 weeks, and the last 80 years, I thought your work must have been done. But as I sit in

the quiet room of the Hospice that currently houses 20 bouquets of flowers that will be used tomorrow to decorate wedding of a young patient who expressed her last wish was to have the wedding of her dreams to the one she loves, I realise just how wrong I was. Somehow you find a way to give your world hundreds of times over. You support families whose worlds come crashing down around them. You give them substance and strength and support, and tea. You facilitate people's understanding that losing someone you love is s**t and painful, but it gets better if you let it. How difficult it is to take that first blind step if you don't believe there is anyone there to guide you through.

You make miracles every day, and this has been nothing but a painfully inadequate attempt to express how thankful I am, and how thankful I will always be.

With the kind permission of IPU relative, Rachel Vogler

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

Welcome to North London Hospice's fourth Quality Account.

I am delighted to report that we have cared for 2232 patients and those important to them this past year. It is important to reflect how the reach of our care to more people with palliative and end of life needs continues to extend with us caring for 1409 patients just three years ago in 2013-14.

Our care of people in their own homes has extended significantly and now NLH provides a community specialist palliative care service in all three boroughs of Barnet, Enfield and Haringey. NLH partnership working is seeing us work as part of an integrated end of life service with 4 other partner providers in Haringey (page..).In Enfield and Barnet our partnership working over the past two years with Macmillan Cancer Support has supported us to pilot a project of delivering extra resources into people's homes enabling earlier referrals, provision of clinical interventions like phlebotomy, rapid response health care assistant care at times of crisis and practical support by trained volunteers providing respite, befriending and good neighbour services (pages…).

Our past year's Priority for Improvement projects (see pages..) have delivered positive results to improving the quality and effectiveness of care to patients. Our proposed projects for 2016-17 (pages…) see us integrating national initiatives like "HelloMyNameIs", the Five Priorities if Care and Schwartz Rounds into our ways of working to continue this commitment to strive for improvements in our care for our users and staff.

Our Education team continue to develop and expand its portfolio of training , courses and placements. Its prospectus details providing development to internal staff and volunteers, external professionals like care home staff, community nurses, student nurses and medical students. Members of the public also attend our monthly hospice tour events which gets people talking about end of life and hospice care helping to dispel some of the misconceptions that can be barriers to accessing appropriate palliative and end of life services like ours.

The recent year's refurbishment of our Finchley site and investments in equipment like beds is showing real improvements for our users with a substantial reduction in the number of days that rooms on our In Patient Unit have been closed. This has reduced from 116 in 2013-14 to just 30 this last year. Our Living Room continues to be a

well-loved space with users enjoying together Tea at 3 or attending Come and Connect (see pages) and we were delighted to see it used by one of our in patient's to host their wedding this year.

I would like to thank our community who continue to volunteer, fundraise and support us in so very many ways who make this all possible.

I will conclude on a quote from one of our relatives, Rachel Vogler, who describes what impact we made to her and her family so eloquently.

"Thank you for treating him like a man with 80 years of wisdom and worldliness and not like someone who had ceased to be able to look after himself… And you were there ready and positioned to do what you do best. To catch the falls of the people whose lives have changed in a second….Thank you for being the embrace that held my family when I didn't think I could give it to them."

Pam McClinton

Chief Executive, North London Hospice, April 2016

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.

NLH started to produce and share its Quality Accounts from June 2012. This year's Quality Account (QA) and previous years' QAs can be found on the internet (NHS Choices) and copies are readily available to read in the reception areas at the Finchley and Winchmore Hill 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)
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 1.

PART 2:

PRIORITIES FOR IMPROVEMENT 2016-17

The following Priority For Improvement Projects for 2016-17 are 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 quality domains of patient experience, patient safety and clinical effectiveness:

Patient experience - Project 1:

Listening to users through creating a user forum

The patient's experience is central to NLH business and is the reason why most emplyees and volunteers associate with NLH. It is one of the three elements of clinical quality - the other two being patient safety and clinical effectiveness. That is why monitoring, evaluation and development of patient experience is crucial to NLH providing high-quality clinical services. The User Involvement Strategy 2015-18 recognises that NLH needs to see user involvement further embedded into the everyday core business and practice of all services. Specialist palliative care user involvement has its challenges owing to many of its users having a frail and deteriorating condition and/or using the service for a short period of time. However, with the widening of referral to patients earlier in their illness being cared for by our OP&T service, the long-held aspirational concept of developing a user forum can now be implemented.

Current baseline: user feedback is received individually through surveying, patient stories, complaints, compliments and comments cards. One-off user focus groups have been held, but no regular user forum exists.

Outcome for success of project: agreed Terms of Reference put in place; users recruited; schedule of planned meetings for the year put in place; minutes of meetings held produced.

Timescale: to develop, consult and introduce the user forum by the end of March 2017.

Patient experience - Project 2:

Introduction of elements of "Hello My Name Is…" national initiative on IPU

Dr Kate Granger, a senior registrar specialising in the care of older people, and who is also terminally ill, was an in-patient in NHS care and noticed that only some members of the healthcare team looking after her introduced themselves. Kate wondered why this fundamental element of good communication (the introduction) seemed to have failed. As a result, the idea of "Hello my Name Is…" was born.

The drive for this initiative is to recognise the human nature of healthcare with the patient being at the centre of this. "Hello my name is…" reminds all staff and volunteers engaging with patients and families to introduce themselves at every patient/family interaction. This develops trust and facilitates dignity and compassion as the bedrock of Hospice care.

Current baseline: IPU Staff have a mixture of name and ID badges and some staff introduce themselves to patients and families. In the User Survey 2015, patients and relatives reported a reduction in staff introducing themselves and explaining their role. In a complaint a relative highlighted that they could not clearly identify staff members. It was decided whilst introducing new name badges that they should be of a dementia friendly design. Dementia friendly "Hello My Name Is…" name badges will be used to support the ongoing work of creating a dementia friendly environment that was started last year. The IPU team have identified this as an area for improvement for 2016-17 and proposed this project.

Outcome for success of this 2 year project: improved scores in response to the question in the IPU user survey 2017 - "Do staff introduce themselves and their roles (to patients)" to "always" by 80% of patients. 100% IPU staff and volunteers to be aware of the project and its rationale, and be using the standard new "Hello My Name Is…" badge. No further complaints or concerns raised by users from 2017 regarding staff not introducing themselves.

Timescale: project implemented by March 2017, evaluation March 2018.

Patient safety - Project 3:

Introduction of Schwartz Rounds

Schwartz Rounds (SR) are evidence-based forums for health-care staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another. Evaluations of SR have been taken in USA and UK, and it has shown that staff involved have reported a vast improvement in dealing with stress, better team working and a greater focus on delivering patient-centred care. NLH consider it is timely to introduce Schwartz Rounds to add to its suite of reflective/reflexive opportunities for all staff including non-clinical. It will also give the opportunity to review the patients pathway by all individuals, teams and services involved in patient care. By providing forums for staff support and learning it will contribute to building staff resilience as well as an opportunity to reflect and share learning in relation to complaints and incidents in order to identify areas for improvement.

Current baseline: group supervison has been established for all front-line clinical staff for the past two years.

Outcome for success of the project: register of attendance of at least three NLH Schwartz Round Meetings.

Timescale: by end March 2017.

Clinical effectiveness - Project 4:

NLH improving its evidence of the implementation of the national initiative "Five Priorities of Care"

Following an independent review of the Liverpool Care Pathway for the Dying Patient (LCP), the Leadership Alliance for the Care of Dying People (LACDP) published "One Chance to Get it Right:

Improving people's experience of care in the last few days and hours of life" (June 2014). This document sets out the approach to caring for dying people that health and care organisations, and staff caring for dying people in England should adopt, irrespective of the place in which someone is dying. The approach focuses on achieving five priorities for care. These are:

1. Recognising that someone is dying and communicating this clearly
2. Communicating sensitively with them and others important to them
3. Involving them and others important to them in decisions about treatment and care as much as they wish to be involved
4. Supporting the family and others identified as important to the dying person
5. Creating an individualised plan of care, delivering it with compassion – Plan and Do

Current baseline: These priorities are well known, by specialist palliative care services like NLH, as core components of everyday palliative care best practice. NLH recognises, however, that its documentation may not be able to consistently evidence that it is delivering this best practice. Therefore this project has been identified by both IPU and Community Service as an improvement area for the coming year. The Community Service has also agreed to work with its respective borough community services to support their own implementation of this initiative.

Outcome for success of the project: New 5 Priorities of Care documentation (SMART form) will be in use to evidence the delivery in NLH IPU and Community Services. In-house and external offer of education programme in place and attended by IPU and Community Team staff.

Timescale: project implemented in NLH services by October 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 2015-16, NLH provided and/or sub-contracted 2 services 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 2015-16 represents 27 per cent of the total operational income generated by NLH for the reporting period .

Participation in clinical audits

During 2015-16, there were 0 national clinical audits and 0 clinical outcome review programmes covering NHS services that were appropriate to NLH provision. During that period NLH did not participate in any national clinical audits or clinical outcome review programme which it was eligible to participate in. The national clinical audits and clinical outcome review programme that NLH was eligible to participate in during 2015-16 are as follows (nil). The national clinical audits and clinical outcome review programme that NLH participated in, and for which data collection was completed for 2015-16, are listed below alongside the number of cases submitted to each audit or review as a percentage of the number of registered cases required by the terms of that audit or review (nil). The reports of 0 national clinical audits are reviewed by the provider in 2015-16 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 6 local clinical audits and 1 Quality Improvement project in 2015-16 and NLH undertook the following actions to improve the quality of healthcare provided.

1. <u>Controlled Drugs and Controlled Drugs Accountable Officer Audit</u> The audit has been devised by Hospice UK to meet the requirements of the Misuse of Drugs Regulations (2001) as amended 2007, The Health Act (2006) and The Controlled Drugs (Supervision of Management and Use) Regulations 2013. The audit highlighted the need to develop some specific Standard Operating Procedures and to ensure corrections made in the Controlled Drugs Register (CDR) are all clearly signed and dated. Policies will be reviewed by June 16 with guidance from the Pharmacist from Barnet and Chase Farm.
2. <u>Safe Practice in the Management of Medicines</u> The audit has been devised by Hospice UK to meet the requirements of the Misuse of Drugs Regulations (2001) as amended 2007 and The Health Act (2006). The audit highlighted the need for some policy updates and the consideration of the need for patient information. <u>3. Monitoring of Patients in the Community on Steroids Audit</u> A steroid prompt laminated card was developed and given to each Clinical Nurse Specialist (CNS) to assist them in documenting accurately the monitoring process for steroids for each individual patient. The community consultants are also reviewing the NLH guidance and utilizing the recently updated Pan National Guidelines (symptom management clinical guidelines).
4. <u>Documentation of Medication Changes on Admission to and from IPU (Quality Improvement Project)</u> Adaptations to the discharge proforma and teaching of junior doctors led to improvement in medication documentation of patients discharged from IPU. Results were also shared with the community teams to encourage accurate timely documentation of community patients medication before admission, although recognised community CNSs are not always able to keep accurate records as GPs are the primary prescribing physicians for this patient group.

5. First Visit Response to Referrals for Psychological support
Referral pathways to social work and other parts of the Patient & Family Support Service, including bereavement, are being reviewed in their entirety as the Social Work Manager has changed. This will involve consideration about the way psychosocial and psychospirtual needs are identified from point of triage, the electronic recording process, so that the initial assessment is built upon by the Multidisciplinary Team (MDT) more generally as well as in more depth. This will be summarized in in a new Patient & Family Support Policy and Procedure to be implemented from September 2016.

6. External Infection Control Audit
There is a comprehensive action plan for both sites.

7. Baseline Audit of Documentation of Admission to IPU
Audit results of the triage process are being used to inform the triage operational policy currently being drafted for May 2016. Standards of documentation from the Hospice UK tool were used to develop a NLH triage SMART (electronic reporting form) form to standardise documentation of triage processes – currently being piloted.

IPU Service Management Team (SMT) are using audit results to review the MDT approach to admissions aiming to ensure adequate holistic information is obtained at admission by the whole MDT, while minimising overlap to keep processes efficient and prevent the burden of duplication to patients. The SMT are also using the Hospice UK audit tool and standards to inform review of IPU 1st admission SMART form.

8. Hand-Washing Audit

This Audit has been completed at the Finchley and Winchmore Hill Sites. A self-monitoring tool is used. Staff members and volunteers working on the IPU and within OP&T were given a compliance sheet with hand-hygiene moments listed. Staff and volunteers were asked to completed compliance over a one-two hour period of their choice.

8.1 Finchley Site Audit

This is the sixth audit completed on the IPU. There was a 97% compliance which is the same result as 2014 -15

8.2 Winchmore Hill Site Audit

This was the second audit carried out. It is extremely disappointing that we have seen a significant decrease in compliance since the first audit. The 2015-16 compliance was 61% compared with 77% for the first audit. The developments at Winchmore Hill have seen an increase in the number of staff and volunteers within the service. It is evident from the audit results, that despite completion of induction training (which includes infection control training), e-learning and face-to-face training from the infection prevention link nurse, the theory of infection control and hand hygiene is not relating into practice. Further training has been, and will continue to be, provided for staff and volunteers. The importance of highlighting poor practice when observed is being reinforced to staff and volunteers.

The audit will be completed again in 6 months to continue to monitor compliance.

9. Audits deferred to 2016/7:
1. Documentation audit across organisation
(Originally planned for IPU only but cross-organisational issue.)
2. Spiritual Care re-audit – deferred to allow embedding of spiritual care SMART form
3. Number of calls to patient in community from referral to first visit

Research

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2015-16 , that were recruited during that period to participate in research approved by a research ethics committee was zero.

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 2015-16 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 against North London Hospice during 2015-16.

At both the Finchley and Wichmore Hill sites, the CQC carried out unannounced inspections as part of a routine schedule of planned reviews last in 2012 and 2013. 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 2015-16 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 (see Appendix 2). As part of the monitoring of the IG Standards within the Hospice, NLH completed the annual IG Toolkit in March 2016 with a score of 97% as satisfactory. It is expected that Health and Social Care Information Centre will notify NLH that it has approved the submission in April 2016.

Information Commissioners Advisory Visit
At the start of 2015, the Hospice requested that the Information Commissioners Office (ICO) undertake an advisory visit, the aim of which was to give advice on how to improve data protection practices. The visit was completed on the 28 August 2015.

Before the advisory visit it was agreed that the three main areas that ICO would look at were:

1. Security of personal data, reviewing how NLH keeps electronic and manual personal data secure
2. Records management, looking at how NLH process records containing personal data, including their creation, maintenance and eventual destruction
3. Requests for personal data, reviewing how individuals' requests for copies of their personal data are handled and how NLH manage one-off and routine disclosures to other organisations.

The Hospice has benefitted from the knowledge and experience of the Auditor to identify what NLH were doing well and areas in which improvements were required. The report received has been reviewed by the Executive Team and the actions are being monitored by the Information Governance Steering Group. Actions that have been taken include:

- Access code number to be changed more frequently
- Printing to be to printers in secure areas or the need to use pass keys to authorise it
- Confidential waste to be stored in secure bins before collection for destruction.

NLH was not subject to the payments by results clinical coding audit during 2015-16 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.

KEY SERVICE DEVELOPMENTS OF 2015-16:

Day and Date Clocks in In Patient Rooms

Clocks have been added into all patient rooms to help patients stay oriented and not lose track of the day /date.

Availability of new hearing aid device

Following user feedback and report by Enfield Healthwatch on improving access to services for the hearing impaired, an individual hearing device which patients or visitors can use to communicate is now available on both sites.

Development of community provision in Haringey

NLH have recruited to the posts and are now delivering a 7-day a week service to the borough of Haringey as part of the Haringey Partnership of providers including: North Middlesex University Hospital as lead provider, St. Josephs Hospice, Whittington Health District Nursing and Marie Curie Hospice

Hampstead.

Enhanced community provision in Barnet and Enfield
Since June 2014, NLH has been working in partnership with Macmillan Cancer Support to pilot a project, delivering specialist care at home for people with life-limiting conditions, which provides extra resources to supplement the existing NLH specialist community teams and Palliative Care Support Service (PCSS).

The key features of the project have been (i) early referral to the service; (ii) the provision of clinical interventions in the home or in an Outpatient setting; (iii) rapid response to patients and families in crisis by trained Health Care Assistants (HCAs); and (iv) practical support to patients and carers by trained community volunteers.

In 2015-16, 181 new patients were referred to the service. There were 80 phlebotomy interventions by the HCAs responding rapidly to support symptom management and prescribing, and potentially prevent unnecessary hospital admissions. 43 patients who were in crisis, or when their condition was unstable, or were at the end of their life, received a rapid response from the HCAs.

There was a total of 81 community volunteer support visits made. These visits may be of three different types:

- "sitting" – providing respite for patients and/or carers
- "befriending" – providing friendly conversation and companionship
- "good neighbour" – providing a visit to do a specific task that make all the difference.

The recent appointment of a Consultant and Advanced Nurse Practitioner has enabled the interventions arm of the project to be expanded and this will continue until 2017. Further funding of the services will be discussed with commissioners.

Extension of PCSS into Haringey

From April 2016, PCSS will be provided in Haringey as part of a 2-year pilot, funded by North London Hospice

Dementia

Dementia Friends information sessions are now included as a core element of the induction programme for new staff and volunteers. 138 staff and volunteers have received training in 2015-16. The Dementia Friend information sessions are being advertised externally in 2016-17. The education team has attended the Dementia Café run at Hornsey Housing Association to support a session.

NLHs dementia champions have started to Benchmark NLH against the Hospice UKs Hospice Enabled Dementia Care: the first steps provided checklists to support the development of an NLH dementia strategy moving forward. The Director of Clinical Services has met with Barnet CCG to understand how NLH can work in partnership to support the CCGs dementia work.

Train the Trainers and Implementing the 5 Priorities Of Care Initiative via education
As part of the national initiative for end of life care, the 5 Priorities Of Care (see page …), we are working in conjunction with our colleagues in the acute sector. Representatives from all 3-community teams and an educator have attended the University College London Partners' Train the Trainers programme to support delivering end of life education and embedding the principles of the 5 Priorities of Care.

"Come & Connect"

"Come & Connect" is for registered patients as well as those who have been discharged from OP&T clinically, but who wish to continue their social relationship with each other and the hospice. We learnt through user feedback that this is particularly important for some patients who are perhaps more

socially isolated and who have found that other means of meeting socially have become compromised through illness. We have moved away from seeing social connection as 'a programme' to a more natural experience so that users adjust their attendance according to their wishes.

"Come & Connect" includes elements of body, mind and spirit. *Body:* patients have the opportunity to access basic Yoga or Tai Chi, both of which can be done from a sitting position. Weather and volunteer numbers permitting, trips to the nearby local park have also become a regular feature of 'Come and Connect.' *Mind:* many patients report a sense of social isolation at home. Attending the socially ('come') allows them to 'connect' with other patients, with volunteers and with staff. Patients have access to a variety of social and craft activities ('knit and natter') which stimulate the mind and provide a sense of social normalisation. In Finchley there is a group and individual Music Therapy element, which has proved very popular. *Spirit:* both Finchley and Winchmore Hill currently have access to Mindfulness based Meditation, led by a member of the Chaplaincy Team. All patients have the opportunity to talk in depth with trained volunteers or members of staff about what matters most to them.

Independent nurse prescribing strategy
NLH are developing a strategy to support its community CNSs to progress through the assessment skills training then prescribing courses to enable them to prescribe certain specified medications for patients. The first nurse is scheduled to start this training in September 2016, which will lead to her becoming an independent nurse prescriber.

Integrated care agenda
NLH are an integral part of working with the Commissioners to develop the integrated care agenda, which will promote joint working and ensure that the most vulnerable in the community are identified and receive prompt referrals into the appropriate services. This may also help to support wishes and preferences for care and helps to promote advanced care planning, supporting people with their choices.
Each commissioning group is developing a strategy for developing integrated locality teams and NLH are ensuring North London Hospice engages with this and is a key member of the newly developed integrated services.

NEW PARTNERSHIP WORKING

North Middlesex University Hospital NHS Trust
North London Hospice
St Joseph's Hospice
Marie Curie Hospice Hampstead
Whittington Health

Haringey Community Palliative Care Team
George Marsh Centre
St Ann's Hospital
St Ann's Road
London N15 3TH

t: 020 8343 8841
f: 020 8343 7672
(North London Hospice)
e: triage.team@nhs.net

Haringey integrated end of life care service
The launch of the Haringey integrated end of life care service, in conjunction with Haringey Health Watch and Haringey Clinical Commissioning Group, is planned for public and professionals to introduce the service on 13/05/2016 at Tottenham Town Hall. NLH are one of 5 partners who deliver the service. NLH are delivering a Community Specialist Palliative Care Service, an out-of-hours advice line and an integrated Triage service with a Single Point of Access for Haringey end of life care referrals.

Joint community working
Clinical Nurse Specialists (CNSs) continue to work closely with general practitioners attending regular practice meetings to discuss and plan patients' care. Meetings are now in place to support joint working with our district nursing colleagues in all three boroughs.

Pilot data set projects
This year has seen NLH work in partnership with Public Health England and NHS England supporting the pilot of two data sets. NLH has been a pilot site for the Palliative Care Clinical Data Set (Public Health England (PHE)) and Palliative Care Funding Review (NHS England). Both pilots have required the organisation to establish the use of a number of outcome measures across the clinical services.
The PHE data set has been concerned with informing the roll out of a data set across all palliative care providers – the pilot has considered the implementation and IT requirements for organisations, ensuring the data set was clinically and technically fit for purpose and to test the submission requirements.
The Palliative Care Funding Review pilot has seen the organisation supporting the quantitative and qualitative testing of a currency (as defined by NHS England in developing a new approach to Palliative Care Funding, March 2015). NLH have been providing a data return and considering with Enfield Commissioners how the data produced in relation to a patient Phase of Illness, functional status and the recorded patient outcomes could support commissioning of services.

Work with Royal College of Physicians(RCP) and Royal College of Nursing(RCN)
NLH's Assistant Director –Quality, Giselle Martin-Dominguez has been the RCN and sole nursing representative on the RCPs Hospital End of Life Care National Audit which produced its report in April 2016.

NICE guidelines review panel for dementia

NLH consultant Dr Jo Brady was appointed to the NICE guidelines review panel for dementia providing palliative medicine expertise in dementia care.

EDUCATION AND TRAINING

New

- The Hospice has started working in partnership with Barnet and Southgate College to develop a CACHE Level 2 Award in End of Life Care. The award is a nationally recognised qualification and can be used as Continuing Professional Development (CPD) across all levels in the Health and Social Care industry.

- The Hospice is offering monthly tours of the Finchley site to get people talking and thinking about Hospice care, to dispel common myths and encourage people to support their local Hospice. The tours have been attended by Health Care Professionals, students and members of the community alike. One person wrote:

"I want to pass on my thanks for the guided tour of NLH last Friday. It was a fascinating insight into a service I knew so little about. You have a magnificent facility, so bright and airy and it was a privilege to be shown around and introduced to the work that goes on there. I left feeling very impressed and grateful to know the Hospice is there for all who need it."

- The Hospice has also welcomed visitors from as far afield as the USA to learn about the care and services offered.

- NLH provides an induction programme for new staff and volunteers as well as annual mandatory training. The Induction training has been revised and now includes emotional resilience and Dementia Friends Information Sessions. Additional internal training is also provided for staff.

NLH continued to deliver

- A bi-annual 'Introduction to Palliative Care' course aimed at trained nurses and allied health professionals that runs over four days.

- A bi-annual 'Introduction to Palliative Care' course aimed at Health Care Assistants and Support Workers that runs over two days.

- Monthly syringe driver training, assisting nursing homes and district nurses to become familiar with the 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 continued to support care homes to help them become accredited GSF homes.

- Bespoke training for care homes and District Nurses.

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- The Hospice has continued to offer free Sage & Thyme, foundation level communication training to both internal and external staff.

- Our own 'Oyster' Training to volunteers to help develop emotional competence and resilience. This is becoming more widely recognised and we are currently seeking the accreditation of this training.

NLH continues to offer a variety of training placements including:

- Student nurses with the University of Hertfordshire

- Speciality Registrars from the Local Education and Training Board (LETB)

- Senior House Officers from Barnet General Practitioner Vocational Training Scheme

- Social work student placements with London South Bank University

- Half- and 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).

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 2015-16 activity only.

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 relate to completed admissions by end of March 2016.

ALL ADMISSIONS	2012 TO 2013	2013 TO 2014	2014 TO 2015	APRIL 2015 TO MARCH 16			
				BARNET	ENFIELD	HARINGEY	TOTAL
Admissions to the IPU:							
Patient admissions (NLH target 330)	313	314	295	161	132	49	342
% Patients with cancer	89%	86%	93%	88%	89%	84%	88%
% Patients with non-cancer	11%	14%	7%	12%	11%	16%	12%
Completed in-patient stays:							
Total of completed stays	357	345	288	167	133	50	350
Total number discharged home (including care home)	89	82	55	52	36	12	100
Discharged to acute	4	7	3	2	3	0	5
% patients returning home	25%	24%	19.1%	32%	27%	24%	29%

Total number of patients who died	264	256	234	113	94	38	245
% patients who died	74%	73%	80.9%	67%	70%	76%	70%
Average length of stay (NLH target 14)	12.6	13.3	14.(13.6*)	16.2	10.5	14.2	13.8
Day Cases	9	8	2	9	12	7	28

*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 & Comment:

It can be seen that there has been an increase in the number of patients that have been admitted to the IPU this past year compared with the previous years 2012-13, 2013-14, 2014-15. Compared with last year a similar percentage were Enfield patients ;an increase in Haringey patients and a slight decrease in Barnet patients . The actual number of Barnet admissions remained fairly constant at 161 this year compared with 166 last year. This past year has seen a return to 2012-13, 2013-14 year's levels for percentage of patient admissions with a non-cancer diagnosis.

A higher percentage of patients have been discharged home this year compared with previous years. This has had the effect on a lower number of patients dying on the unit compared with 2014-15. It should be noted, however, that the % of patients who died on IPU in 2015-16 was similar to 2012-13 and 2013-14.

There has been a significant increase in day-case admissions. The majority of these (20) were for blood transfusions.

Bed usage

ALL ADMISSIONS	2012 TO 2013	2013 TO 2014	2014 TO 2015	APRIL 2015 TO MARCH 2016			
				BARNET	ENFIELD	HARINGEY	TOTAL
Bed occupancy (NLH target 75%)	73%	73%	81%	38%	21.3%	10.7%	70%
Closed bed days: Refurbishment			596				
Closed bed days	85	116	75				30

9% of beds were closed for refurbishment during the Year 2014/15

Analysis & Comment:
It is noted that bed occupancy is lower this past year compared with 2014-15 but similar to 2012-13 and 2013-14.
Decrease in bed occupancy may be attributed to a variety of factors. There were more available bed days this year, whereas last year there was a high number of unavailable beds owing to the IPU refurbishment. This may explain why occupancy of available beds was higher. Bed occupancy can be affected by the ebb and flow of referrals, problems with NHS transport, and staffing shortages of nurses and doctors. There are times when we receive referrals,but there is no bed availability and times when there are available beds and no referrals.
It is pleasing to see closed bed days continues to reduce year on year. This could be attributable to the purchase of 18 new beds made possible by the Fund a Bed Campaign, extending the availability of housekeeping, the replacement of carpeted bedrooms to hard flooring making cleaning of rooms quicker as part of last year's IPU refurbishment and the resolution of long-standing plumbing issues.

OP&T services

Until March 2015 the Hospice operated a single OP&T Service. These were split in to two separate services from 1 April 2015. The overall activity figures for 2013-15 are provided for information purposes only

OP&T 2013-15

	2013 TO 2014	2014 TO 2015
	ALL PATIENTS	ALL PATIENTS
Total number of patients	184	243
Patient attendances (NLH target 1665*)	927	1316
Patient did not attend		890
% patients with cancer	88%	82.9%
% patients with non-cancer	12%	17.1%
Nursing and Therapies session (NLH Target 3300)	621	819
Complementary Therapy session-patient	1638	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).

Outpatients service 2015-16

	April 2015 to March 2016			
	Barnet	**Enfield**	**Haringey**	**Total**
Total number of patients	113	115	20	248
Number of attendances	330	388	83	801
Patients did not attend	39	54	8	101
% of patients with cancer	68%	85%	71%	77%
% of patients with non-cancer	32%	15%	29%	23%

Therapies service

	April 2015 to March 2016			
	Barnet	**Enfield**	**Haringey**	**Total**
Total number of patients	116	107	24	247
Patient attendances Winchmore Hill	137	588	94	819
Patient attendances Finchley	265	44	8	317
Patients did not attend Winchmore Hill	27	73	2	102
Patients did not attend Finchley	46	5	2	53
% of patients with cancer	70%	84%	70%	77%
% of patients with non-cancer	30%	16%	30%	23%
Complementary Therapy Sessions	257	401	50	708
Other Therapy sessions	142	227	26	395
Social Program attendances	138	188	38	364

Analysis & Comment:

Only a decrease in patient non-attendance can be noted.

Community teams

	2012 TO 2013	2013 TO 2014	2014 TO 2015	APRIL 2015 TO MARCH 16			
				BARNET	ENFIELD	HARINGEY	TOTAL
Total number of patients	1265	1251	1299	830	687	456	1973
% Patients with cancer	76%	80%	83.5%	76%	78%	77%	77%
% Patients with non-cancer	24%	20%	16.5%	24%	22%	23%	23%

Completed periods of care	930	851	1056	647	547	338	1532
Patients discharged from the service	158 17%	179 21%	215 21.5%	158 24%	129 24%	118 35%	405 26%
Number of patients who died within the service	772 83%	672 79%	841 79%	489 76%	418 76%	220 65%	1127 74%
Died (%) at home (including care home)	55%	58%	59%	63%	60%	52%	60%
Died (%) hospice	22%	21%	18%	19%	17%	26%	19%
Died (%) hospital	20%	20%	19%	17%	22%	21%	20%
Died (%) other	3%	1%	4%	1%	1%	1%	1%
Average number of visits and telephone calls made by the Community Team to each patient during office hours							
Visits	5	5.1	5.2	4.9	5.3	5.2	5.1
Phone calls to patient/family	12	12	14.9	10.1	10.4	8.2	9.5
Phone calls to other professionals	12	8	9	5.7	5.7	7.0	6.3
Average number of telephone calls made out of hours and at weekends to each patient							
Phone calls to patient/family	3	2	0.8	1.8	2.7	1.0	1.9
Phone calls to other professionals	1	1	0.5	0.9	1.3	0.8	1.0

Note: During the half-year Haringey did not provide a 7-day service.

Analysis & Comment:

The number of patients seen by the community teams has increased significantly. This is in partly attributable to the extension and development of NLH's community service provision in Haringey. The percentage of patients discharged this year has increased. Year on year the number of patients the service supported to die in their homes has increased and is now at 60%.

PCSS

	2012 TO 2013	2013 TO 2014	2014 TO 2015	APRIL 2015 TO MARCH 2016		
				BARNET	ENFIELD	TOTAL
Total number of patients (NLH target 400)	241	278 (277)	279	148	173	321
% Patients with cancer	83%	81%	82%	73%	72%	72%
% Patients with non-cancer	17%	1 (19%)	18%	27%	28%	28%
Total hours direct care (NLH target 14589)	9497	16244 (14278)	14985	5179	7883	13062
Home death rate			97.5%	98%	94%	96%
Average hours direct care per patient	39.25	58.4 (51.55)	53.7	35	45.6	40.7

Please note in 2013-14 the difference in figures provided in parentheses and out of parentheses 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 parantheses.

	PCSS CARE PROVIDED FOR EACH BOROUGH APRIL 2014 TO MARCH 2015			PCSS CARE PROVIDED FOR EACH BOROUGH APRIL 2015 TO MARCH 2016		
	BARNET	ENFIELD	TOTAL	BARNET	ENFIELD	TOTAL
Total hours of care	6286	8699	14985	5179	7883	13062

Health Care Assistants	5813	7578	13391	4083	6643	10726
Registered Nurses	473	1121	1594	1096	1240	2336

Analysis & Comment:

PCSS data show an increase in number of total patients and an increase in non-cancer patients seen. There is a similar high home death rate at 96%. Average hours of direct care per patient total numbers has reduced as well as the total hours of care. This was noted by the Service Lead and meetings with the District Nursing services were held and a promotion exercise is underway.

Supportive care team

1. Spiritual care team (IPU)	**2014 TO 2015**	**APRIL 2015 TO MARCH 2016**			
		BARNET	**ENFIELD**	**HARINGEY**	**TOTAL**
Number of clients in the IPU	295	162	130	52	344
Number of clients seen by the Spiritual Care Coordinator	222	52	46	17	115
Number of contacts by Spiritual Care Coordinator	590	156	103	45	304
Average number of contacts by Spiritual Care Co-ordinator	2.65	3.0	2.2	2.6	2.6
Number of clients seen by the Spiritual Care Chaplains	208	111	86	33	230
Number of contacts by volunteer IPU Chaplains	1380	680	412	177	1269
Average number of contacts by volunteer IPU Chaplains	6.6	6.1	4.8	5.4	5.5

2. Social workers team (IPU and Community)	**2014 TO 2015**	**APRIL 2015 TO MARCH 2016**			
		BARNET	**ENFIELD**	**HARINGEY**	**TOTAL**
Number of clients seen by social workers	557	315	193	165	673

Number of face-to-face visits by social workers	1102	770	353	393	1516
Number of telephone contacts by social workers	2869	168/3	675	596	2954
Average number of contacts by social workers	7.1	7.7	5.3	6.0	6.6

3. Loss and transition service (including crimson volunteers)	**2014 TO 2015**	**APRIL 2015 TO MARCH 2016**			
		BARNET	**ENFIELD**	**HARINGEY**	**TOTAL**
Number of clients seen by staff	399	99	79	116	294
Number of visits made by staff	942	186	133	247	536
Average number of visits by staff per client	2.4	1.9	1.7	1.9	1.8
Number of clients seen by volunteers	121	144	103	39	286
Number of volunteer sessions	1153	588	383	124	1095
Average number of sessions by volunteers per client	9.5	4.1	3.7	3.2	3.8

Client=patient or significant others

Analysis & Comment:

The data show the significant contribution that 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 more patients this year than previous. This could be attributable to the expansion of the team with Haringey community provision. 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. More clients were seen by the Spiritual Care Team than last year, but received less average contacts by the volunteer IPU chaplains. The Loss and Transition service (see Appendix 1 for service role description) saw significantly less clients with a lower average number of visits by staff and trained volunteers. This service is currently being reviewed and will return to be part of the Social Work team.

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. This year on the IPU and Outpatients Service patients have been offered the opportunity to complete the survey with trained user volunteers (see Priority for Improvement Project 2015-16 on page…).
Comments cards remain in use. This year any feedback that raises a concern is now processed formally where possible by the service to see if improvements are required. 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 (see pages …). These have enabled us to gain more up to date feedback and as they are not anonymised enables us to take immediate positive action where needed.
Below the number and examples of concerns and compliments received from April 2015-March 2016 are recorded.

Concerns

Total: 40 received.

Example 1:Bunch of keys used to open drug cupboard on Inpatient Unit makes a lot of noise at night and disturbs those in nearby room.
Response: Lock to drug cupboard changed

Example 2:Patient felt she was dealt with abruptly when calling the Hospice
Response: Staff informed and undertook Sage & Thyme communication training

Compliments

Total: 195 recorded on Compliments Log

Community Team Barnet: Total for service=37
"Thank you for all you've done to help my father, He liked you very much and thought of you as a caring and kind person. Thank you for caring."

Community Team Enfield: Total for service=30
"Thank you so much for your support and reassurance. With your support I was able to keep my Aunty at home where she wanted to be and for that I am grateful. Thank you once again."

Community Team Haringey: Total for service=10
"I just wanted to thank you and all the other staff involved in XXX's care. She was given so much time in her final months of her life to reflect on what we were all facing and I know she faced her death without any fear."

Inpatient Unit: Total for service=94
"You put so much thoughtfulness into everything you all do. Thank you so much"

PCSS: Total for service=2
"Just a few brief words to thank you for your support to XX for end of life care. XXX, XXX and other younger lady were of inestimable value to me in last few days. I am most grateful."

Outpatients: Total for service= 5
"I would like to thank everyone at North London Hospice for their help. I found it easy to discuss my illness with members and staff. There is always a good relaxing presence with everyone around. I myself have felt less stressful and I enjoy my talks with the staff. Cancer is a terrible illness to live with, but with places like the Hospice it helps greatly to know you're not alone."

Therapies: Total for service= 9
"I have had six sessions of acupuncture for hot flushes, which are a side-effect of medication. The treatment has been life changing because the hot flushes have now stopped. Thank You"

Supportive Care: Total for service= 6
"Thank you and everyone involved with yesterday's Ceremony of Remembrance. It was an enormous amount of work and was so tastefully done. My mother would have also been very complimentary to you and I only hope she is somehow looking down at everything."

Volunteers: Total for service= **2**
"To all the volunteers at the Hospice. Thank you for everything. "

Case Studies

Total: 5

Barnet Community Team: 2
"Happy with service from NLH although would have liked more visits".
Community Nurse helped all along the way and didn't speak in 'medical talk'. When patient came into IPU, he was in the best place and died peacefully and quietly. Relative looked after well too – made sure she was warm at night.

Haringey Community Team: 1
NLH involvement minimal as patient deteriorated and was taken to hospital, which was easier for family to get to. Thought some bereavement counselling would be useful which was passed on to Haringey bereavement services.

Therapies: 1 (Winchmore Hill)
Patient comes along to sit and be quiet – feels safe as staff would know what to do if he needed help. Finds it peaceful, people decent and enjoys the conversation. Good food, nice chef.

IPU: 1
Thank you for treating him like a man with 80 years of wisdom and worldliness
and not like someone who had ceased to be able to look after himself.

User Surveys 2015

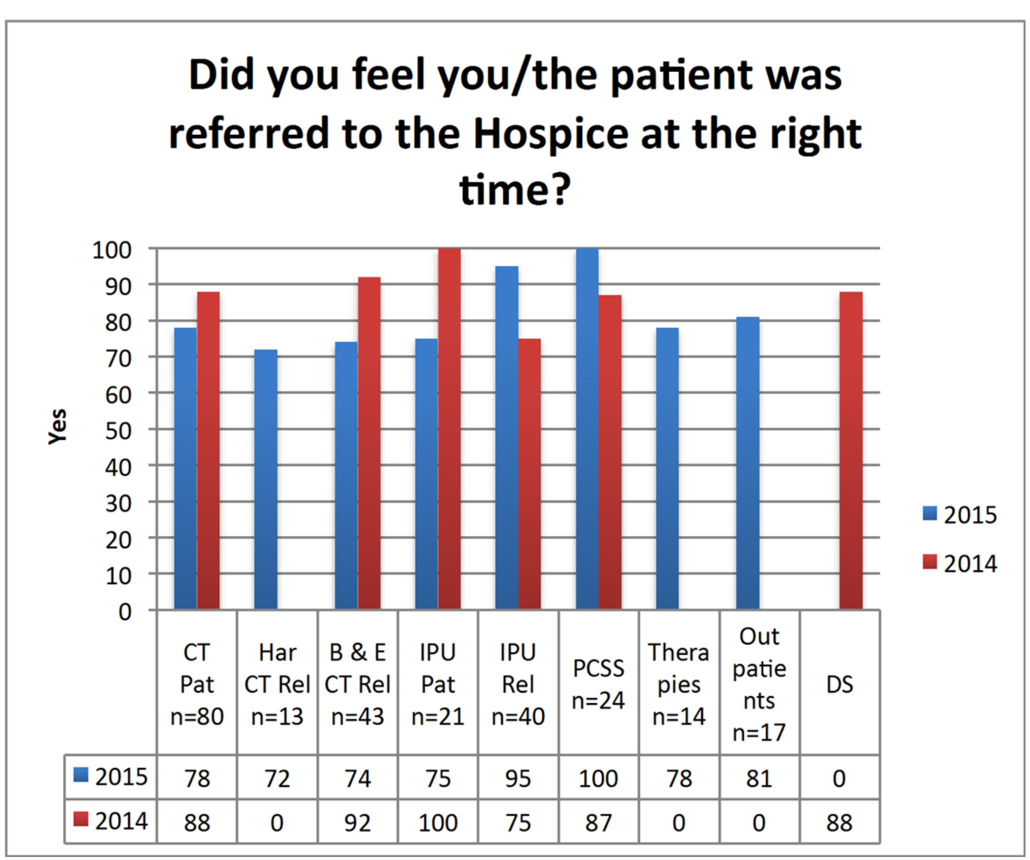
As in previous years surveys were sent out to all services in a 6 month period from May-Oct 2015.

For the first time this year the results were reported using new 'real time' software which meant that for the first time, any questions that had been 'skipped' were included in the reporting under 'Not applicable / Not answered'.

This means that for 2015, n=all responses including Not applicable / Not answered, which may be a contributing factor as to why the 2015 results are on the whole lower than in previous years.

Key Performance Indicators

Key Performance Indicator 1



	CT Pat n=80	Har CT Rel n=13	B & E CT Rel n=43	IPU Pat n=21	IPU Rel n=40	PCSS n=24	Thera pies n=14	Out patie nts n=17	DS
2015	78	72	74	75	95	100	78	81	0
2014	88	0	92	100	75	87	0	0	88

If not referred at the right time, more people felt they had been referred 'Not soon enough' than answered 'Not sure'.

	Not soon enough	Not sure
CT Pats	n=12	n=5
Har CT Rels	n=3	n=1
B&E CT Rels	n=10	n=3
IPU Pats	n=5	n=2
IPU Rels	n=1	n=1
Therapies	n=3	n=1
Outpatients	n=1	n=2

Across the services, 2% did not respond to the question.

Not answered

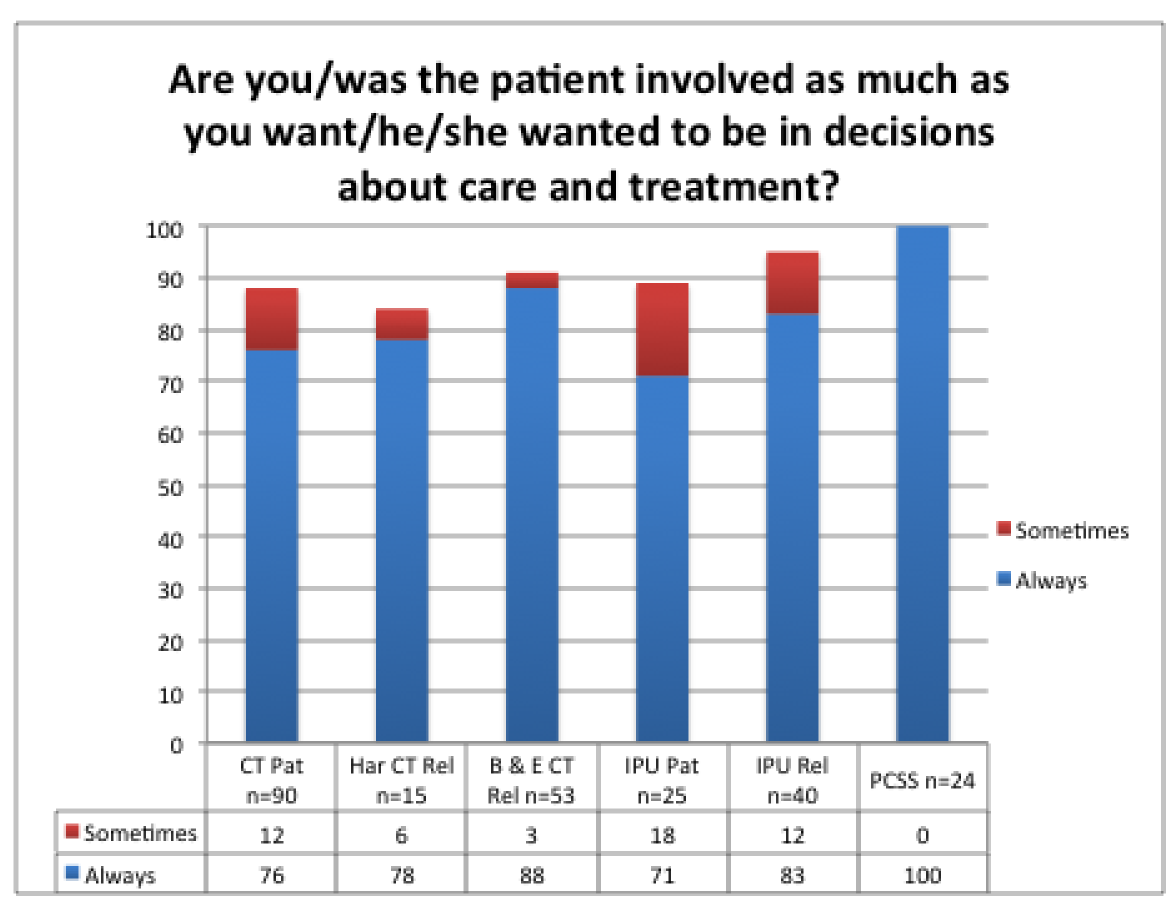
CT Pat	Har CT Rel	B&E CT Rel	IPU Pat	IPU Rel	PCSS	Therapies	O/P
5%	6%	3%	0	0	0	0	5%
n=5	n=1	n=2	0	0	0	0	n=1

Comment:

After consideration, it is felt that this is not a question that NLH are able to sufficiently influence or improve upon, nor is it integral to the user's experience of our service.

We will therefore be replacing this Key Performance Indicator from 2016/17 with the following question: Do you feel staff treat you with compassion; understanding; courtesy; respect; dignity? This will give us
clear information of how users across the services experience our care and gives us the opportunity to see where improvements could be made.

Key Performance Indicator 2



This question did not feature on the 2015 OP&T survey.

In 2014 the results were all slightly higher, with the exception of the PCSS who have remained at 100%.

Across the services, 6% did not respond to the question.

Not answered

CT Pat	Har CT Rel	B&E CT Rel	IPU Pat	IPU Rel	PCSS
9%	17%	7%	7%	5%	0
n=9	n=3	n=4	n=2	n=20	0

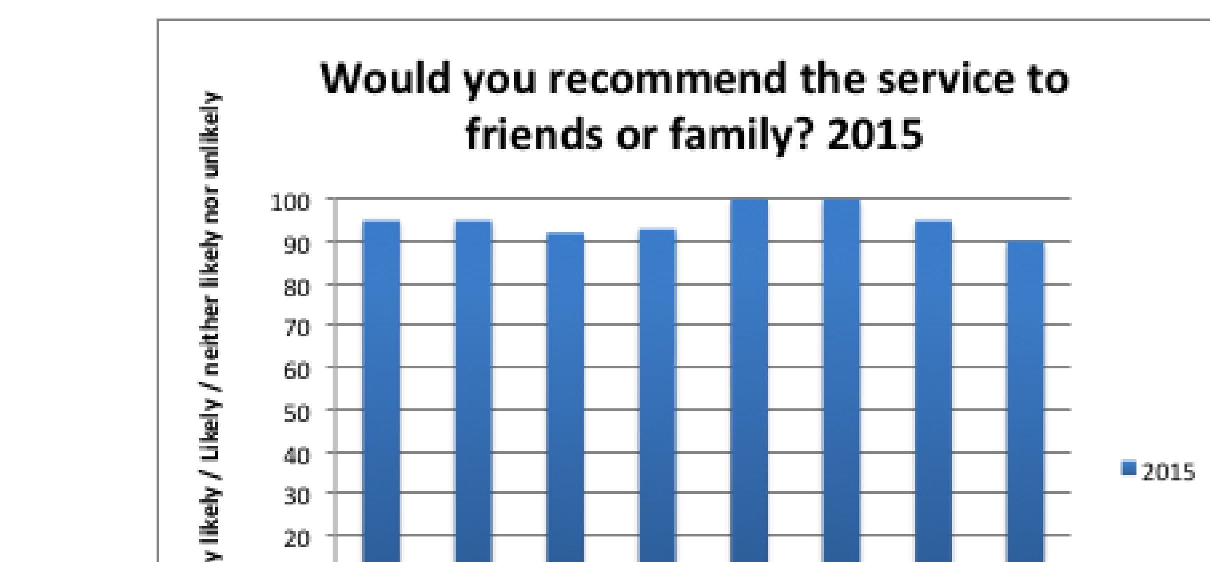
Key Performance Indicator 3 - Family and Friends test

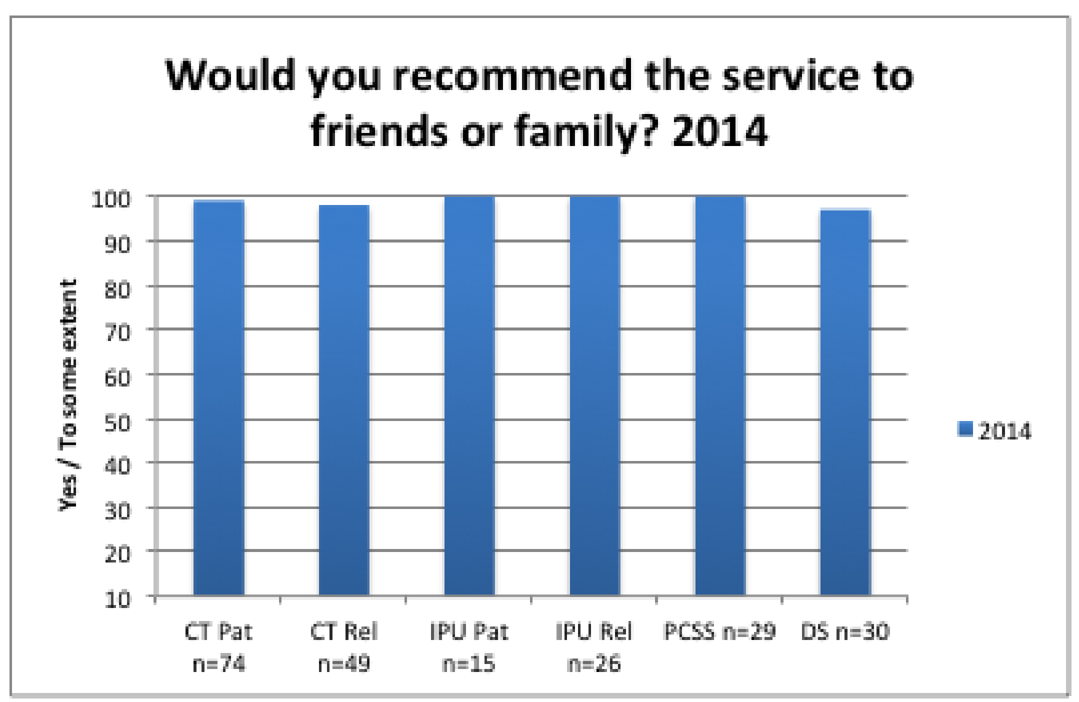
This year we brought our responses to the Family and Friends test in line with those used across the NHS in their Family and Friends test.

Q. Would you recommend the service to friends or family?

LH response wording 2015 (as NHS):
Extremely likely
Likely
Neither likely or unlikely
Unlikely
Extremely unlikely
Don't know / not applicable
NLH response wording 2014:

Yes
No
To some extent
Not sure





In 2014, the average of the responses 'Yes' and 'To some extent' across the services was 99%.

In 2015 the average of the responses, 'Extremely likely', 'Likely' and 'Neither likely nor unlikely' across the services is 95%.
The average of those who answered 'Don't know/Not applicable' is 4% (Reported for the first time in the new system.)

Both the IPU Patient and Haringey relatives had one person who said they would be unlikely to recommend the service.

Haringey CT Relatives, PCSS and IPU Relativess had no instances of 'Don't know/not applicable'.

Comment: It is noted that NLH performs well in this indicator.

Following consideration by services of their service's user survey results, below are listed some areas services have identified for improvement in 2016-17:

- Review of verbal and written patient information about community service to emphasise contact numbers for users (Community Team)
- Review of catering provision (IPU)
- Seek clarification form users that they understand answers given to their questions (Therapies)
- Therapy volunteers to undertake refreshers course in listening skills (Therapies)
- Review of how information is given by staff to users

COMPLAINTS

Quality Performance Indicator	2012-13	2013-14	2014-2015	2015-2016
Total number of Clinical and Retail Complaints -NLH annual targets less than (n)	19	34	18 (30)	21 (20)

Quality Performance Indicator	2013-14	2014-15	2015-16
Investigations completed, complaint upheld/partially upheld	18	12	9
Investigations completed, complaint not upheld	7	0	6

Analysis:

21 complaints have been received this year. 12 complaints relate to clinical services, of these 5 relate to quality of care, 5 relate to communication and 2 to staff behaviour.
There were 5 shops complaints.
15 complaints investigations are completed. Of the remaining 6:
one multi-agency complaint & not about care from NLH (other providers investigating)
one about care given by NHS only(other providers investigating)
one complainant failed to respond to NLH requests to progess complaint
one complaint not progressed as matter had previously been addressed (shops)
two complaints investigations are ongoing

(One multi-agency complaint from 2014-15 has now been referred to The Parliamentary and Health Service Ombudsman.)

The following are some examples of actions taken following completed investigations (15) this year:

- Customer Service training is being given to all shop staff.
- Interpreter to be used at all Community visits for patient to avoid mis-interpretation or misunderstandings and provide an equitable service compared with other patients and families. NLH will endeavor wherever possible to use an interpreter when required, but sometimes this is not possible if a visit has to be urgenty arranged.

PATIENT SAFETY

Incidents

	2012-13	2013 -14	2014-15	2015-16
Total number of incidents	279	250	216	250
Total Number of clinical incidents	168	173	152	205
Clinical incidents as a percentage of total number of incidents	60%	69%	70%	82%

Analysis & Comment: total number of incidents appears consistent with previous years, but with an increase in clinical incidents as percentage of total.

COMPARISON OF CATEGORY OF CLINICAL INCIDENTS

	2013-14	2014-15	2015-16
Major	6	5	3
Moderate	60	53	59
Minor	62	68	153
No effect	45	26	35

Of the three major clinical incidents in 2015-16, one related to unaccounted CD ampoule which had significant internal and external investigation; a second related to a missing wedding ring, the recording of patients property on admission is under review in addition to the information given to patients and their families and the third related to a patient admitted to the IPU with a Grade 4 Pressure Sore.

Falls:

	2012-13		2013-14		2014-15		2015-16	
Number of patient-related slips/trips/ falls(% of all incidents) (NLH target less than 65)	60	22%	61	24.4%	49	22.7%	36	14.4
Falls per 1000 occupied bed days	13.45		13.7		9.75		7.83	
Hospice UK Benchmarking Falls per 1000 occupied bed days								

Comment [GM1]: To be added once data available in May

Analysis & Comment:number of reported falls is lower. The level of harm caused to patients who have fallen remains low (30%) or none (70%). It is pleasing to see the falls per 1000 occupied bed days improving.

Pressure sore monitoring and reporting

Summary of pressure sores reported 2015 to 2016

	2013-14		2014-15		2015-16	
	UNAVOIDABLE	AVOIDABLE	UNAVOIDABLE	AVOIDABLE	UNAVOIDABLE	AVOIDABLE
Developed Grade 3 more than 72 hours of admission	9	0	6	0	0	15
Pressure sores developed Grade 3 more than 72 hours of admission per 1000 Occupied Bed Days*	2.02	0	1.3	0	0	3.26

*Occupied bed Days April to March = 4727 April to March 16 = 4593 bed days, 25 Grade 2 acquired after 72 hours

Hospice UK Benchmarking Project looks at grade 2 and above pressure sores that developed after 72 hours of admission and has shown this year that NLH at is…

Comment [GM2]: Full year Hospice UK data to be added in May

Explanation:

NLH's services and governance systems scrutinise Grade 2 and above 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 so that Governance Systems review care being provided and take any necessary additional actions. Grade 3 and above pressure sores are reported externally also to local Clinical

Commissioning Groups, tissue viability nurses and Local Authority Safeguarding teams. NLH carries out in-depth case review called "Root Cause Analysis" or abbreviated commonly to "RCA" for all Grade 3 and above pressure sores that develop after 72 hours of hospice admission. These are undertaken in house and scrutinised by NLH's governance systems described in Part 3-Quality Systems and Appendix 3. A judgement is made by the investigator leading the RCA as to whether the pressure sore development is considered "avoidable" or not and reviewed by governance groups. Please see Appendix 4 for definition of "avoidable" and "unavoidable" pressure sores.

Analysis & Comment:
An increase in the number of Grade 3or 4 pressure ulcers developed more than 72 hours after admission on IPU has been noted. 14 of the 15 patients who developed Grade 3 or 4 pressure sores were admitted with pressure sores which progressed under NLH care. While it is internationally recognised (Skin Changes at Life's End –SCALE- Final Consensus Statement of the European Pressure Ulcer Advisory Panel ,2009) that the Hospice client group is prone to increased incidence and vulnerability to pressure ulcers , NLH continue to scrutinise care to ensure its quality of care. RCAs have been completed for 12 of the 15 Grade 3 or 4 pressure sores developed more than 72 hours, with the remaining RCAs currently being completed.
In previous years pressure ulcers have been deemed as "unavoidable". NLH's improved scrutiny through this year RCAs, have demonstrated a paucity of documentation of care delivered, therefore the ulcers that developed could not be deemed as " unavoidable".
The completion of the RCAs and review of the themes has resulted in significant focus on the management of pressure ulcers, informing changes in practice. This has been supported by the publication of NICE Guidance for Pressure Ulcer Prevention 2015 to develop a systematic approach to demonstrate effective care delivery. The use of the SSKIN (any defn needed?) bundle has been introduced to the IPU to improve documentation and to evidence the nursing care delivered. Improvements in documentation are being noted.
This year will see the reporting of Grade 1 pressure ulcers through NLH incident reporting processes in line with the Hospice UK Benchmarking requirements.
Questions remain for the organisation in regard to the increase in Grade 3/4 hospice acquired pressure ulcers, i.e. whether this is related to the education and training that has been undertaken this year, which means pressure ulcers are being graded more accurately and consistently than in previous years, or whether changes are required to our care. April 2016 will see the publication of the Hospice UK 'Management of pressure ulcers in the in-patient unit' audit tool. The tool was created by the National Quality Advisory group and has been endorsed by NHS England. The audit will be completed in 2016-17 to support the ongoing review of pressure ulcer management on the IPU

Infection control

QUALITY AND PERFORMANCE INDICATOR(S)	2012-13	2013 –14	2014-15	2015/16
The number of patients known to be infected with MRSA on admission to the IPU	4	3	7	1
The number of patients known to be infected with *Clostridium Difficile, Pseudomonas, Salmonella, ESBL* or *Klebsiella pneumonia* on admission to the IPU	0	2 with known *Clostridium Difficile*	1 patient known to have Vancomycin-resistant *Enterococci*	1 Patient known to have vancomycin-resistant *Staphylococci* 1 patient known to have *Clostridium difficile*

Patients who contracted these infections while on the IPU (NLH target 0)	0	0	0	0

Comment: It is pleasing to report that patients did not contract any of the above infections while under NLH IPU care and it could be concluded that NLH Infection and Prevention Control Plan and processes are effective.

PRIORITIES FOR IMPROVEMENT 2015-16

The following priorities for improvement for 2015-2016 were identified by the clinical teams and were endorsed by our internal governance structures.

1. Priority one: patient experience:

Listening and responding to current individual user feedback

NLH wanted to pilot real time user feedback to identify what aspects of the current service experience could be improved so prompt actions could be made to improve the individual's care experience. 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 in April 2015:
NLH carried out user postal surveys each year over a 6-month period. Feedback was 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 as this patient group is often quite frail and unwell.

Outcome proposed in April 2016:
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. NLH would hope to increase the number of volunteers to 6 involved in supporting patients to complete the user survey. It is envisaged this would support the completion of at least 32 IPU patient surveys and hence provide a minimum of 32 patients with increased social/personal interaction time with volunteers.

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.

Project delivery:
Two tablets and new patient Experience Real Time reporting software were purchased with a grant from Towergate. More time than expected was involved in transferring NLH surveys into the software package, which did cause some delays to the project. 4 patient feedback volunteers were recruited and trained for the first phase of introduction of the project on IPU. Since the start in September of the use of the tablets with IPU patients, a total of 32 surveys have been completed on the tablet by volunteers with IPU patients. This is double the amount of paper surveys that were returned in the 2014 survey period for this group of patients. This mode of surveying will continue throughout 2016-17. 14 surveys have been completed with Therapy Service patients.

We have had 9 instances of realtime feedback:

Request	Action
Patient wanted morning shower earlier	Entry made in patient's notes
Patient wanted a daily newspaper	Newspapers now available for purchase
Hot water in patient's room never hot	Reported to facilities and engineers are actioning
Bacon always burnt and portion too small	Reported to co-ordinator
Diabetic food required	Now a small range of diabetic products are available
Patient requested dressing change 3 times – not actioned	Discussed with patient and apologized. To be discussed at ward meeting 9/5/16
Member of night staff 'brisk' when helping patient to bathroom	To be discussed at ward meeting 9/5/16
Patient given prunes with stones in	Kitchen will only order food without stones in future
Request for protective bib when eating	Responeded to patient need.To be highlighted to staff at ward meeting 9/5/16

The remaining 2015 paper surveys were inputted into the software by supported volunteers and have facilitated the easier production of this year's User Survey Report that was presented to the Hospice's Board in April 2016.

Challenges to date:

- Usability of software package
- Sometimes it is not possible for the volunteer to find a patient to survey owing to the presence of visitors, patient sleeping, patient requests survey at another time, etc.
- Recruitment of patient feedback volunteers
- Winchmore Hill – patients often come for a therapy and then go home, sometimes difficult to 'catch them'

Conclusion/ongoing plan:
The project has realised the provision to NLH services of user feedback that can quickly improve current patient experience. The delivery of the project in IPU and OP&T is continuing and will be reviewed regularly. The vision is to deliver the user survey to PCSS and Community Service users via the same software using patient feedback volunteers telephoning users and supporting the survey completion online.

2. Priority two: to introduce a bespoke risk management database

To introduce a bespoke risk management database

Baseline

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. NLH had previously logged and managed incidents using a number of in-house developed Excel spreadsheets, which had limitations in their use and effectiveness. The introduction of a new bespoke risk management database, Sentinel, will enable the Hospice to build on the progress we have made with patient safety. The database will enable ongoing improvements of reporting, monitoring of outcomes and learnings.

The database provides:

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.

Initial plan

To complete the construction of the bespoke database by the end of May 2015, with all data on incidents, complaints, critical feedback and compliments from the 1st April to be uploaded centrally on to the system. To have members of the Quality Team trained on the system by the end of the first quarter and roll out training across all services to 60 key staff.

Project delivery

All incidents, complaints, compliments and critical feedback are now logged and managed on Sentinel. Training was completed with the key staff across the organisation who are now supporting their teams in recording on the Sentinel.

The Quality and Governance Team and Service Managers are becoming familiar with the system and developments are ongoing in relation to reporting, presentation and use of reports within internal governance meetings.

Conclusions/ongoing plan

We have seen an increase in reporting of incidents in 2015-16, which could be attributed to how the profile of incident reporting and management has been raised within the organisation through the training, and the ease of access to the system for logging and reporting of incidents.We need to ensure that we fulfil the ongoing training needs of staff, identifying and addressing areas of improvement in the content and quality of incident reports.

We have established the reporting requirements for the key governance meetings. In 2016-17 further work will be undertaken with teams and departments to understand and meet their reporting requirements to ensure the database is supporting them in delivering feedback to teams and supporting outcomes and learning.

Staff views and experience of incident reporting will be sought in the summer of 2016 to continue to inform developed of the database and processes.

3. Priority three: clinical effectiveness:

There was a change in the Clinical Effectiveness Priority for Improvement project delivered this year. The scoping exercise on supporting those living and beyond chronic illness was unable to progress following the project Lead leaving the organisation. It has not been possible to identify another member of staff to progress the work. The organisation, however, remains committed to supporting this patient group through the OP&T service, and revised the project to investigate the needs of people living with Long Term Conditions (LTC) in the catchment areas of Barnet, Enfield and Haringey to support future investment and service development.

Investigating the need of people living with LTC

Baseline

The Hospice wanted to ensure the best use of its resources and wanted to look at how to broaden its reach to more patients, and to make maximum use of its facilities and staff.

Initial plan

The following questions were addressed through the scoping exercise and resultant report:

1. Is there an unmet need for patients living with LTC's in our catchment area?
2. Can NLH do more to meet this need?

Project delivery

An external management consultant was appointed and a project plan developed. They successfully engaged and met with internal and external stakeholders to scope the needs. The process of external engagement in itself is acting as an opportunity for promoting and marketing the current service provision.

It proved challenging to gain clear data on the numbers of those living with a LTC within the three boroughs. The scoping did identify that there are needs of those living with LTCs that can be met through the provision of Hospice Service, in particular through the development of the OP&T service provision.

Conclusions/ongoing plan

The scoping identified a model of care for the LTC group of patients, including the need for outpatient clinics, therapies provision, social support, carer services and, in addition, continuing to develop wellbeing/social support for patients and carers in the community.

The report recommended that the organisation continues to explore the development of models of care through a process of Experienced Based Co-Design engaging with patients, carers, staff and volunteers.

The scoping highlighted the need for the organisation to consider how current and future service developments are marketed to both users and referrers. The report identified that GPs and referring clinicians were unaware of the extent of the Hospices services and the support available for those with a LTC.

A proposal was submitted to the Board of Trustees in February 2016 for investment in staffing for the OP&T service to further develop services. The Board of Trustees approved the appointment of an Associate Director for Outpatient and Therapies, part time Physiotherapy, Occupational Therapy and Social Work provision.

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.

	2012-13	2013-14	2014-15	2015-16
Staff joined	38	52	54	50
Staff left	16	30	50	52

Comment:

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

The staff Information & Consultation Forum has been firmly established as an effective representative body, meeting regularly and communicating with the Executive Team on a wide range of employment and other topics. It has enabled senior management to present, explain, obtain feedback on, and develop significant ideas and plans. It has acted as an important further conduit through which individual employees have been able to express views or concerns (anonymously if they wish) and have them addressed.

The Hospice has adopted the Bradford scoring approach to sickness-absence monitoring/reporting. That has enabled speedy, informed, management intervention to examine and handle absence issues, and has reduced the incidence of sickness absence.

Processes have been developed to alert managers on a timely basis to significant events in the employment cycle of their staff (induction progress, probation review, contract expiry, etc.), as an aid to efficient staff management and planning.

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

Once again this year, the Board of Trustees of the North London Hospice welcomes the Quality Account. The 2015/16 report reflects continued high standards of care, the extension of services to reach more people in the community and a commitment to providing safe, effective care in whatever settings best meet the needs of those who use the services provided by the North London Hospice.

In reviewing progress made against the quality improvement priorities for this year the Board is assured that improvements to the quality of care and patient experience have been effectively demonstrated. The user feedback pilot, using the real time methodology drawing on the work of trained volunteers, has offered opportunities to respond promptly to issues raised by patients and their carers. In terms of the improvements to Risk Management through the Sentinel system, assurance to the Board has been strengthened by the demonstrably improved data quality that underpins risk management at the Hospice, as well as the learning from complaints and incidents. The Board has been particularly interested in and encouraged by progress in relation to the Outpatients and Therapies services developing at both the Enfield and Finchley sites. These developments have been informed by the scoping exercise undertaken as one of the priorities for improvement in this last year, and also informs the priorities for the coming year.

The Board welcomes the priorities identified for 2016/17 introducing a User Forum, the Schwartz round model, *"Hello my name is…"* and the Five Priorities of Care approach. The User Forum initiative builds on our long held aspiration to extend the reach of our services to meet the needs of people earlier in their experience of long term illness and being able to engage users more in the shape and design of services and care provision. The national *"Hello my name is …"* initiative highlights the need to constantly refresh and refocus attention on the ordinary small kindnesses and courtesies at the heart of human interaction. Again, the national Five Priorities of Care model is another opportunity to refresh and update practice. The Board especially welcomes the introduction of the well established model of Schwartz rounds as a means of supporting staff, and facilitating learning to enhance the quality of care in often challenging circumstances. All these initiatives will contribute to greater consistency of approaches to care across all settings, improve shared learning and raise standards of practice.

Of note this year is the number of national initiatives that Hospice staff have been engaged in, using their experience and expertise to inform wider developments. All these achievements reflect the dedication and commitment of skilled staff both clinical and non-clinical, as well as the huge contribution of the Hospice Volunteers to the whole enterprise of making the Hospice work for patients.

This report once again illustrates that the Hospice is committed to serving the local community and making services more accessible to a greater number of people. Of importance this last year has also been the successful partnership with MacMillan, a model to build on in the future in order to continue to be able to offer the best possible services for the community.

John Bryce
Chair
North London Hospice Board of Trustees

STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

Barnet Health and Overview Scrutiny Comittee

The Committee scrutinised the NLH Quality Account 2014/15 and wish to put on record the following comments:

APPENDIX 1: OUR CLINICAL SERVICES

1. CSPCT

They are a team of Clinical Nurse Specialists, Doctors, Physiotherapists and 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.

2. 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.

3. OP&T

The OP&T service aims to improve the quality of life for patients and carers in a supportive environment. Referrals are based on the patient's needs rather than diagnosis, allowing for access at an earlier stage in their illness. Outpatient Clinics are held throughout the week at both sites.

Outpatient Clinics include
- Medical Clinics
- Clinical Nurse Specialist Clinics
- Physiotherapist Clinics
- Complementary Therapy Clinics

Following the initial assessment, a management plan based on the patients reported goals will be agreed. This may include referral on for Therapies support.

The Therapies service includes access to Psychological Therapies (including Psychology and Art Therapy), informal Art and Music groups. There is access to a Macmillan CAB advisor and support for Carers. The service enables patients to access volunteer-led social support through 'Come and Connect'

4. 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.

5. 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 PCSS enables more people to do this.

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

6. Loss and Transition Service (including Bereavement Service)

The Loss and Transition Support Service supports:

- Individual NLH 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.

7. 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 2: INFORMATION GOVERNANCE (IG)

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 NLH is able to deal consistently with, and adhere to, the regulations, codes of practice and law on how information is handled e.g. Data Protection Act 1998, Confidentiality NHS Code of Practice.

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

1. The Department of Health and NHS commissioners of services.

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

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

1. Information Governance Management.

2. Confidentiality and Data Protection Assurance.

3. Information Security Assurance.

4. Clinical Information Assurance.

APPENDIX 3: 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. 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 NLH's Balanced Scorecard bi-annually.

Executive Team (ET)

ET will review NLH's Balanced Scorecard quarterly.

Quality, Safety and Risk Group (QSR) is a sub-committee of the Board and provides assurance that an effective system of control for all risks and monitoring of quality is maintained. It reviews NLH's Balanced 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 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)

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

APPENDIX 4: 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 person's 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 STORY

Patient Story Taken at Winchmore Hill, 1st Sept 2015

" I had some hospital tests today and decided to come here afterwards, to relax. I wanted to be somewhere quiet. I feel safe with the staff here – nice to be here in case something goes wrong.

It's very peaceful here. I'm a bit shy but the people are decent here and I enjoy the conversation.

I'm still in shock about getting the cancer diagnosis. It changes your life, the way you think and the way other people think about you. Sometimes they treat you with pity.

I've been offered some therapies but I want to take my time. The food is very nice and the chef is lovely. Sometimes I see the same faces here. I'm happy so far."

Comment:

A key objective of the Social Programme is to provide patients with a place where they can feel safe, supported and 'normal', in spite of their life-limiting diagnosis. It is important to hear from patients that we are achieving these objectives, and also when we are not achieving them. In this instance, the patient refers to feeling safe.

The patient also speaks of the way in which people treat him/her, resenting people's pity. Another key objective of the social programme is to offer a context in which we can assist the patient in building confidence, as well as enriching their quality of life. The patient clearly appreciates the fact that staff do not focus on his/her illness per se, but respond to the whole person. If we contribute positively to the patient's sense of personal dignity, then it is important to know that we are on the right track.

ACCESSING FURTHER COPIES

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

HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

NLH welcomes feedback, good or bad, on this Quality Account.

If you have comments contact:

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Director of Clinical Services

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Email: nlh@northlondonhospice.co.uk

CLCH QUALITY ACCOUNT 2015 – 16

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APPENDIX 1 Complaints and compliments annual report

PATIENT STORY
Offender Health – Seacole Service

When I first came to Seacole*, I was unsure about the activities. They gave me a list of all the activities and I chose all of them, just to get out of the cell. I got very fond of the lead girl from the 'Only Connect' charity at Seacole. She was an inspiration as I am interested in carry on doing the same charity when I leave prison. They allow me to express myself. The activity they do was new to me and I very much enjoyed it. It made me come out of myself as a person.

As a criminal person I will never be in front of the camera. It was hard for me to speak in front of other people, but they encouraged me to take centre stage to properly express myself. In the group, I was taught presentation skills and acting skills, things that I was always wanted to do but was too shy. The highlight of the course was to give a presentation in front of audience. They arranged executives from John Lewis to come and watch me as I give my presentation. Their reaction was very good and I felt elated and overwhelmed. I have achieved something that was foreign to me. It was an amazing experience.

I always led my life by my own moral code and not the codes set by society, but the experience with the centre made me feel positive about joining society. Therefore, I decided to stay in touch with the charity and carry on working with Only Connect. In my opinion, 'the devil finds time for idle themes'. The few hours I spent in the centre, made me forget that I am in prison. I regret the time was limited here. I hope it will expand and be promoted for a longer time for other prisoners. The classes are now getting bigger and prisoners are spreading the word around. I suggest spreading the word among prisoners and improving communication between governors and prisoners to encourage them to join the Seacole centre. And to put more leaflets, so people can learn more about the activities at Seacole.
The team were very professionals and welcoming and I felt like in 'my true comfort zone'. I was laughing constantly. The way that the class is set up was amazing. I was exposing more of myself and I discovered more skills I didn't know I had before.

Leaning from this story
This story illustrates the positive difference that the Seacole service can make and suggests that there is a need for more awareness about this service within the prison environment.
In response to this feedback, a leaflet has been developed by the staff within offender health, so people can learn more about the role of the Seacole service and the sort of activities that are offered.

*The Seacole centre is based within HMP Wormwood scrubs; interventions and therapies are run from the centre with the aim of improving prisoners' awareness, life planning skills and self-esteem.

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ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2015/16. The Quality Account is a summary of our performance in the last year in relation to our quality priorities and national requirements. We have incorporated feedback from our clinical teams this year showing how they have changed the way they deliver care in order to improve the quality of our services.

What is a Quality Account?

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

Why has CLCH produced a Quality Account?

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

What does the CLCH Quality Account include?

Over the last year we have collected a lot of information on the quality of all of our services within the three areas of quality defined by the Department of Health: safety, clinical effectiveness and patient experience. We have used the information to look at how well we have performed over the past year (2015/16) and to identify where we could improve over the next year, and we have defined three main priorities for improvement.

Patient stories have been interspersed throughout the account to demonstrate how quality makes a difference to them as well as informing us of what we do well and where we might improve. Also incorporated into the account are examples of quality put into practice within our services.

Developing the Quality Priorities 2016/17

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 2016/17.

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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

ABOUT CLCH

We provide health care in people's own home and in over 400 community settings including GP practices, walk in centres (WiCs), 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, osteopathy
- End of life care – for people with complex, substantial, ongoing needs caused by disability or chronic illness
- Specialist services including 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

CLCH map to be inserted

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CHIEF EXECUTIVE'S STATEMENT

It gives me great pleasure to introduce the Central London Community Healthcare NHS Trust Quality Account. Over the year we have continued to strive to provide the highest standard of clinical care and ensure that our patients remain central to everything we do. The Quality Account contains many examples of our approach to quality and we will continue to focus on providing high quality services in the year ahead.

At CLCH we have made a firm commitment through our quality strategy and patient and public engagement (PPE) strategy to keep patients at the heart of everything we do. Our three-year quality strategy entered its final year in 2015/16 and with the publication of our Quality Account this year we will also be publishing our new three-year quality strategy. Our board and staff are committed to providing quality healthcare for our patients and their families.

Patients continue to tell us what they think of our services by taking part in our regular surveys. The results allow us to see if we are improving by comparing results to survey findings from previous years and also allowing us to compare our progress against other NHS Trusts. We want our patients and the public to play an active role in shaping their own care and treatment and in developing and redesigning our services especially as we develop our membership strategy.

This year we were pleased to be one of a minority of trusts rated as good by the Care Quality Commission (CQC) and welcomed the feedback we received in relation to how we are improving. Our progress against the CQC recommendations is contained in the account. I was also pleased to see that the Trust was one of only 18 Trusts to receive an outstanding rating for learning from incidents in the NHSI league table. This is the first year Trusts have been measured in this way and it will be a key objective for the Trust to remain in the top group of NHS Trusts.

We also welcomed a number of new services to the Trust this year and in 2016 community services in both Harrow and Merton join us.

Finally, I would also like to take this opportunity to thank our staff, who strive to continue to improve the quality of care they deliver, our patients for taking the time to give us feedback and our colleagues across health and social care for working with us to provide a comprehensive local service.

The information contained in this document is an accurate reflection of our performance for the period covered by the report. In particular I certify that the following mandatory data quality statements within the CLCH Quality account are accurate:

The use of the NHS number (which measures the completeness of the data held on patients);

The clinical coding error rate (which measures the accuracy of data recording)

The use of the GP medical practice code and;

The information quality and records management score (covering the quality of data systems and process within the organization)

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STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

As the Chair of the trust Quality Committee I am pleased with the progress the trust has made this year in relation to Quality and also our achievements against the objectives we set ourselves in the Quality Strategy.

As well as gaining assurance through review and scrutiny of our key performance indicators; the Quality Committee has continued to receive a presentation each month from our clinical services which has included both staff and patients.

The Care Quality Commission (CQC) inspected Central London Community Healthcare NHS Trust from 7–10 April 2015 and undertook an unannounced inspection on 29 April 2015. This was carried out as part of the CQC's comprehensive inspection programme and included the following core services:

- Community health inpatient services
- Community adult and long-term conditions
- Community end of life care
- Community health services for children, young people and families
- Urgent care centres.
- Dentists

We were pleased to be awarded a rating of "good" and as our Chief Executive has already said, are committed to improving in the areas the CQC highlighted and have already made substantial progress against their recommendations.

The Quality Committee will monitor the Trusts new quality goals outlined in the quality strategy and the new priorities laid out in this account; we will also be ensuring that as the organisation expands that we maintain our track record on quality and safety.

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

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PATIENT STORY - Ruby Ward Inpatient Rehabilitation

I came to Ruby Ward for rehabilitation from Northwick Park hospital after I had a stroke. I found my stay on Ruby ward was excellent and the attitude was excellent. I was there over Christmas and it was one of the most sociable events without me having to do any work. They arranged all these presents for every patient on the ward. They had cooked breakfast. They couldn't have worked harder to make it a lovely day; naturally they must have been short staffed over Christmas. I was disappointed not to be at home as it was my granddaughter's 21st birthday. They allowed us to have a celebration on the ward with no problems in the day room. On Christmas my family came and I used the day room to have a celebration. They installed a TV on the ward before Christmas, it was on most of the time, but it was a disturbance most of the time. It would be good if people had headphones. All were able to watch the Queen's speech.

I found the staff on the ward sympathetic and encouraging, particularly the physios. I didn't think it was enough physio, however from what there was it was good. For visitors it did take a very long time to get into the wards. Sometimes you can stand waiting, waiting outside the door and no one opens the door. There was an altercation with a patient and staff on the bay however, it didn't affect me, I became the spokesperson as I would press the bell for everyone as my bell was the only one working on the bay. Staff were accommodating and didn't brush us off as amateurs. They took note of the fact that I found it hard to sit in the wheelchair, so they did change the timings for my seating. Food however was an issue as I am lactose intolerant. The person in charge of the kitchen on the ward used to go to great lengths to try and find something. Sometimes she found it hard to get things in, so sometimes I had to ask family to bring in food from home.

I would definitely recommend this service to friends and family. I think my daughter has already done so, her friend was offered rehab and recommended she went to Edgware Community hospital, she said, "my Mother's experience was really good there I would go if I were you".

I would speed up the change over from day staff to night staff on the ward. A couple of times I was on the chair and I had to wait a while before I saw anyone from the night staff. I was ringing my bell and nothing happened. I would put more staff on, as nurses were rushing and rushing all day. There are not enough nurses. A 12-hour shift is a long time and they definitely need more staff. Training for my husband on how to use a rota stand would have been useful; He was there all day using it with no problem but were then told he couldn't due to manual handling. I understand you can't do this because of health and safety however it ignores the reality as we need to do it at home anyway. My husband visited in the afternoon and in the evening for four months. He could have helped many times.

Learning from this story

The learning from this story has led us to recruit an additional ward receptionist so that the doorbell can be answered more promptly reducing the time that people have to wait outside the ward when visiting. An audit of patient call bell response is taking place each week. Additional rehabilitation support workers have been recruited to the service so that more groups and activities can be provided for patients within the ward. A lactose free menu has been developed and menus will be laminated for patients to use. Staff are monitoring the sound level of the TV to ensure that it does not disturb others and the provision of earphones is being explored.

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LOOKING BACK - QUALITY IN 2015-16

Progress against our 3-year (2013 – 2016) 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

Within each of the campaigns a number of key work streams were put in place. Progress against the priorities is described in the score card and explanation below.

Quality Campaign	Key Performance Indicator	End of Year Target	Year End Actual
A Positive Patient Experience Patients' Experience **Caring & Responsive Services**	Proportion of patients who were treated with respect and dignity	95.0 %	93.9 %
	Friends and family test - net promoter score	85.0	82.5
	Proportion of patients whose care was explained in an understandable way	90.0 %	91.2 %
	Proportion of patients who were involved in planning their care	80.0 %	80.3 %
	Proportion of patients rating their overall experience as good or excellent	80.0 %	90.7 %
	Number of PREMS responses	1,600	1,759
	20% reduction in complaints related to poor communication and attitude from 2012/13 baseline	35	38
A Positive Patient Experience Patients' Complaints, Concerns & Compliments **Caring & Responsive Services**	Number of compliments	-	492
	Proportion of patients' concerns (PALS) responded to within 5 working days	90.0 %	94.8 %
	Number of complaints received	-	148
	Proportion of complaints responded to within 25 days	90.0 %	100.0 %
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %
Preventing Harm Incidents & Risk **Safe Services**	Proportion of patient-related incidents that were harm free	54.0 %	73.8 %
	30% increase in harm free incidents from 2012/13 baseline	1,970	3,347
	50% reduction in medication incidents that caused harm from 2012/13 baseline	73	36
	50% reduction in falls incidents that caused harm from 2012/13 baseline	97	85

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	50% reduction in CLCH acquired category 2-4 pressure ulcers from 2012/13 baseline	212	416
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	8
	Proportion of external SIs with reports completed within deadline	100.0 %	93.2 %
	Percentage of time bedded units achieving minimum staffing each month	100 %	108 %
	Statutory and mandatory training compliance	90.00 %	88.28%
Preventing Harm Prevalence (NHS Safety Thermometer) **Safe Services**	Proportion of patients with harm free care	98.0 %	92.4 %
	Proportion of patients who did not have any NEW harms	98.0 %	97.5 %
	Proportion of patients who did not have a pressure ulcer	98.0 %	93.7 %
	Proportion of patients with Category 2 pressure ulcers (old)	2.0 %	2.7 %
	Proportion of patients with Category 3 pressure ulcers (old)	2.0 %	0.9 %
	Proportion of patients with Category 4 pressure ulcers (old)	2.0 %	1.6 %
	Proportion of patients with Category 2 pressure ulcers (new)	2.0 %	0.8 %
	Proportion of patients with Category 3 pressure ulcers (new)	2.0 %	0.2 %
	Proportion of patients with Category 4 pressure ulcers (new)	2.0 %	0.2 %
	Proportion of patients who did not have a fall	98.0 %	98.7 %
	Proportion of patients with no harm - falls	2.0 %	0.6 %
	Proportion of patients with low harm - falls	2.0 %	0.5 %
	Proportion of patients with moderate harm - falls	2.0 %	0.2 %
	Proportion of patients with severe harm - falls	2.0 %	0.0 %
	Proportion of patients who died - falls	2.0 %	0.0 %
	Proportion of patients who did not have a catheter associated UTI	98.0 %	99.4 %
	Proportion of patients with a catheter associated UTI (old)	2.0 %	0.3 %
	Proportion of patients with a catheter associated UTI (new)	2.0 %	0.3 %
	Proportion of patients who did not have a venous thromboembolism	98.0 %	99.8 %
Smart, Effective Care **Effective Services**	Standardised mortality ratio in bedded units	3.8 %	0.1 %
	Proportion of services capturing patients' clinical outcomes	100.0 %	100.0 %
	Proportion of patients who were satisfied with the wait for treatment	80.0 %	78.1 %
	Proportion of patients reporting a positive Goal Attainment Score	90.0 %	86.7 %
	Proportion of safety alerts due, and responded to, within deadline	100.0 %	97.1 %

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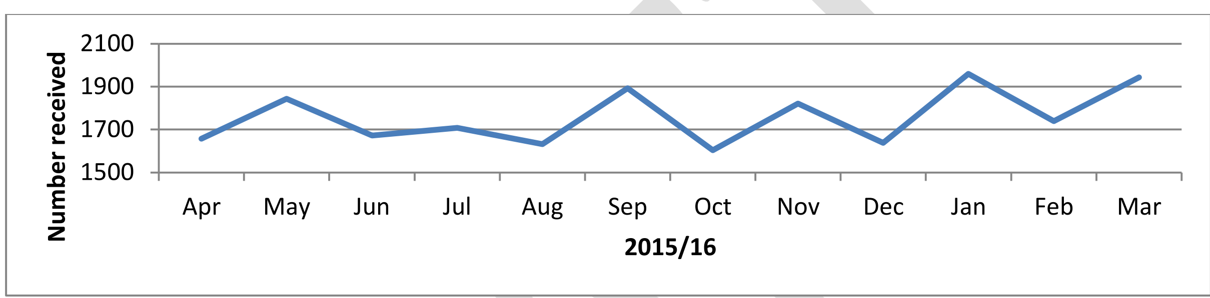
POSITIVE PATIENT EXPERIENCE

Patient Reported Experience Measures (PREMS)

The Trust is committed to receiving feedback from as many patients as possible and from all groups that represent our patients' diversity; to this end we use PREMS. We collect PREMS using a range of methods including electronic tablets, paper surveys, kiosks, comment cards and telephone interviews. We have tested a redesigned survey for people with learning disabilities. Each service has a patient experience engagement plan outlining how they will collect this data and how they will increase patient feedback. In areas where it is hard to garner feedback; the Trust is developing volunteers to support the process. The Trust is also adding a new question to the PREMs survey asking if patients were told how to complain and raise concerns.

The Trust has consistently collected over 1600 surveys per month in 2015/16.

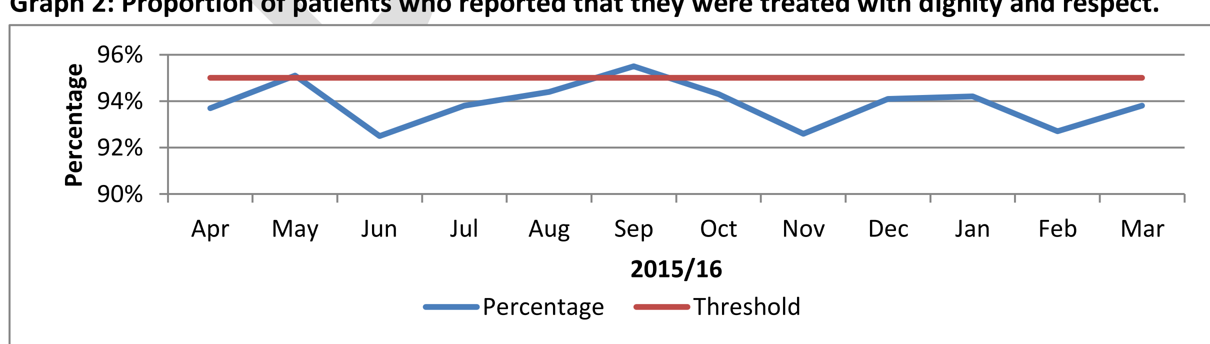
Graph 1: Number of PREMS received



Dignity & Respect

Patients are asked if they feel they were treated with dignity and respect. The data described in graph 2 shows the proportion of patients who responded "yes definitely". We have not met the target for the last quarter and continue to work with the Compassion in Care lead to improve this. Having analysed the narrative from patient feedback, there are no specific comments relating to privacy and dignity. However, there are some comments about patients feeling that there is a lack of continuity in care and a lack of information regarding who is caring for them which may be contributing to the score. This has been fedback to staff.

Graph 2: Proportion of patients who reported that they were treated with dignity and respect.



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Friends & Family Test (FFT)

In the FFT we ask patients how likely they would be to recommend our services to their friends and family. The score is calculated by subtracting the number of people who would not recommend the service from the number who would recommend it. This is measured according to national guidelines against a board target of 85. This was not met in February and March largely due to a high proportion of negative comments about the Walk in Centres; specifically waiting times and accessibility. The service is taking forward a number of actions to address this including a review of staffing levels to assist with the demand at peak times.

NHS England (NHSE) now presents the percentage of people that would recommend the service (extremely likely and likely responses), and the percentage of people that would not recommend the service (unlikely and extremely unlikely responses) rather than using the net promoter score. NHSE considers this easier for patients to understand and fairer as it includes 'likely' responses which were previously excluded. The table below outlines how the Trust is performing using this approach. This method will be used in our 2016/17 reports.

NHSE FFT presentation

FFT	Base size	Recommend %	Not Recommend %
February 2016	**n=1929**	**90.2%**	**5.0%**
January 2016	n=1725	90.4%	5.3%
December 2015	n=1939	91.2%	4.1%
November 2015	n=1625	89.0%	5.7%
October 2015	n=1804	87.1%	7.2%

(Please note that February 2016 is the most up to date data available from NHSE at the time of writing the account).

Graph 3: Number of patients who would recommend the service to their families and friends

Overall Experience

We ask patients to rate their overall experience of care. Graph 4 shows patients who said that their care was good or excellent. We have consistently and significantly exceeded the target.

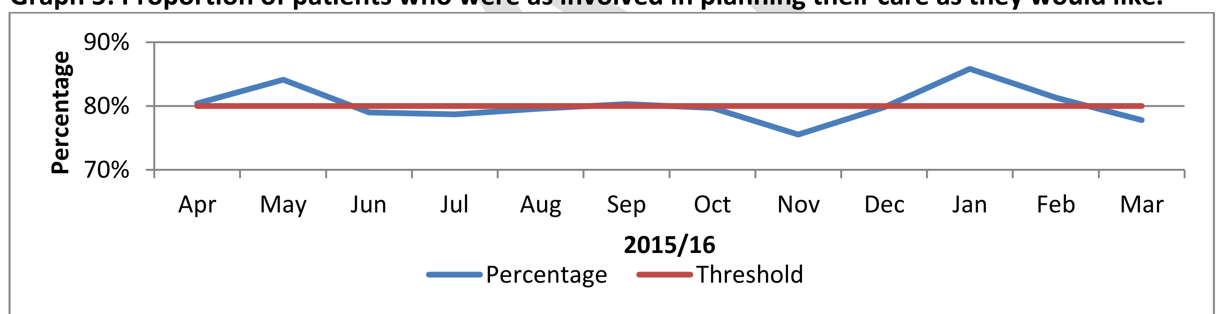
Graph 4: Proportion of patients who rated their overall experience as good or excellent

95%
85%
75%
Percentage
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
Percentage Threshold

Involvement in care

We ask our patients how involved they have been in planning their own care. Graph 5 represents those patients who said that they were as involved as they wanted to be. This target has been achieved for most of the year. However, there has been a decline in positive responses in the last quarter. Mobile devices are being rolled out and it is hoped that this will facilitate collaborative care planning in patients' homes. The Patient Experience Group will also work with users to find out how they think this can be improved.

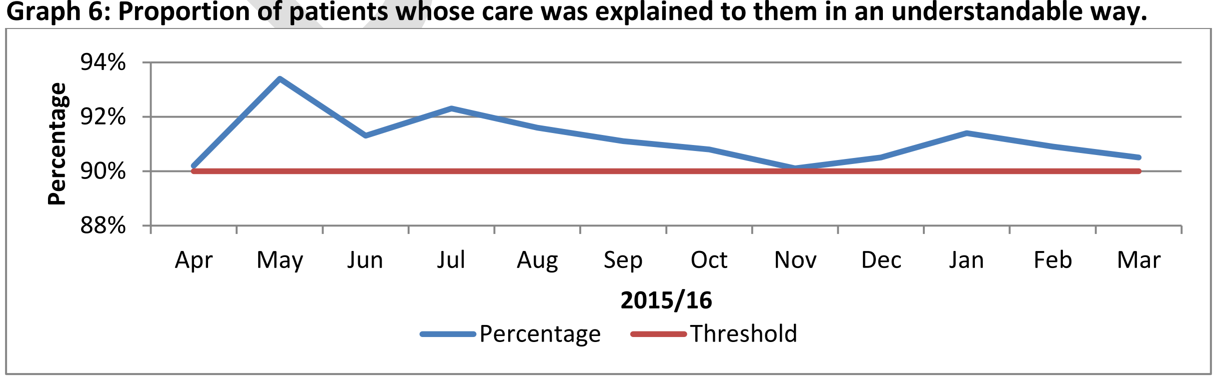
Graph 5: Proportion of patients who were as involved in planning their care as they would like.



Explaining Care

We ask patients if their care was explained to them in a way they could understand, graph 6 shows those patients who said that it was. We have achieved or exceeded the target all year.

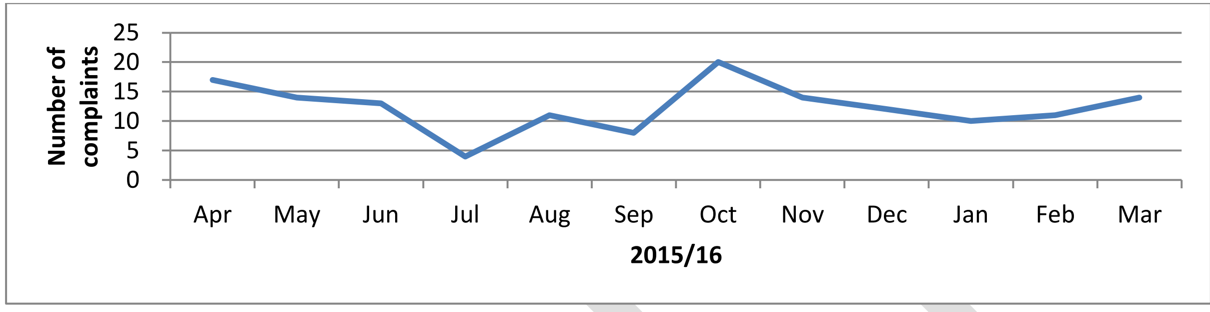
Graph 6: Proportion of patients whose care was explained to them in an understandable way.



Complaints

We categorise complaints as either simple or complex. This decision depends on the nature of the complaint and how difficult it is to investigate. The national target requires NHS Trusts to respond to all complaints within a time limit agreed with the complainant. To drive quality, the CLCH Board has set the Trust a more challenging target of responding to 90% of simple complaints in 25 working day and 100% of complex complaints within the agreed timescale. All complaint targets have been achieved this month and all simple complaints have been responded to within 25 days for the whole of 2015/16.

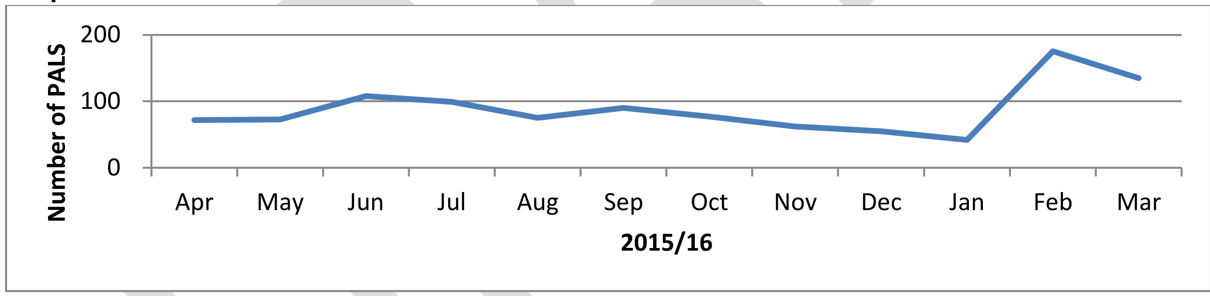
Graph 7: The number of complaints received



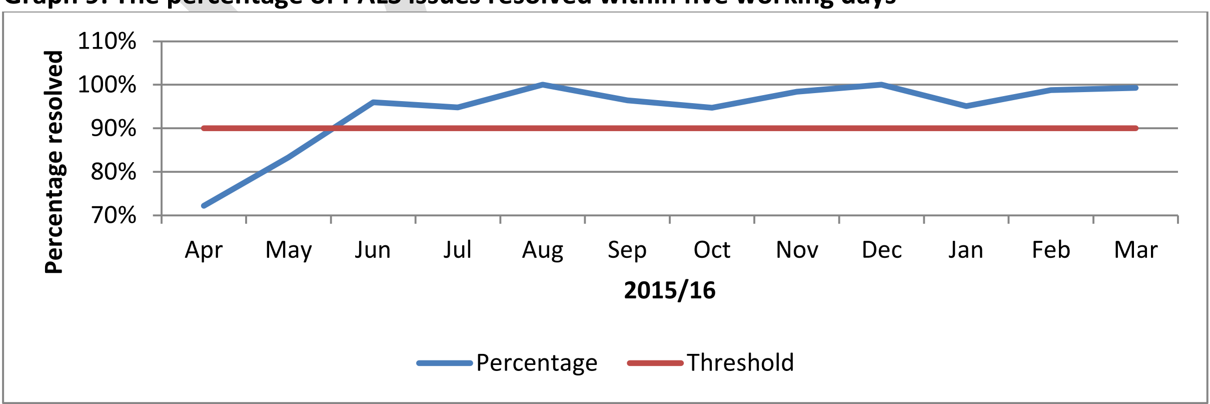
Patient Advice & Liaison Service (PALS)

We aim to resolve 90% of all PALS issues within 5 working days. This has been achieved for most of the year.

Graph 8: The Number of PALs received



Graph 9: The percentage of PALS issues resolved within five working days



PREVENTING HARM

NHS Safety Thermometer

The NHS safety thermometer is a national prevalence survey. It is conducted on one day each month when our nurses review all relevant patients to determine if they have suffered any harm as a result of their healthcare. The categories they review include VTE, catheter associated urinary tract infections (CAUTIs), falls, venous thromboembolism (VTE) and pressure ulcers. Their data is fed back to a national data base, which is used for comparison and benchmarking. All data can be reviewed at www.safetythermometer.nhs.uk. The national target is that 96% of patients are harm free; this applies to the overall score as well as each individual category. The CLCH Board has set a more challenging target that 98% of patients are harm free.

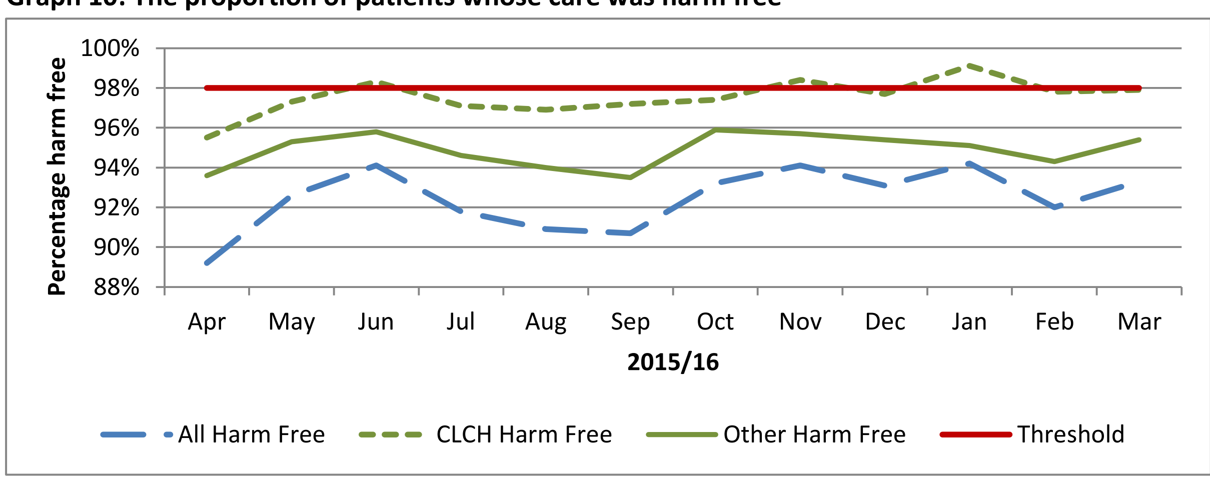
The limitations of prevalence data are well known, one day each month is unlikely to capture normal variations in occupancy, dependency and a variety of other factors, but it acts as a starting point for a more in depth analysis. A more reliable and robust picture can be gained by reviewing the incidence of harm over time. CLCH collects both types of data and uses the incidence analysis as necessary. Incidence data is collected as reports on the DATIX system.

Harm Free Care

We calculate the percentage of patients on the survey day that did not have any of the harms being monitored. This includes harms which occurred within CLCH (new harm) and those that occurred with other providers (old harms). The vast majority of patients suffer no harm at all. For the whole of 2015/16 more than 96% of patients were free from any CLCH acquired harm. At the end of 2015/16 more than 93% of our patients were free from any harm (including harms acquired with other providers).

It is important to differentiate between all harms and new harms. New harms are those which occurred whilst the patient was under CLCH care and exclude harms that the patient had already sustained when they arrived in our care, for example a patient discharged from an acute hospital to the district nursing service with a pressure ulcer. We exceeded the national target for new harms in all bar one month last year. The board target was exceeded three times during the year. At the end of 2015/16 the Trust was just 0.1% shy of achieving the board target.

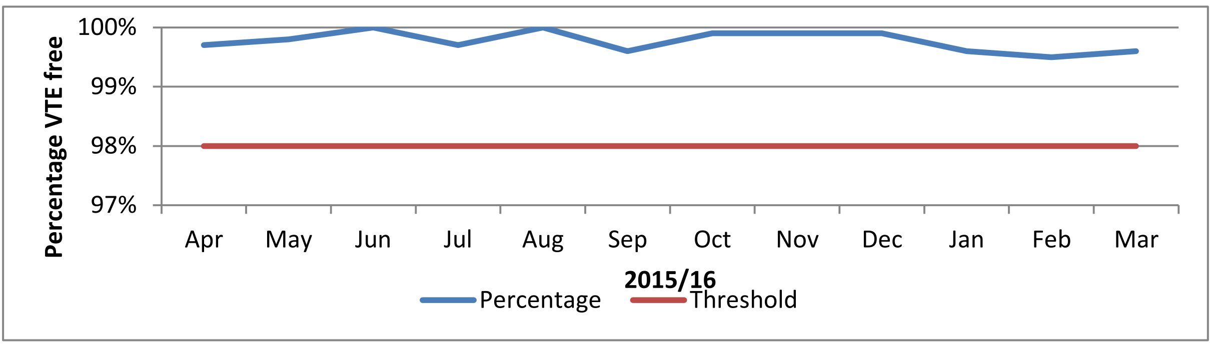
Graph 10: The proportion of patients whose care was harm free



Patients free from venous thromboembolism (VTE)

We count the number of patients on the survey day who have a VTE, such as a deep vein thrombosis (DVT). We have exceeded this target all year.

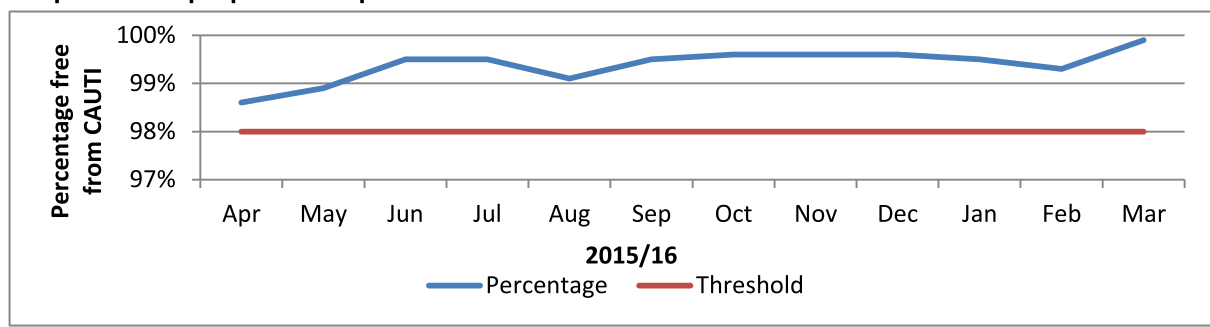
Graph 11: The proportion of patients free from VTE.



Patients free from catheter associated urinary tract infections (CAUTIs)

This category of harm counts the number of patients on the survey day who have a CAUTI. We have exceeded this target all year.

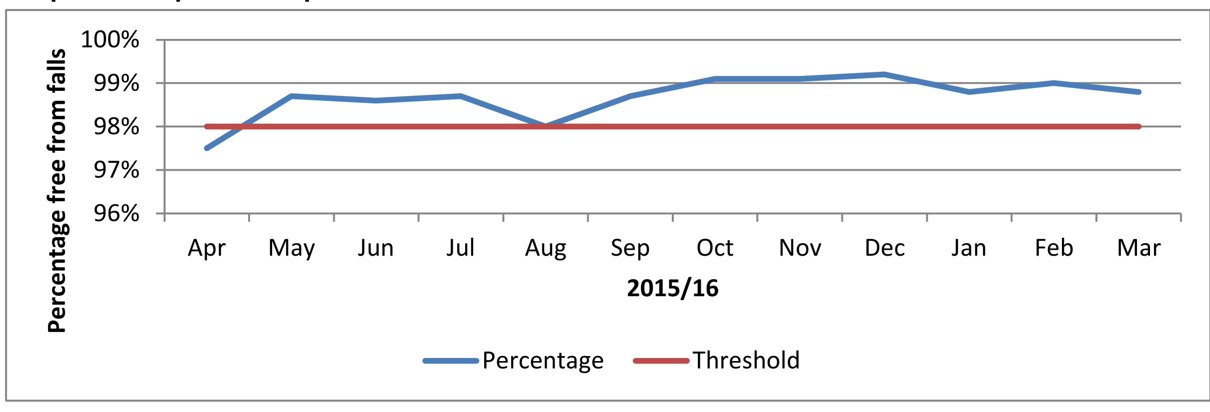
Graph 12: The proportion of patients free from CAUTI.



Patients who did not fall

On the survey day, we count the number of patients who fell in the previous 3 days. This target gas been achieved since May 2015 as demonstrated in Graph 13. Graph 13 is prevalence data, whereas graphs 14 and 15 show the incidence of falls in Q4 2015/16.

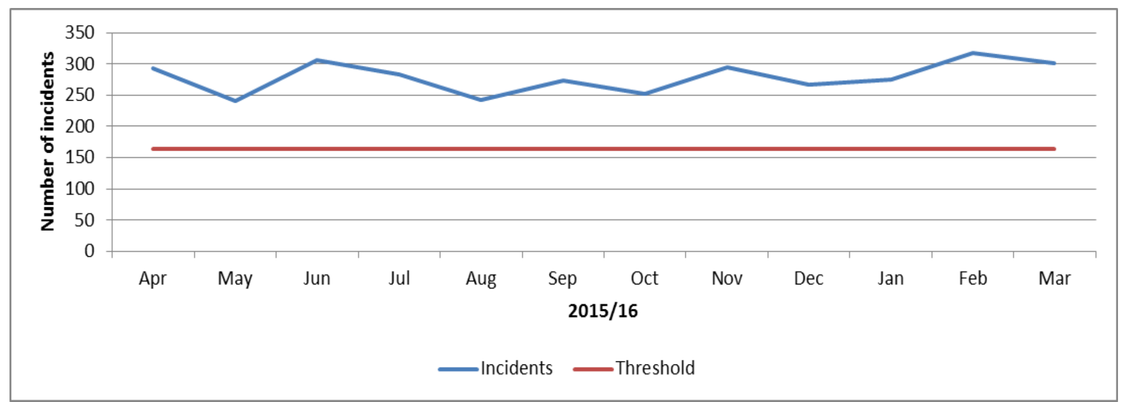
Graph 13: Proportion of patients who did not fall



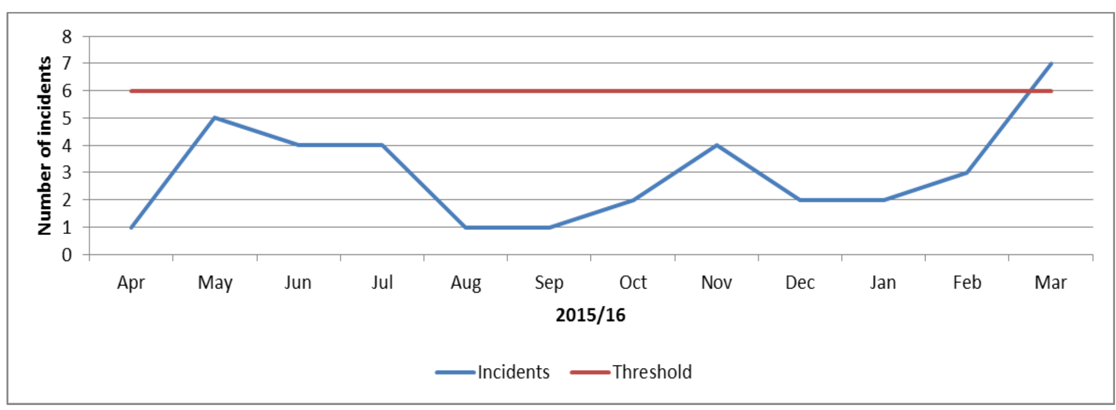
Safety Indicators by Incidence

We continue to meet our target of a 30% increase in harm free care as measured by incidence.

Graph 14. 30% increase in harm free incidents from 2012/13 baseline



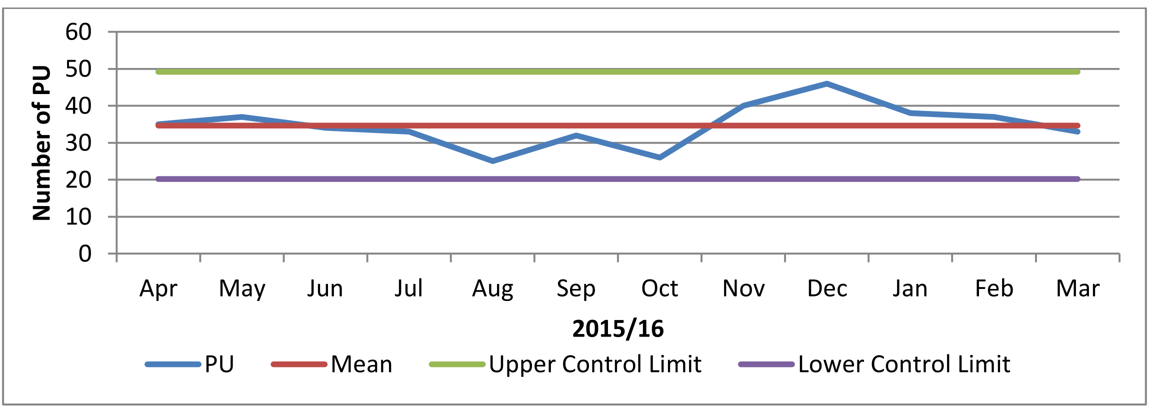
Graph 15: 50% reduction in medication incidents that caused harm from 2012/13 baseline



Pressure ulcers

Graph 16: Incidence of CLCH acquired (i.e. acquired in our care) pressure ulcers

The number of new ulcers has remained stable with no statistically significant changes.



Pressure ulcer cases are reviewed by serious incident panels. The reports from these panels are submitted to our commissioners. All cases have agreed action plans, which are monitored through the SI process. The lessons learned are discussed and shared in a number of ways:

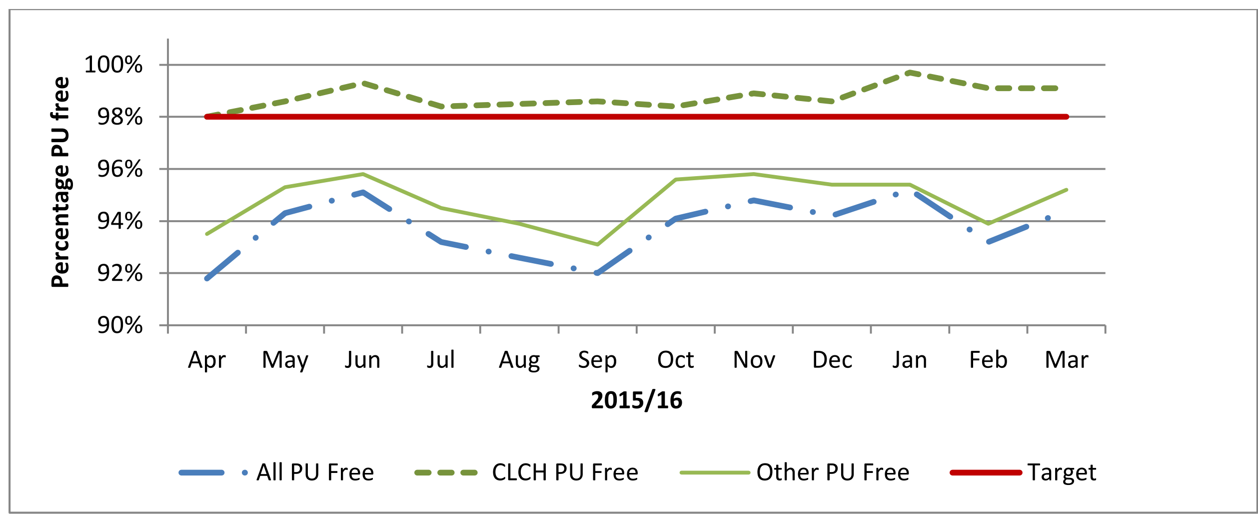
- Back to the staff/team directly involved in the case
- At the local and Trust wide complaints, litigation, incident and pals (CLIPS) meetings
- At the Pressure Ulcer Working Group

When key messages are identified they are included in the *Spotlight on Quality Newsletter*.

Prevalence of pressure ulcers

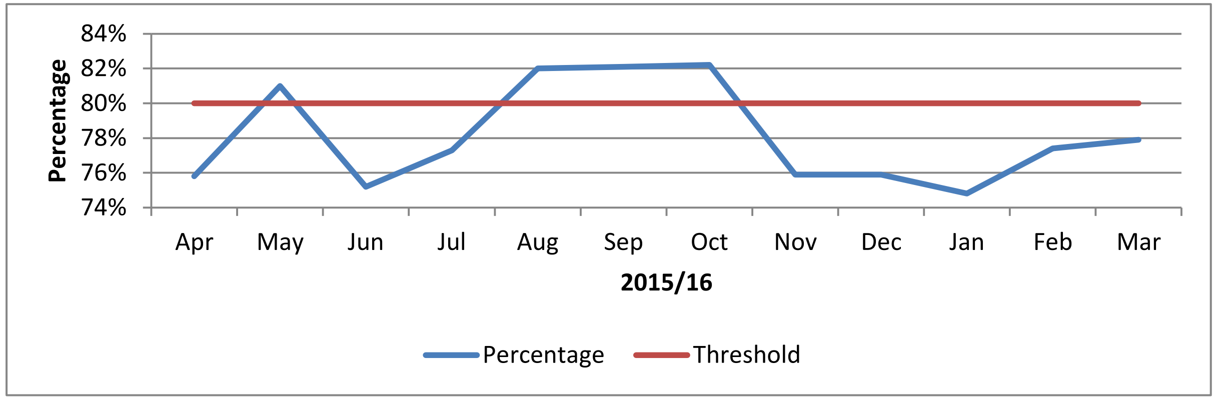
For the last 12 months more than 98% of patients were free from CLCH acquired pressure ulcers, consistently exceeding the national target.

Graph 17: The proportion of patients who did not have pressure ulcers.

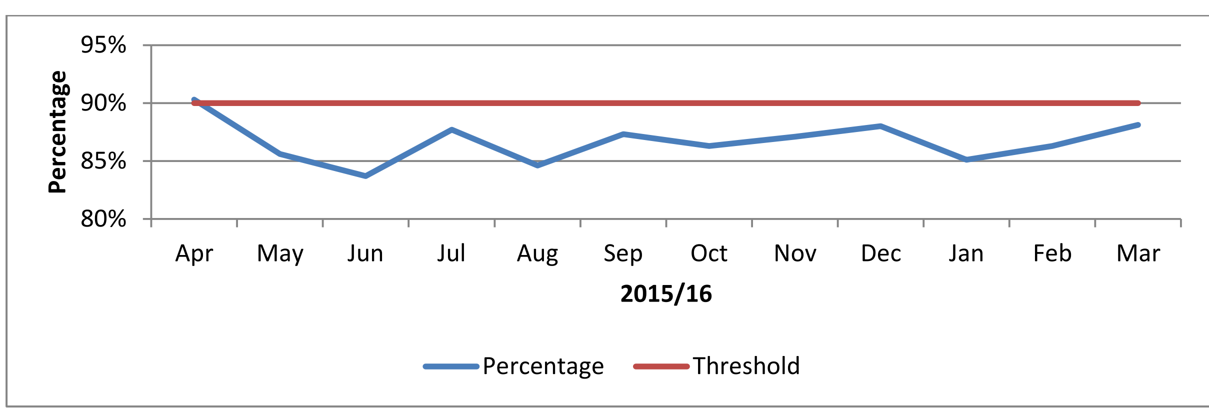


SMART, EFFECTIVE CARE.

Graph 18: The percentage of patients who were satisfied with their wait for treatment



Graph 19: The percentage of patients reporting a positive goal attainment score (GAS)*



*** This is a way of measuring whether a patient's individual goals are met.**

PATIENT STORY - Sickle Cell Service

I was first aware of the service for sickle cell at Richford Gate in 2004 when my twins were diagnosed with the condition. I met a lady called 'Y' who came round to visit me and gave me a book on sickle cell to read which was very scary because I had no clue how bad it really was.

Then 'Y' retired and another lady took over the service. She was there for about six months before she made contact with me and by then I had kind of given up with Richford Gate because the time had lapsed. Then I started receiving phone calls from a lady called 'Z' but I was too stubborn to return the calls because what was the point? She was probably only going to be there for six months and then leave as well. One day I went to St Mary's Hospital and this lady came up to me and introduced herself as 'Z'. She reassured me that she would always message or call me back if I sent her an email or text and if she was unable to do so that day somebody else would, and usually within 24 hours.

We then built up a kind of friendship which put some of my faith and trust back into Richford Gate. She made some home visits just to see how I was doing generally and how the kids were doing. 'Z' has become like part of the family I suppose. If I cannot speak to 'Z' I talk to her colleague called X who has been a great help as well.

I think that the service could arrange meetings locally where children with sickle cell could get together because my children feel very alone because there are not many children locally who have it. Maybe if they were to provide counselling sessions for children with sickle because when you miss time off school your confidence deteriorates because you have missed out on so much learning. Also with parents who have to spend time in hospital with one child if they could provide hotel type accommodation near the hospital with room for the parent with the other children, and keep the family together.

I think we need a parent's forum where we can get together and talk it would be beneficial. An online forum would also be good, for older children as well as parents. Maybe if the local hospitals do not have the facilities that they have at St Marys they should be aware that if someone does come in with a child with sickle cell it makes more sense to send the child straight to the specialist hospital instead of delaying the process by doing blood tests.

A good thing would be an out of hours Haematology Helpline where you could get professional advice instead of rushing to the hospital because sometimes you go to the GP and the Doctor doesn't always know what Sickle Cell is. A sickle cell youth club would also be a good idea where children with the same condition could meet, say once a month, and do fun things together at small cost. Parents could volunteer for some hours each with some professionals too.

I feel they should do more in the way of information and let School Nurses know that when they are doing school staff training allergies they should include sickle cell

Learning from this story

From this story, a number of actions are being taken forward by the Sickle Cell service. A blog will be developed with the help of a local support group whilst the service will also develop a peer support group and enable access to an existing youth group. So that more professionals are confident in caring for children and adults with the condition, the service will provide additional training for staff groups whist also informing patients about urgent care facilities to enable fast track to specialist care.

LOOKING BACK – TRUST QUALITY PROJECTS AND INITIATIVES

As well as the implementation of the Quality Strategy described above, the trust was involved in a number of other quality projects and initiatives and several of these are described below:

TRUST PROJECTS - POSITIVE PATIENT EXPERIENCE

ACHIEVING EXCELLENCE TOGETHER

This is a campaign focussed in improving the quality of district nursing services across our organisation whilst also improving the morale of our staff working in these services. Our campaign lead supported staff and teams in taking forward the following campaign priorities;

Lifting the mood: We have initiated a newsletter 'by district nurses, for district nurses' which is sent to all district nursing teams monthly. This newsletter highlights exciting news, includes staff and patient stories and keeps community nurses up to date with the ongoing work of the campaign and other programmes such as our continuous improvement programme. Team building events have been organised for each borough for community nurses and we held a celebration event for staff in November 2015

Fit for practice: We have appointed practice development nurses for each borough who work with new and less experienced community nurses, enabling their competence and wider personal / professional development

Filling the gaps: We have developed a range of approaches to support recruitment including the mapping of career pathways. A fast-track programme has been developed for less experienced staff which will now be piloted. This is a 12 month work-based programme that will support their succession into deputy team leader roles and is attracting nurse recruitment and we envisage that it will also support staff retention.

Modelling the way: We are focussing on safer staffing and defining team structures, numbers and skill mix

Leading the way: We have developed a 12 month clinical leadership programme for our district nursing team leaders, a programme for deputy team leaders as well as leadership development for our clinical business unit managers and clinical leads within district nursing services.

DEMENTIA CHAMPIONS PROGRAMME

We aim to develop an informed and effective workforce for people with dementia and to this end we were successful in gaining funding from Health Education North West London to develop and host an innovative Dementia Champions Programme for staff working closely with those who have dementia. The programme was developed collaboratively with a range of stakeholders and Buckinghamshire New University and it is open to staff from differing professions who work in CLCH and other care organisations in North West London. Champions may work in hospitals, care homes, hospices, clinics or community teams providing a range of differing services for those with dementia.

The purpose is to provide practical, needs led and accessible approach to developing people's knowledge and skills in dementia care and also to enable them in taking forward a range of service improvements.

DEMENTIA ENGAGEMENT PROJECT

We are hosting an innovative 18 month project in collaboration with the Point of Care Foundation and Health Education North West London. The purpose of this work is to engage with people with dementia and their carers across North West London to create an effective, inclusive process to involve people with dementia and their carers in the design, planning and implementation of locally relevant training to change the culture in dementia care.

COMPASSION IN CARE:

We have continued to implement our Compassion in Care project which aims to promote dignified and compassionate care through making a difference to the experience of service users and carers. Through this project we aim to embed the 6Cs across the whole of CLCH (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).

We have received funding from Health Education North West London to further implement the Compassion in Care model with partner organisations and to develop a Compassion in Care Community Provider network. This will enable staff to contribute to the promotion of compassion in practice where they work, and promote a consistent culture of compassion through the patient journey, through the attainment of Compassion in Care competencies.

END OF LIFE CARE:

We have taken forward work to develop and embed our End of Life Care Strategy (2015 – 2018) through our End of Life Care Model to ensure the delivery of holistic, competent, compassionate care for the dying and their families regardless of where they are cared for. The strategy encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision. It aims to increase the proportion of patients who are cared for and die in their preferred place of care.

The strategy is actioned through a number of work-streams including the following:

Advance Care Planning: We are implementing Advance Care Planning documentation which has been incorporated into our electronic care records. Advance care planning master classes have taken place in each of the boroughs facilitated by the Royal Marsden Hospital and further classes are planned.

Assessment and Care Planning: An individual plan of care and support for the dying person in their last days and hours has been developed. This is used to record individualised tailored care provided to the person whilst also supporting their families, carers and others close to them.

Education and Training: Core education standards for the care and support of the dying person in their last days and hours have been developed for all staff. An education programme has also been developed to support the core education standards and implementation of an Individual Plan of care and support.

Bereavement information: We have held focus groups to consider our bereavement information and this has now been updated for staff, families and carers whilst we also plan to implement Schwartz rounds.

Symptom Management: We have reviewed our symptom management guidelines and our administration of the subcutaneous medicines policy.

LEARNING DISABILITIES

Traditionally, whilst people with Learning Disabilities often have complex health needs, their outcomes have been poorer than the general population. CLCH is committed to eliminating this inequality and believe that people with a Learning Disability have the right to the same level of healthcare as that provided to the general population. To this end we have worked collaboratively with the Local Authority to provide services to people with Learning Disabilities. These specialist services are expert in assessing and meeting the needs of this client group. People with learning disabilities may also access our general services such as walk in centres, community nursing and dentistry, so it is essential that the care we provide in such areas also meets the needs of this client group.

PATIENT STORY – Learning Disabilities

I have been receiving services from Hammersmith and Fulham Learning Disability team for over twenty years. A lot has changed over these years, including moving buildings three times. I have seen nurses, counsellors, social workers, and psychologists over this time; they have helped me with my emotional problems, my diabetes, my medication, and other doctor and hospital appointments. My experience of most of the service has been very good. I have always got on with the staff here; particularly my nurse and psychologist because I can have a laugh and a joke with them and they are all nice people. I feel comfortable talking about my problems with them because I know that they will help me. With some staff I feel that they are like family to me; it is like having lots of other sisters and brothers!

It is important to me that I can get hold of staff easily by calling them. I find this very helpful with my nurse who always answers their phone and who I am in regular contact with. However, I get frustrated when I cannot get hold of other staff- like my social worker- and it makes me think that they do not do their job properly and that they do not want to help.

The services I have received have made my life much better by helping me with a lot of things. In my psychology sessions, for example, I learnt a lot of skills to help me manage my anger and feel calmer. I have also been helped with my diabetes and other physical problems and the nurses remind me when to take my medication which has also helped a lot. Another thing they help me with is supporting me to meet new people and attend new things; without this support I would not go to first appointments because I need to know that I can trust people before I spend time getting to know them.

I have always felt involved in the decisions made about my care and know that I can ask questions and refuse or agree to different types of care if I want- it is always my choice. I feel that all staff communicate well with me; they listen to my problems, ask me questions, and have a laugh and a joke with me. When I come to appointments here I normally get here early because I like to chat with staff. This is also my favourite building over the years because it is the biggest. However, it frustrates me when there are no staff on reception who know about the learning disabilities team.

As well as having good reception staff, I think that appointments should be quicker and everything should be on time. I would suggest that the staff start earlier and that the service maybe opens at 8am rather than 9am to make sure that everything runs quicker. For most of my sessions I am seen on time but there are some where people tell me to wait ten minutes and this frustrates me.

If I had a friend who needed help I would recommend the service because of the staff. My one message to new staff is to just look after people. If you do this you will be doing a good job!

Learning from this story

A key message from this person's story is about staff being aware of the needs of those with learning disabilities and planning to meet their individual needs. We have developed a 'flag' within the electronic patient record so that those with a learning disability can be easily identified. We are planning to implement mandatory training for all staff to raise awareness of the needs of those with learning disabilities whilst also implementing specific training for staff who work in the Single Point of Access and Single Point of Referral services so that appointment times can be tailored to people's needs.

TRUST PROJECTS - PREVENTING HARM

SIGN UP TO SAFETY

Sign up to Safety is a national patient safety campaign, one of a set of national initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives.
The campaign has five safety pledges:

1. Putting safety first
2. Continually learn
3. Being honest
4. Collaborate
5. Being supportive

We joined the national Sign up to Safety campaign in September 2014 and in response to the pledges, we set out a number of actions that we would undertake to form the basis of our patient safety improvements. In February and March 2015 four listening events were held for patients and members in the four principal boroughs in which CLCH deliver care; Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster. Five themes emerged from these events - Supporting and signposting patients and carers; raising awareness to raise standards of care; working together within the community; better use of information and technology and treating the person as an individual.

These themes were shared at a staff conference where staff were asked to identify safety improvement measures for their specialist areas of care and from this to develop service improvement projects to address these issues. These themes included: educating and signposting patients, their families and carers in pressure ulcer care through using new technology; improving knowledge of specialist formulae with GPs; ensuring joined up working between hospital and community care; fully utilising information and technology within the dental service and improving communication between district nurses and patients in Hammersmith and Fulham. Each project is led by a member of our frontline staff who is supported to implement and monitor their projects through workshops, training and the provision of expert advice.

From the outset of the campaign, CLCH has been clear that clinical staff should lead their own safety projects. This fundamental belief has not changed and therefore the aim remains *'to engage the ambition of staff by identifying the changes to their practice that are required to identify, implement and evaluate change in their service that will improve its quality'*.

The next stage of our campaign will now be to integrate sign up to safety into the safety groups using the shared governance approach set out in our Quality Strategy 2016 – 2019.

More detailed information about the Trust's *Sign up to Safety* plan can be found on the following link: https://www.england.nhs.uk/signuptosafety/whos-signed-up/clch/

DUTY OF CANDOUR

Since November 2015 the *duty of candour became* a statutory requirement. This duty focuses on prompt notification, together with an apology, explanation and reasonable support for patients, or those acting on their behalf, who have been harmed. In practice this means that as soon as practicable after being made aware of an incident that has caused harm, the trust must conduct an investigation and notify the relevant person within ten days. Compliance with the duty is monitored via the trust's DATIX incident reporting system. Additionally the patient safety managers review and support staff to ensure our duty is met. Compliance is reported via the serious incident reports which are presented to the trust board and serious incident reports which are submitted and presented to the CCG clinical quality review groups. Within 2015/16 we reviewed our Being Open policy (which incorporates the duty of candour); this helped lead the compliance with the duty to 100% from November 2015 onwards.

INCIDENT REPORTING

Learning from serious incidents

Serious incidents can be described as events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Within the Trust we use Root Cause Analysis (RCA) methodologies to investigate every serious incident to enable lessons to be learnt and disseminated across the organisation. Following the RCAs actions plans are created, monitored and key messages shared widely.

Within the year, we have achieved some improvements on incident reporting indicators, for example those measured within the NHS 2015 staff survey published on 23rd February 2016 which indicated that we are better than average in the following two key indicators:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
  Our score for 2015 was 94% compared to the national 2015 average for community trusts which at 90%.
- Staff confidence and security in reporting unsafe clinical practice
  There has been a statistically significant positive change in this finding since the 2014 survey, and we are ranked above average compared with all community Trusts in 2015.

We were also ranked 'Outstanding' in first annual 'Learning from Mistakes' league which was published in March 2016. We are one of only eighteen providers in the country that has achieved this ranking in one of the latest quality initiatives launched by NHS Improvement.

To further the quality of our services, we have taken the following actions to improve learning from incidents:

- 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 and updating of the Datix (and incident reporting system) to improve the integrity of the data.

- Established feedback notifications on Datix so that incident reporters receive the lessons learnt and action taken as a result of the incident that they reported, upon final approval of the incident.

- Regularly included articles in the 'Spotlight on Quality' monthly publication from the Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) group, for example Pressure Ulcers in August/September, Falls in November 2015, Information Governance in December 2015 and January 2016.

- Held a cold chain summit in October 2015 following a number of Cold Chain serious incidents. The event, which 32 clinical staff attended, focussed on presentations outlining the background, events and learning surrounding the cold chain incidents, followed by group work looking at the reasons why these incidents occurred, with particular reference to the human factor elements on adherence to policies and clinical practice.

- Developed a Datix / Incidents discussion board on our Intranet; The Hub, to enable staff to report any issues they have with reporting incidents or using the system. The Patient Safety Team monitors and responds to all posts.

- Maintained a database of Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) Groups to share the learning from serious event.

During 2015/16 the total number of incidents reported on the Datix system was 6,328. This is a 1.7% decrease from 2014/15 when a total of 6,436 incidents 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. In addition, as part of the Trust induction, an e-learning package was launched in March 2015 which was made available to all staff during the year via the ESR Learning portal and publicised through Communications including Spotlight on Quality.

INCIDENT REPORTING - NHS ENGLAND PRESCRIBED INFORMATION

The following two questions were asked of all trusts.

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.

The national and reporting learning system (NRLS) reported 1,154 incidents during the first half of 2015. This equates to 38.22 per 1,000 bed days. This puts us in the lowest 25% of reporters, within a cluster of other NHS Community Organisations, and below the median reporting rate for this cluster of 146.03 incidents per 1,000 bed days.

During this period, we reported 58 incidents (5.0%) resulting in severe harm, which was higher than the cluster rate of 0.7%. There was one incident which resulted in the death of a patient.

This was 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 we reported were grade 3 and 4 pressure ulcers and three falls.

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.

This metric is normally only applied to acute units where the measure is an indication of inappropriate early discharge. As such, it is not reported by community trusts and so has not been responded to.

PATIENT STORY – Psychological Health

I originally went to the GP to talk about my perceived issue of aggression. The GP asked me to complete an assessment, which revealed high levels of anxiety it felt as though I was contacted very quickly to have the initial phone assessment. I found the assessment a little repetitive. I felt I got asked the same questions as I had from the GP. I felt that for some, this might be the opportunity to answer questions differently, if they still weren't sure about having therapy and admitting to their problems.

I knew my GP pretty well so it was easy to bring up problems especially as it was face to face, but I had to answer these questions [the triage] when stood outside McDonalds on a busy road and that was hard. However, the therapist I spoke with was empathetic and non-judgemental. This was different to other experiences I've had with hospitals where no one has done that. As I walked in the door of the service I felt it was perfectly welcoming. Everyone was perfectly friendly, informative, asked me to fill in the forms and sign in with just my initials, so there was privacy. I wasn't made to wait, which is what people don't like. There was good information around on keeping fit, stopping drinking and smoking, which was helpful. I couldn't think of anything to improve it!

The initial meeting with my therapist was good. At the time I didn't know my problem was a problem so it was good to hear someone else's side and their understanding of what you described and what might have been causing it. I knew it would never be a case of someone rolling their eyes and saying you don't have a problem with that, but they immediately understood and were empathetic. As the sessions went on I could actually see myself changing as I filled in the questionnaires. Conversation was free flowing and not too structured, which I liked. My therapist was a good interrogator; I felt able to voice any concerns!

In my last session the therapist said that everything was going very well and improvement had been made over the course of treatment. We didn't complete a firm staying well plan but they said they would be happy for me to come back if I needed further help. I felt by this session ready to finish as I hadn't had anything to write down that week in terms of negative thoughts. If I was the manager of the service, there's not much I would change, it was great from my experience. I suppose the only thing might be increasing awareness; awareness of the problems that you can help with, not just depression and anxiety but post-accident difficulties as well.

Learning from this story

Some people may not be aware of our self-referral process. We now cover this in community outreach sessions. We have also raised awareness about the alternatives of telephone sessions if people can't attend in person. Our website has been revised and we have added this information. We also intend to develop electronic leaflets and add our web site details to our letter templates. People may be uncertain about the purpose of the triage, so are sometimes not in an appropriate place to discuss sensitive issues when contacted. The team has had a lot of new members so we explained to all new members how to appropriately describe a triage appointment to a patient. We also identified that people may not be sure about the number of sessions to expect. Clinicians now set up a treatment contract with the client in their initial assessment/follow-up

TRUST PROJECTS - SMART EFFECTIVE CARE

CLINICAL OUTCOMES

Over the past 2 years the Trust has worked extensively with clinical teams to identify appropriate electronic measures for clinical outcomes using a consistently applied methodology. Discussion with teams has identified that focusing on the management of variation across the three outcomes is the next developmental step aligning with the Trusts intent to develop continuous improvement leaders and organisational capability.

Clinical outcomes are a key strand of clinical effectiveness at CLCH and, alongside patient safety and patient experience, are an important component in the assurance and improvement of quality in clinical practice.

The aim for 2015/16 was to ensure that all CLCH clinical services were competent in the basic use of outcomes measures i.e. that they understand what outcomes should be expected from their interventions, have identified a minimum of three outcomes which they are able to demonstrate performance against on a continuing basis, and have established an aspirational goal for improving performance.

Going forward, services are now being asked to review and analyse the variation in their outcomes each month to establish a 'normal' level of performance and to understand the amount of variation that results within current service delivery. Once the normal level has been established and the common causes of variation have been identified, services should be able to identify a goal for improvement.

Discussions with commissioners are commencing to explore how to incorporate this work into contracts and schedules.

PARTICIPATION IN CLINICAL AUDITS

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 forward clinical audit plan was approved and agreed for 2015-16.

National confidential enquiries

During 2015-16 the Trust was not eligible for participation in any national confidential enquiries but was registered for the following six national audits.

(Information awaited)

National Clinical Audits	Participation	Number of cases submitted or reason for non-participation
Sentinel Stroke National Audit Programme (SSNAP)		
BTS Pulmonary Rehabilitation Audit (part of the national COPD audit)		
Audit of Imperial's Laser Books		
National Audit of Intermediate Care (NAIC) 2015		

National Audits

UNICEF Baby Friendly Initiative audit		
National Parkinson's Audit 2015		

Local and Trust-wide audits

No	Item	Division	Service	Outcome and Actions 2015/16
1.	Re-audit of intervals of taking Bitewing radiographs in children	APC	Dental	The aim of the audit was to ascertain appropriate use of Bitewing radiographs in children in line with national guidelines and if the service had made an improvement on the 73% compliance from the previous cycle. The compliance of the re-audit was 93%. The mandatory requirement for recording the radiograph reports was 100% compliance. To action is to continue to reinforce the guidelines and mandatory requirements.
2.	Audit on Bitewing radiograph for new Paediatric dental patients	APC	Dental	The aim of the audit was to establish if radiographs were taken at the initial assessment appointment of all new patients. 100% patients were considered for radiographs. 64% patients were given a radiograph. 36% were not given a radiograph as on the day the child was unable to co-operate. Request for radiographs has been incorporated in the new referral forms.
3.	Audit of appropriateness of radiographs taken for adult patients across CLCH - Inner	APC	Dental	The aim of this audit was to ascertain if adult patients within the dental service had radiographs taken where there was clinical justification and had a film full report. 100% radiographs taken were clinically justified and all of them had reports. Action is to continue maintaining the compliance.
4.	Audit on frequency of taking Radiographs in adults in Barnet Dental Services (CLCH)	APC	Dental	The aim of the audit was to determine if the radiographs were taken at the set frequencies stated in the Faculty of General Dental Practice guidelines. 73% compliance was noted. The actions identified were to re-audit after one year and to reiterate the guidelines to the clinicians.
5.	Re-audit of dental Recall Process	APC	Dental	The aim of the audit was to establish if dentists were recording the next oral health review appointment after completing the treatment as per NICE guidelines CG19 and to observe if compliance had increased since the first audit. 95% compliance was noted. The compliance had increased from 79% to 95%.The action remains to

				reinforce that all patients should have a recorded agreed interval for routine dental examination.
6.	Blood Borne Virus (BBV) Screening & Vaccination Audit	APC	Homeless Health	Aim of the audit was to establish the current practice after the implementation of BBV Screening & Vaccination Protocol supported by NICE guidelines (PH43). 41% new patients referred to the service were offered BBV screening and 14% were offered 1st dose of Hepatitis B vaccination. The actions include offering health check and screening as standard practice, improve patient information and update the protocol.
7.	Generalised Anxiety Disorder	APC	Primary Care Psychological Health	Aim of the audit was to measure current practice for treating generalized anxiety disorder in adults against the recommendations in the NICE CG113 (Steps 2a, 3a & 3b). 68% met the recommendations in the guidelines. The main actions are to improve the documentation at the point of triage and provide patient information by the practitioners.
8.	Audit of intra uterine device insertions (IUDs) in the Contraception and Sexual Health Service. (CASH)	APC	Sexual Health	The aim of the audit was to assess the performance of clinician inserting the IUD against three Faculty of Sexual & Reproductive Healthcare guidelines namely to insert copper device TCu380 with banded copper on the arms and recording uterine version and length. Compliance for choice of device was 54%, recording uterine version was 99% and for length was 95%. The action is to increase the number of TCu380 IUD to reduce the number of devices replaced early and prevent untoward events.
9.	DAT Scan requests and management outcomes for patients attending Edgware Parkinson's service	BCSS	Parkinson's Service: Barnet	The aim was to ascertain the number of DAT scan requests for the year and to evaluate how the results influenced the management outcome for the patients. 47 DAT scans were requested in the year. DAT scans ruled out Parkinson for 46% cases and helped to provide clearer clinical understanding in uncertain cases, improving management and outcomes for patients.

10.	Safety indicators for patients starting oral anticoagulant treatment	BCSS	Specialist Nursing/ Anticoagulation	The aim of the audit was ensure regular monitoring of safety indicators for the anticoagulant service supporting the British Committee for Standards in Haematology. 100% compliance in following the appropriate loading doses. 15% new referrals were incomplete and were from GP surgeries. All the patients were provided information, written dose instructions and next INR measurement appointment No patients suffered major bleeding in the first month and whilst using INR. No patients had sub-therapeutic INR after stopping heparin. The action identified is improving the quality of new referrals from GPs.
11.	Antimuscarinics prescription by continence specialist nurses for overactive bladder syndrome treatment	BCSS	Specialist Nursing/ Continence Service	The aim of the audit was to assess if NICE Guidelines (CG171)2013 were met in relation to prescribing antimuscarinics in overactive bladder syndrome. There was 100% compliance
12.	Nutritional Care Audit Tool	BCSS	Community Nursing Services – Barnet/Inpatient Rehab: Barnet	Aim of the audit was to ascertain whether malnutrition audit tool, MUST, and dehydration tool, AGULP, were being used in line with the local policy and effectively in care of patients as per NICE (2006) Nutritional Support in Adults. The findings were that use of MUST was complied with and appropriate care plans were being put in place. However, it did not fully comply with NICE guidance as not all patients were assessed on arrival. AGULP tool was not being used and the appropriate care plan was not in place. Actions identified were to ensure MUST assessment was carried out on arrival. AGULP, which was identified as unsafe tool, would be replaced with FURST and appropriate training and practice would be put in place.
13.	Splinting for the prevention and correction of contractures in adults with neurological dysfunction	BCSS	Inpatient Rehabilitation (Barnet)/Inpatient Rehab: Barnet	The aim of this audit is to ensure correct assessment, treatment and management of patients needing and using splints to prevent or correct contractures after a neurological dysfunction as per COT and ASPIN guidelines 2015. WAITING FOR RESPONSE TO QUERY

14.	Audit of MSK clinical staff against NICE guidance of behaviour change: individual approaches PH49	BCSS	Specialist Therapies/MSK	
15.	Management of Osteoarthritis in Adults within the Musculoskeletal Service: adherence to NICE Guideline CG177	BCSS	Specialist Therapies/MSK	The aim of this audit was to ensure the compliance of the musculoskeletal service in accordance with NICE guideline CG177. The service was 80% compliant. The actions include improving the holistic approach to supporting the patient with osteoarthritis of the knee and providing patients with more information regarding any surgical options.
16.	No. of patients with reduced HbA1c within 6 months of treatment from the community diabetes team	BCSS	Diabetes: Barnet & West Herts	
17.	COPD “Hospital at Home" project.	BCSS	Respiratory (Barnet and West Herts)	
18.	Adult Home Enteral Feeding Audit Team Compliance with NICE guidelines CG32	BCSS	Dietetics (Nutrition Support Team)	The aim of the audit was establish that the service was complying with the NICE guidelines CG32. 2 out of 5 criteria met 100% compliance, 93% met the provision of contact details of the healthcare professional and homecare company and 88% records were completed with updated feeding regime. Actions taken have been to produce Patient Information Leaflet which includes all contact details and the assessment form has been updated to include a prompt for ‘updated feeding regime’.
19.	Incidence and management of oedematous wet legs in community setting	BCSS	Community Nursing Barnet	The aim of the audit was ascertain if patients with oedematous wet legs were managed as per NICE guidelines D007871. 61% of patients underwent Doppler Ultrasound assessment and 25% of patients were put in compression bandaging.
20.	Preferred place of death (PPD) in end of life patients	BCSS	Community Nursing/ Community Nursing Barnet	Aim of the audit was to identify the preferred place of death for end of life patients and if the preference was met. 94% patients died in their preferred place. In 4% of the records PPD was not recorded. The action identified is to ensure PPD is stated in 100% records.

21.	Audit of pulmonary rehabilitation uptake after hospitalised acute exacerbations of COPD discharge	BCSS	Integrated Long Term Conditions – Barnet & West Herts /Respiratory (Barnet and West Herts)	
22.	Self- management in COPD in the respiratory service	BCSS	Integrated Long Term Conditions Inner Boroughs/Respiratory Inner London	
23.	Biopsychosocial components of Respiratory admissions within Charing Cross Hospital	BCSS	Integrated Long Term Conditions Inner Boroughs/ Respiratory Inner London	
24.	Venous Leg Ulcer Assessment and Management	BCSS	Community Nursing/Tissue Viability	The aim of the audit was to establish if the current practice of leg ulcer and management aligned with NICE guidance 2012. There was overall 89.5% compliance. A re-audit is recommended.
25.	Pain Tool Audit (re-audit)	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	The aim of the re-audit was to ascertain if there had been an improvement in the use of pain charts for appropriate patients. The compliance for use of the charts in appropriate patients was 87% (58% improvement) and 50% completed regularly for ongoing use. The action is to continue improving.
26.	Slip, Trips & Falls Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care /IPU (nurses & OT)	The aim of the audit was to establish adherence to the CLCH slips, trips and falls policy and practice guidelines on the prevention of falls (NICE, 2013). 100% patients had their falls risk discussed at MDT. 75% had continence assessment and postural BP recorded. MEFRA was completed within four hours for 25% fall patient. The actions include recording time and date when MEFRA completed and where assessments cannot be done, follow up process to be put in place.
27.	Weekend Admissions to Hospital Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community	

			Team	
28.	Opiate Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community Team	The aim of this audit was ascertain the current practice for prescribing analgesia against Palliative Adult National and NICE guidelines. QUERY
29.	Steroids Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Pharmacy	The aim of the audit was to ascertain the collection and recording of the information of the steroid use for patients on steroids on admission to the inpatient unit. 45% had an indication recorded and 45% had a plan for the steroids on admission. The action is to ensure that name of steroid, dose, indication and management plan are recorded at time of admission and if the information is not available within 72hours.
30.	Review of Residents' Medical Records and Care Plans	BCSS	Continuing Care Nursing Homes/Athlone House, Garside House, PLK	
31.	Management of Frozen Shoulders	BCSS	Specialist Therapies/MSK	
32.	Effectiveness of the STarT Back allocating patients to different treatment pathways based on their prognosis with current best practice	BCSS	Specialist Therapies/MSK	
33.	Pneumococcal Treatment Compliance	CHD	0-19 Services H&F/Children's Community Nursing	
34.	Paediatric nasogastric tube feeding management (re-audit)	CHD	Children's Therapies/Dietetics	
35.	Giving of Buccal Midazolam by care workers during Seizure management	CHD	0-19 Services H&F/Children's Community Nursing	

36.	Compliance with the Hepatitis B Clinical Practice Standard: for health visitors and Children's Nursing teams working with parents/carers and babies	CHD	0-19 Services H&F/Health Visiting: H&F 0-19 Services K&C/Health Visiting: Westm.	
37.	Rating effectiveness of physiotherapy interventions within Employee Health	Corporate/ Employee Health	Employee Health	
38.	Stress reduction of CLCH employees	Corporate/ Employee Health	Employee Health	
39.	Aseptic Non Touch Technique (ANTT)	Medical Directorate/ Trust wide	Infection Prevention	
40.	Mealtime Mantra audits - bedded services	Medical Directorate/ Trust wide	Infection Prevention	
41.	Urinary Catheter Care Documentation Audit	Medical Directorate/ Trust wide	Infection Prevention	
42.	Dental audits	Medical Directorate/ Trust wide	Infection Prevention	
43.	Hand Hygiene audits - Community Services	Medical Directorate/ Trust wide	Infection Prevention	
44.	Hand Hygiene audits - bedded services	Medical Directorate/ Trust wide	Infection Prevention	
45.	Safe and Secure Handling of Medicines & Cold Chain - Bedded Areas	Medical Directorate/ Trust wide	Medicines Management	
46.	Security of Prescriptions	Medical Directorate/ Trust wide	Medicines Management	

47.	Safe Management and Use of controlled Drugs - Clinics	Medical Directorate/ Trust wide	Medicines Management	
48.	5 Patient Audit on transfer and discharges	Medical Directorate/ Trust wide	Medicines Management	
49.	Safe and Secure Handling of Medicines & Cold Chain - Clinics	Medical Directorate/ Trust wide	Medicines Management	
50.	Use of Antimicrobials	Medical Directorate/ Trust wide	Medicines Management	
51.	Omitted Medicines	Medical Directorate/ Trust wide	Medicines Management	
52.	Safe Management and Use of Controlled Drugs - Bedded Areas	Medical Directorate/ Trust wide	Medicines Management	
53.	Safe Management and Use of Controlled Drugs - Bedded Areas	Medical Directorate/ Trust wide	Medicines Management	
54.	Health Records Keeping Clinical Audit – Re-audit	Medical Directorate/ Trust wide	Clinical Effectiveness Team	
55.	Health Records Keeping Clinical Audit	Medical Directorate/ Trust wide	Clinical Effectiveness Team	
56.	Falls assessment and management in-patient rehabilitation	BCSS	Inpatient Rehabilitation Barnet/ Inpatient Rehabilitation Barnet	
57.	Audit of clinical practice against NICE Falls in older people: assessment after a fall and preventing further falls (2015) Quality standard 86	NCNR	Community Independence Service/Falls Prevention Service	

58.	Re-audit of Dysphagia Outcome Measure (DOM)	CHD	Speech and Language Therapy (Adults)	
59.	Adult Community Nursing Medicines Management	NCNR/ Quality & Learning Division	Community Nursing Service Central London/District Nursing: Central London	
60.	Community Nursing NICE Guidance Pressure Ulcer CG029 2014 - 15	NCNR/ Quality & Learning Division	Community Nursing/District Nursing: Central London	
61.	Falls assessment in the Falls Clinic at Finchley Memorial Hospital	BCSS	Falls prevention service / Intermediate Care Services	
62.	PACE/Rapid Response Assessment Pack Documentation	BCSS	PACE/Rapid Response - Intermediate Care Services	

Service Evaluations

1.	The use of telehealth for patients with long term conditions	BCSS	Integrated Long Term Conditions – Barnet & West Herts /Respiratory (Barnet and West Herts)	
2.	Morning Handover Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
3.	DNAR Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
6.	Service Evaluation of the Cross Care System at CLCH with Version 12 of the Liverpool Care Pathway (LCP)	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
7.	Inpatient Admissions Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (doctors)	
8.	Out of Hours Telephone Calls Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (nurses)	
9.	Admissions Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/IPU (nurses)	
10.	Missing Information of Referral Forms Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community Team	

11.	Response Times Audit	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Community Team	
12.	Syringe Drive Monitoring Charts	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Pharmacy	
13.	Social Work Response Rate – Community and IPU Referrals	BCSS	Integrated Long Term Conditions – Inner London/Palliative Care/Social Work	
14.	Implementation of the Ages and Stages Questionnaire [ASQ- 3]	CHD	0-19 Services Westminster/ Health Visiting: Westminster	
15.	Weighing and Measuring Service Evaluation	CHD	0-19 Services Westminster/ Health Visiting: Westminster	
16.	Audit of the movement in process	CHD	0-19 Services Barnet/Health Visiting: H&F and 0-19 Services H&F/Health Visiting H&F	
17.	Effectiveness of Employee Health consultations	Corporate/ Employee Health	Employee Health	
18.	Audit of research governance compliance	Medical Directorate	Research and Development	
19.	Audit to determine compliance to the Trust's Policy on consent to examination, treatment or therapy	Medical Directorate	Research and Development	
20.	Audit of implementation of MCA (Mental Capacity Act 2005) across services	Quality & Learning Division/Safeguarding	Safeguarding Adults	

21.	Audit of supervision record - safeguarding	Quality & Learning Division/Safeguarding	Safeguarding Children	
22.	The impact of the Specialist Weight Management Services (SWMS) on GP practice appointments	BCSS	Specialist Therapies/Nutrition & Dietetics Specialist Weight Management Team	
23.	Panic alarm system in the Podiatry clinics of CLCH, Hammersmith and Fulham branch Audit 2014-15	BCSS	Safeguarding Children	
24.	WIC UCC Safeguarding Audit	Quality & Learning Division/Safeguarding	Specialist Therapies/Podiatry	
25.	Mouth Care Training for Health Care Assistants	CHD	Speech and Language Therapy (Adults)	

PARTICIPATION IN RESEARCH 2015/16

Participation in clinical research demonstrates CLCH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. 'Clinical research' means research which has received a favourable opinion from a research ethics committee within the **National Research Ethics Service (NRES).**

Research activity is monitored through the Clinical Effectiveness steering group, overseen by the Quality Committee a subcommittee of the Board. It is an established fact that active research within organizations promotes the highest standards of care in its settings. Health research in community healthcare has a potential to create new knowledge which will benefit many NHS organizations. Our Trust is keen to adopt such innovative approaches and practices, improving care and outcomes for our patients.

CLCH offers great potential for research opportunities with its broad range of community services across the whole age spectrum, including: adult community nursing services, children and family services, specialist services to help manage long term conditions, rehabilitation and therapies, palliative care services, NHS walk-in and urgent care Centre's. Future research opportunities for growth within the Trust are focussed on four main disease/service areas: Parkinson's disease, Stroke, Diabetes, Sexual Health and commercial studies.

The Trust Research Strategy (2014-2017) sets out eight key objectives aimed collectively at extending and enhancing the research profile of the organisation.

The research goals are as follows and are intended to be implemented during the period 2014-17. Each goal translates into several actions that are taken forward via an annual implementation plan.

- 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.

These objectives map onto all areas of research activity within the Trust and will be achieved by working in collaboration with partners. We are making steady progress to both promote research activity and develop a research culture in the Trust; this is demonstrated by the achievement of exceeding our recruitment target for 2015/2016 and our annual Trust Research conference. We are ambitious to develop a supporting environment for health research by encouraging and facilitating researchers and to make effective partnerships with clinical research networks, other NHS Trusts, academic and industry sector.

CLCH was involved in 24 clinical research studies in a number of specialities during 2015/16 either as a Participant Identification Centre (PIC) or a host site including; Diabetes, Children's health, Stroke, Sexual Health and Parkinson's. The number of patients receiving relevant health services provided by Central London Community Healthcare NHS Trust during 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 150. These patients were recruited into a clinical trial research project within the Sexual Health service.

In 2015/2016, there were over 40 clinical staff participating in research covering 4 specialities approved by a research ethics committee. CLCH is a host site for approximately one third of studies, for a further third, CLCH acts as a Participation Identification Site (PIC) and the remaining studies are educational projects either self-funded by students or funded by the Trust for educational purposes such as MSc or PhD qualifications.

The following are a few examples of current studies that CLCH is involved in:

- Health visitors' knowledge about pre-term infants care within the community
- A cross-sectional study of young-onset diabetes in 2 UK ethnic groups
- Patient-consented samples for STI diagnostic development & evaluation
- Exploring the training needs of health visitors working with children with Down syndrome:
- Working Memory Training in Type 2 Diabetes

PATIENT STORY – Parkinson's Service

I came to the Parkinson's Unit through the Manager in my Doctors surgery, she referred me. I received a letter from the Parkinson's Unit with an appointment date to see a doctor. I saw her a few months ago. My walking wasn't so good then and she said it was Parkinson's.

They asked me to see the nurse next door. I am no good at drawing or maths and couldn't get the figures right. The nurse may have thought I had something wrong with me as I couldn't do it. It was nothing to do with my memory. The only thing that surprised or concerned me was the nurse was asking me maths questions I am not good at. They did not explain why they were doing it. It may have been good to explain why they were doing the test. The doctor organised to see me in 6 months time.

A therapist told me they would like me to go on a 6 week course. It would have been difficult for me as I have to get 2 buses to Edgware so they organised the hospital transport. They organised everything. I found the course extremely helpful. The therapist also came to my home. She arranged for someone to put a handrail under my mattress. I find it a big help. She also felt my coffee should be moved. She said my toilet frame should be raised but I felt it wasn't necessary, she respected my decision. The Physio was excellent and Occupational Therapist was very good. Even the woman who does the tea was lovely. I phoned the helpline the other day. I spoke to a man who put me straight through to a Nurse who spent 30mins speaking with me. This was very helpful.

When I saw the doctor she wanted to up my dose of Parkinson's medication more and I said no. I don't know if I need to up it now, but she respected my decision. I was worried the medication would need to keep going up. The Occupational Therapist involved me in everything. She left a couple of magazines with things I can buy. This was very helpful.

To be honest, I do not like being a patient with Parkinson's, but I must say the Parkinson's Unit down to the receptionist, Occupational Therapist and Physiotherapist were all very kind, caring and nice. There are always staff around and the receptionist if there are any problems. I am still trying to come to terms with my Parkinson's. I have accepted it as I have been told by 2 Doctors. It's like anything I wish I didn't have it as I get very tired in the afternoons and don't sleep well at night.

If people didn't know the staff, it would be helpful if people said who they are, when they come into the waiting room. It may also be helpful to introduce the patients to each other.

Learning from this story

This person tells us a very positive story about their experience within the Parkinson's service. We learn, however about the importance of staff introducing themselves and providing explanation. The trust joined a national campaign in March 2015; 'Hello my name is'. This reminds staff to introduce themselves to patients as the start of making a vital human connection, beginning a therapeutic relationship and building trust between patients and healthcare staff. Patients are asked in our feedback surveys if care and treatment was explained in a way they could understand, and teams are provided with this feedback to inform their future practice.

LOOKING BACK - PROGRESS AGAINST THE AGREED 2015-16 QUALITY PRIORITIES

AT A GLANCE SUMMARY OF PROGRESS AGAINST 2015 – 16 QUALITY PRIORITIES			
Quality domain	**Priority**	**Achieved**	**Further Action**
Patient experience	1. We will improve patient engagement in relation to working together in partnership to change/improve quality	YES	This work will be incorporated into the Trust Patient Experience Strategy
Patient experience	2. We will work to support a single point of access for patients with long term conditions	PARTIALLY	
Preventing harm	3. We will improve service users' involvement in service improvement projects and safety campaigns	YES	This work will be incorporated into the Trust Patient Experience Strategy
Preventing harm	4. We will continue to reduce medication errors in practice	YES	We will continue to monitor medication errors as part of our Quality Dashboard and act where errors are noted
Smart effective care	5. 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	PARTIALLY	We will ensure that more information is available on our improved internet site
Smart effective care	6. We will improve the percentage of relevant NICE clinical guidance that have been assessed by eligible clinical teams	YES	The Trust will continue to monitor as part of our clinical effectiveness group reporting to the Quality Committee.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 1 - WE WILL IMPROVE PATIENT ENGAGEMENT IN RELATION TO WORKING TOGETHER IN PARTNERSHIP TO CHANGE/ IMPROVE QUALITY.

Our approach to patient engagement was informed by our engagement strategy which translated into local plans for each Clinical Business Unit. In reviewing our strategy we have used the Trust Development Authority Patient Experience Framework to assess our current position and to determine our objectives for the next three years. Feedback from listening events has also been used to help inform our approach.

We use a variety of approaches in capturing patient experience feedback to inform continuing service and quality improvement. These include the Friends and Family Test, Patient Reported Outcome Measures (PREM's), patient stories, 15 steps challenge visits and listening events. The Trust also uses formal and informal complaints (Patient Advice and Liaison Service, PALs) and has an active Quality Stakeholder Reference Group to support us in understanding the quality of our patient's experience.

During the year, we have held a number of listening events within several of the boroughs in which we deliver care; Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster. The purpose of these was to engage with as wide an audience as possible to share information about services and health related issues, ask what matters to patients most and to identify what is working well and what could be improved. In May 2015 four listening events were held across our boroughs to explore a positive patient experience. We enabled wider participation through telephone interviews and an online survey. Our aim was to find out what aspects of the patient experience are so important that we should always get them right. In these discussions people identified what good care should look like and what we should always do. People also told us their views about involvement in care, health information and expectations of professional staff. Additionally, we sought people's views on what we do well and what we could do better.

From these discussions, the following themes emerged: the importance of consistency of healthcare professionals continuity of care and experienced front line staff), communication (Improvement in healthcare professionals communication skills and better training for telephone staff, being well-prepared (reading notes in advance and knowing about the patient), telephone access and response (not easy for people to leave messages or have their calls returned) and incorporating patient feedback (making sure people's feedback is used to improve what happens day to day).

This feedback will enable us to develop 'Always Events'; practices or behaviours that, when implemented reliably, ensure an optimal patient and family experience and improved outcomes. They provide clarity about what should happen for every person, every time they encounter our teams within CLCH. These Always Events will be incorporated into our new Quality Strategy and Engagement Strategy whilst each clinical division will develop local plans to embed these Always Events into their services.

In November 2015 a series of listening events were held to engage specifically with children and young people, their parents or guardians. The purpose was to explore what makes a good experience, how it could be better and whether information provided by healthcare professionals is easy to understand. Engagement in this discussion was widened through paper or online surveys.

Overall, it was seen that friendly, approachable and professional healthcare staff contribute to a good experience, and that information provided to them is largely clear and understandable. Areas for improvement related to poor communication or interaction with individual professionals at their appointment. In response to the feedback, local action plans have been developed in Children and Young Adult's services and these themes have informed the revision of our Engagement Strategy.

Our Continuous Improvement Programme (CIP) enabled our staff to take forward Rapid Improvement projects. The intensive 10 week course uses a combination of classroom teaching and practical work to provide our staff with the skills and confidence to apply methods to improve services and ultimately help provide better care for patients. A recent project focused on improving working practices between GPs and community nursing teams. A patient co-facilitated a training session for the programme participants and we have also had a patient participating in a Rapid Improvement Event for our staff.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 2 - WE WILL WORK TO SUPPORT A SINGLE POINT OF ACCESS (SPA) FOR PATIENTS WITH LONG TERM CONDITIONS

All referrals come via the SPA. Referrals are then transferred in to the services for clinical triage every day. There is one phone number for patients to contact regarding appointments. Considerable work has taken place to improve communication between the SPA and our clinical services. This means that patient queries are signposted appropriately and promptly; there is now more integration between the SPA and our clinicians. Our Patient Advice and Liaison Service has been able to resolve appointments with callers promptly as a result of these changes and stakeholders, especially General Practitioners, find the system easier to use.

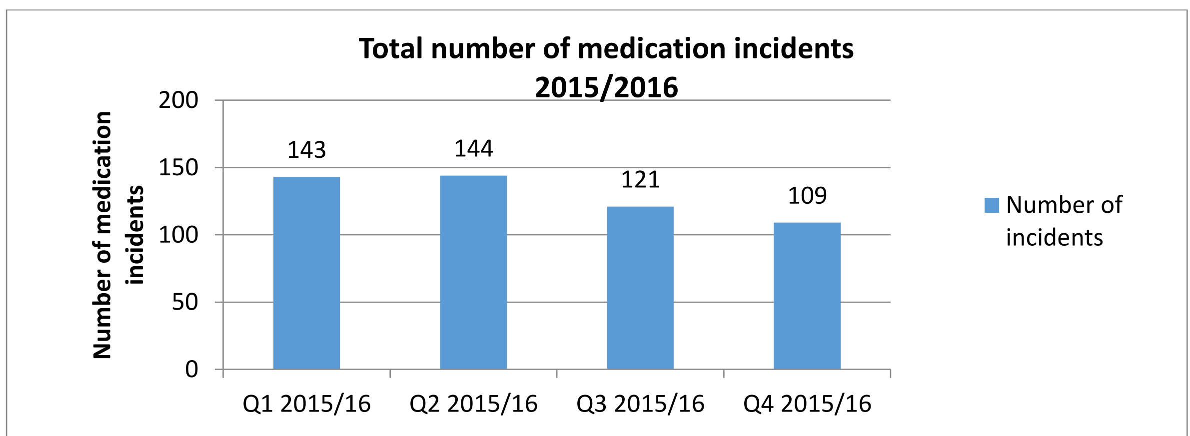
PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 3 - WE WILL IMPROVE SERVICE USERS' INVOLVEMENT IN SERVICE IMPROVEMENT PROJECTS AND SAFETY CAMPAIGNS

As described elsewhere in detail in this account, CLCH joined the 'Sign up to Safety' campaign and was one of the first trusts to do so. We believe that listening to our patients, families, carers and staff is paramount and we want them to play an active and valued role in shaping and influencing how safety and improvement plans are developed. We know that the patient voice is a powerful force for change if listened to and learned from.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 4 - WE WILL CONTINUE TO REDUCE MEDICATION ERRORS IN PRACTICE.

As can be seen in graph 15, there was a decline in the total number of reported medication errors in 2015 - 16 with a 24% reduction reported in Q4 compared to Q1.

Graph 15 – **Total number of medication incidents 2015-16**



Of the 517 reported incidents, 30 were categorised as having caused a level of harm in 2015/16. This is a significant reduction from the baseline in 2012/13 where 156 incidents were reported as having caused a level of harm.

During the year in question, there were a number of projects led by the medicine's management team that helped reduce the number of medication incidents. These included:

- The procurement and implementation of a remote fridge monitoring system and face to face cold-chain training sessions to tackle the cold chain incidents
- A review of the medicines management training packages for staff with a new programme ready for rollout in 2016/17
- A Medicines Optimisation Service (MOpS) service that was commissioned by Central and West London CCGs. This service helps to keep patients safe in their homes and prevent avoidable medicine-related hospital admissions by undertaking clinical medication reviews in patient's homes
- A continuation of the audit programme focussing on Safe and Secure Handling of Medicines at approximately 200 community clinics and bedded services, Omitted Doses and Antimicrobial Audits
- An increased reporting on errors on transfer from secondary to primary care with feedback to the relevant Acute Trusts
- A review of the Clinical Pharmacy services at bedded rehabilitation units with a change in the model at one unit and support on the roll out of a new drug chart at Barnet bedded services
- A review of Datix incident reporting and refining of categories within the medication field on Datix to help capture more accurate data

PROGRESS AGAINST QUALITY ACCOUT PRIORITIY 5 - 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 are awaiting the delivery of the new electronic dashboard. This is a quality dashboard which will be available on the Trust's intranet. One in-patient ward now has a quality board in place that gives members of the public information on patient experience and safety.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 6 - WE WILL IMPROVE THE PERCENTAGE OF RELEVANT NICE CLINICAL GUIDANCE THAT HAVE BEEN ASSESSED BY ELIGIBLE CLINICAL TEAMS

During its monthly meetings, the NICE (explain?) Core Group, which is chaired by the Medical Director and consists of professional and clinical leads, systematically reviewed all NICE guidelines published in 2015/2016 while aiming to meet the Trust's key performance indicator that all specialities are fully compliant with relevant NICE guidelines within 6 months of publication.

In the process, 30 guidelines were considered relevant to the Trust and were subsequently circulated to specific clinical services for information or for assessment by means of a gap analysis tool using the NICE Baseline Assessment form (NBAF) electronic system. Where there was a gap, services were expected to develop action plans to ensure compliance with attention being paid to whether the services needed to work beyond the boundaries of their own service or required resources. Completion evidence was provided at NICE Core Group meetings.

PATIENT STORY - Health Visiting

I said to your Nursery Nurse that because we are a 2 mummy family we have found while people try to be inclusive and while I suppose it is a relatively new concept in terms of society, we have had a really relaxed experience at your clinic. There has been no stumbling over words or people second guessing or trying to include us as a separate entity. It has been a very natural inclusive experience and that is really important for us because it's really important for us that our little girl grows up in a society that doesn't treat her and her family any differently.

The Nursery Nurse has been totally invaluable to us. Actually we got ourselves into the habit after baby had her injections because she wouldn't settle on her own so she was sleeping between us and then we got stuck. We couldn't get her back to her cot and the Nursery Nurse advised us and we have got her back in her cot now. She has been really lovely.

The first time parents group has made a massive difference it has saved us so much 'googling' which is just a nightmare, just knowing that other people have the same situation as you. We are lucky we have a really supportive family but I would imagine for people that don't, we look at each other and say how do they do it on their own.

Because baby was premature it has been quite interesting coming to the baby clinics and next time we weigh her she will probably be about 5 stone!! because she has really caught up. But it has been important to us to track her progress perhaps more than someone else.

What is really good is that within the group all the mums have different experiences. A good example is when she was going for her injections - I said 'my baby has her injections tomorrow' and one mum said to me 'don't forget to buy the calpol and straight away another mum swooped in and said 'my doctor said don't do it unless she has got a fever'. So I was faced with 2 opinions and I said 'thanks I will just ask my nurse' and then I spoke to the Nursery Nurse because I thought she is a professional and I will take her guidance.

The only thing that frustrates me about the clinic is having to leave your buggy downstairs which I can understand but that is my only issue but they are making it accessible for people.

Learning from this story

This story identifies a positive experience of the service, but the person expressed their initial frustration as buggies need to be left downstairs at this clinic. The staff have recognised this concern and have put a system in place to provide locks so that these can be secured whilst people attend their appointment

LOOKING FORWARD - OUR QUALITY PRIORITIES FOR 2016-17

In this section we detail our quality improvement priorities for the coming year. Our Chief Nurse and Director of Quality Governance, Louise Ashley has overall responsibility for the development of our Quality Account. The priority leads within the account are as follows:

Positive Patient Experience: Ms Holly Ashforth, Director of Patient Experience
Preventing Harm: Professor Charlie Sheldon, Director of Patient Safety
Smart, Effective Care: Dr Joanne Medhurst, Medical Director

Progress against our priorities will be reported to the Quality Committee on a quarterly basis as part of our comprehensive quality report.

QUALITY PRIORITY 1 – POSITIVE PATIENT EXPERIENCE, PREVENTING HARM – DEVELOPING A QUALITY ALERT PROCESS FOR STAKEHOLDERS

We will develop a mechanism by which clinicians in other organisations can quickly alert CLCH to issues about our service; either those experienced themselves or issues reported to them by patients. We will establish a secure email system for these alerts and will set targets for reply and resolution of these issues.

What will success look like?

In quarter one we will communicate with referrers to our service regarding the process for using the alert system. The alert system will be implemented from quarter two. Alerts to the central inbox will be responded to by close of next working day. Logged and monitored.

A summary of the alerts received will be included in the weekly incident and complaint pack for the Executive Leadership team. A quarterly summary of quality alerts will be reported to the relevant CCG as part of the quality monitoring process.

QUALITY PRIORITY 2 – POSITIVE PATIENT EXPERIENCE, PREVENTING HARM - IMPLEMENTING A QUALITY EARLY WARNING SYSTEM

The Trust's quarterly Quality Report and monthly Quality Key Performance Indicator (KPI) analyse progress against all aspects of quality performance, including the Quality Strategy and Quality Account. The reports currently use funnel charts to identify outlying teams and the action being taken to support them. Within the report there are exception reports for any 'red' areas. Discussions at Trust Board and subcommittees look to triangulate information from performance reports and KPIs with professional judgement and insight from walkabouts and listening events. If there are ongoing concerns regarding any of the indicators, members of the Board can request further deep dives into areas of concern. An example of this is the community nursing teams in one of the Boroughs who had appeared as 'red' on several indicators for staffing, appraisals, pressure ulcers and falls.

In 2016/2017 we will develop a set of red flags to compliment this work and to provide an early warning system that will identify issues ahead of the reporting systems, therefore allowing very immediate actions to be taken prior to having to consider instigating a quality action team. This will allow us to maintain a spotlight on quality in the expanded organisation.

WHAT INDICATORS WILL WE USE?

Preventing Harm
A 10% increase in incidents causing harm (moderate or above)
Any new serious incidents reported

Positive Patient Experience
An increase in complaints
A drop in FFT score

Smart, Effective Care
Reduction in clinical outcome reporting
Any care/ clinical related internal serious incidents

Workforce
Absence of a team leader for >1 month
Vacancy rate above 12%

WHAT WILL SUCCESS LOOK LIKE?

How will the system work?
A red flag report will be triggered if:

i. a team has 2 flags or greater.
ii. A team has 1 indicator red > 2 months

How will we act upon Red Flags?
Departments/teams with a red flag will be asked to put a risk on the risk register and provide monthly progress as part of their report to the Patient Safety & Risk Group. The risk will be managed with an action plan in the usual way.

Support for Teams
It is expected that teams with a red flag will have assistance from the Divisional ADQ (explain) in drawing up plans. The appropriate Director (for example HR Director, Director of Patient Safety should ensure that the team lead has access to their specialist team).

Reporting of Red Flags
The red flag report will be reported to the Quality Committee monthly and will also be highlighted monthly at the Executive Leadership Team Meeting.

Commissioners will receive a report on relevant red flag teams as part of the monthly quality reporting and updates on action plans and progress as necessary.

QUALITY PRIORITY 3 – SMART, EFFECTIVE CARE - WE WILL ENSURE THE BALANCE BETWEEN ASSURING SAFE EFFECTIVE CARE AND ENABLING SYSTEMATIC IMPROVEMENT OF SERVICE QUALITY.

What indicators will we use?

- % new NICE guidance reviewed, assessed and implemented within 12 month deadline
- % completion of actions from Audits within deadline (TBC)
- % services reporting clinical outcomes (via reporting platform)
- Number of staff been trained via Continuous Improvement Programme
- % Continuous Improvement graduates participating in improvement in past 12 months

WHAT WILL SUCCESS LOOK LIKE?

Monitoring

- The Trust will monitor the adoption of best practice through the monthly assessment of new NICE guidance and its implementation.

- Every Clinical Business Unit (CBU) will undertake clinical audits to assess adherence to best practice standards.

- All services will monitor patient outcomes to understand the effectiveness of clinical interventions.

Development

- The Trust will develop capacity and capability for quality improvement through the delivery of the CLCH Continuous Improvement Training Programme.

- Graduates of the Continuous Improvement Programme will participate in improvement projects annually.

- Supporting services to identify improvement opportunities through effective analysis of quality data.

PATIENT STORY – District nursing case management

I left school when I was sixteen; I was brought up in the slums in Glasgow and joined the army, moved all over. I used to go to hospital a lot. I had 2 strokes, couldn't walk and couldn't talk. In 2004 I had a dislocated disk. It was a lot to deal with.

I started to see 'A' for the past 3 or 4 weeks I think. Before that it was different people. I like 'B' she is very nice, but she doesn't talk much. 'A' has more conversation with me. In the past people came to do a job, but now it feels like they care about me. 'A' cares about me more. I feel like she listens, she understands me better. I didn't want to attend the meeting at the hospital. Doctors and nurses don't listen to me in hospital so there is no point in me going. I was happy for 'A' to explain everything on my behalf as she understands me. I was able to tell her how I wanted my care to be given and 'A' listened and answered all the questions I had. I am able to tell her what I want in my care and I can also tell her if it's not working.

I've read the plan crisis plan and I agree with it. I have given the warden of the sheltered accommodation a copy of the plan and I know where my crisis plan is. The plan is very easy to understand. The staff are very committed and helpful. I still want to socialise and they are helping me, referring me to the groups at St Charles and other local groups.

The ambulance has come to see me, but I didn't want to go to hospital. With the plan I was happy to stay at home. I feel more confident talking but I get pain after talking for a long time my speech gets gibberish. I don't go to hospital anymore as I don't like hospitals, and staff in hospital bullied me. Having a Community Matron made my care more individualised. My confidence has increased and I feel more respected, not like in hospital. I feel I have better treatment now. The crisis plans are great and people care more. I can use the plan and now I have a rescue pack. The patch makes it very easy for my pain. I do it myself and change it every Friday at 3pm. It is very easy and they taught me.

Hospitals are not nice places to be, so the crisis care plan is good. I'm glad this is bringing change. Changes are for the better. I love change that is the secret to survival.

Learning from this story

We will aim to link the issues raised in this story around communication with the Trust's work on compassion (one of the 6cs) and `knowing you matter - see me, know me, connect with me'

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

This year we asked members of the public our users and staff to proposed areas for consideration under our 3 campaign headings. All the comments made are considered by the Trust and are taken forward where appropriate.

In response to this consultation we received 32 comments; not all of which proposed quality priorities. As might be expected from an open question, there was no single opinion as to which areas CLCH should take forward as their quality priorities. Responses were received about a number of issues ranging from the quality of reception staff and administration staff; the time it takes to get an appointment; medication errors, and staff training. All the issues raised (where relevant to CLCH) are looked at via the performance scorecard.

In some cases the replies referred to acute or mental health care trusts or the care that had been provided by a GP – all of which were not applicable to CLCH.

In addition, we wrote to the Chairs of Healthwatch, 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.

PATIENT STORY – Finchley Walk in Centre

I burnt my lower left leg on a motorbike exhaust whilst on holiday in Poland. I attended a local chemist who sold me an antiseptic cream which l applied. On my return home l had and abscess. I attended Barnet Hospital and was given a course of antibiotics. I was referred to your service by my GP for a review and change of dressing of my wound. I was informed by the GP twice that they do not do dressings at the surgery although there is a nurse at the surgery. I wondered why the nurse at the GP surgery could not review and change my dressing. I was not given any choice of a local Walk in Centre to attend but chose to come to the Finchley Walk in Centre.

I travelled there by bus and when l reached the main entrance I noticed the building was new. It had a car park facility which was free although l don't drive. The waiting room was packed with patients and I was informed the waiting time was 4 hours on my first visit, but then the total time from registering to being discharged was only two hours and today I was seen with 45 minutes.

My main concern is about the waiting time and too many people at times. I am lucky to be within the Finchley Walk in Centre catchment area and would highly recommend it. I am grateful and appreciative of the way I was treated by the staff. The care has been outstanding at every level from the receptionist to the nursing staff.

Learning from this story

The key issue for this person related to reliable information about waiting times within the Walk in Centre. To address this issue, we now have display screens which are updated regularly with information about current waiting times. We have introduced a new numbered queuing system for patients who arrive in the morning before opening time and a 'Triage and Treat' system has been introduced during busy times whilst doctors provide increased hours within the Walk in Centre.

REVIEW OF QUALITY PERFORMANCE - REQUIRED INFORMATION

The following is information that has not been reported on elsewhere in this account but that is required to be included by the Department of Health.

CARE QUALITY COMMISSION

The Trust was inspected by the Care Quality Commission in April 2015.

CQC findings – Good and Outstanding Practice to be replicated across the Trust

- The tissue viability service had developed innovative practice and had taken part in international research and the development of NICE guidance
- The nutrition and dietetics service provided excellent, patient centred care based on leading and setting standards in dietetics and nutrition including NICE guidance development and facilities for patients. The service participated in international research and publication
- In Adults services:

  The service responded proactively to reported incidences of pressure ulcers through training, Communication and distribution of resource packs to residential home staff

  Multi-disciplinary, patient centred care was evident and involved a range of specialist staff involved in joint visits to the patient. External partners included GPs, housing and social services, police, the prison service and mental health

  The turnaround work undertaken on Jade Ward was noted to have effected significant improvements in delivery of care

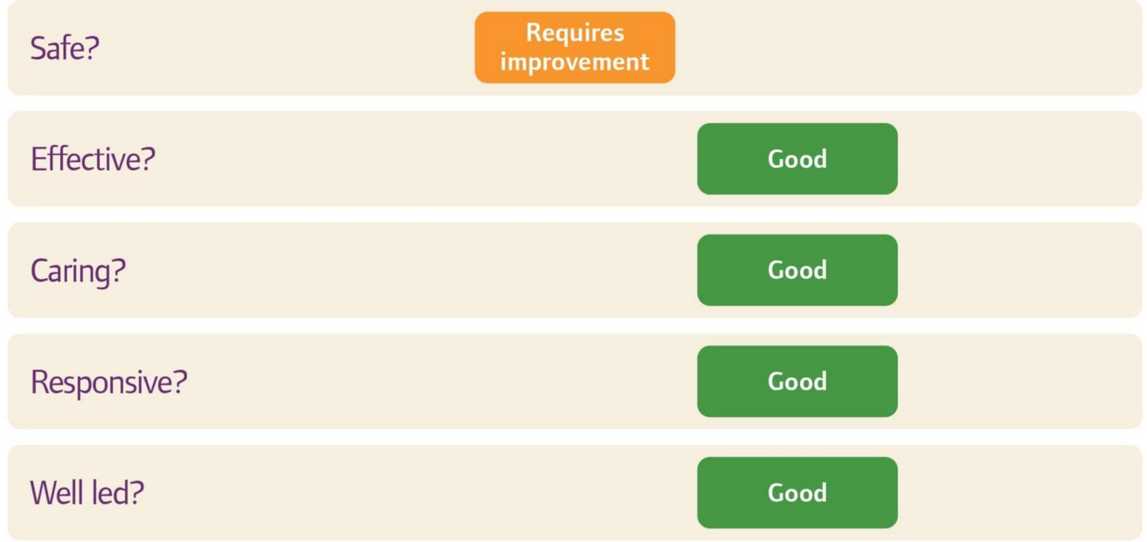
CQC findings – areas for improvement (must do’s)

- End of Life Care services were caring and responsive although required improvement to safe, effective and well-led domains
- Children’s services were caring, effective, responsive and well-led although required improvement in the safe domain
- Recruitment and retention of staff across a number of areas
- End of Life Care services were caring and responsive although required improvement to safe, effective and well-led domains
- Children’s services were caring, effective, responsive and well-led although required improvement in the safe domain
- Recruitment and retention of staff across a number of areas

Central London Community Healthcare NHS Trust

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
Urgent care services	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Central London Community Healthcare NHS Trust



The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/provider/RYX

We would like to hear about your experience of the care you have received, whether good or bad.

Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

As can be from the grid above, CLCH was rated as *requires improvement* in the *safe* domain. This was mainly due to vacancies in some services. Like most trusts in London, CLCH is affected by the shortage of available nursing staff. In response to this, CLCH has put in place a number of initiatives to address this – these include a recruitment summit, chaired by the CN to look at innovative ways of trying to recruit hard to reach groups and international recruitment.

CQUIN PAYMENT FRAMEWORK

A proportion of CLCH's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between CLCH and the three CCGs which make up North West London (NWL) Clinical Commissioning Groups and Barnet Clinical Commissioning Group (CCG).
Our achievements against the CQUIN goals for 2015/16 are detailed in the following tables:

(NB these are currently still draft)

North West London (NWL)

CQUIN	Goal	Plan 15/16 £	Forecast 15/16 £
Dementia	Staff Training in CLCH and in Care Homes Carers' survey	£169,000	£118,000
Shared patient record and real time information system	Implementation and roll out of shared care records across all services- Year two of two year CQUIN- Emphasise full roll out and implementation- Interoperability is Key	£439,000	£439,000
Diagnostic Cloud across the NW London health economy	Introduction of the Diagnostic Cloud across CLCH services. This is an IT system enabling staff to view a patients diagnostic results across providers and to order diagnostic tests	£639,000	£639,000
Tissue Viability	To standardize and improve the quality and effectiveness of Tissue Viability services across Central London, West London and Hammersmith & Fulham CCGs	£217,000	£174,000
Supporting 7 Day Working	Analysis of current 7 day working requirements and plan for extending 7day working to support a 7 day health system and discharge from hospital	£150,000	£150,000
Continuous Improvement		£80,000	£80,000
NWL TOTAL		**1,914,592**	**1,425,700**

CQUIN	**Goal**	**Plan 15/16 TOTAL £**	**Plan £TOTAL**
Value based commissioning (Long term condition management)	Reduce unplanned admissions into hospital or attendances at A&E for patients over 65 through crisis care planning	206,966	157,294
Children's Safe Transition into Adult Services	Increased attendance at multidisciplinary /professional meetings. Increased patients with key transition planning evident within their care plan.	68,989	34,494
Dementia	Dementia awareness training (1) and screening (2)	(1) 41,393 (2) 27,595	(1) 31,046 (2) 24,837
Tissue Viability	Improved access to leg ulcer clinics	344,943	155,225
NCL TOTAL		**689,886**	**402,896**

NHS England

CQUIN	**Goal**	**Plan 15/16 TOTAL £**	**Forecast 15/16 £**
Diabetic retinopathy – uptake of screening services	Increase uptake of screening services (April 16 to Oct 16 only)	£7, 400	£7,400
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)	£6,100	£6,100
Child immunisations co-ordination	To co-ordinate immunisations across CLCH	£3,800	£3,800
Offender health – TB screening (Non digital)	TB screening; Escort and Bedwatch Audit; Ensuring adequate staffing levels	£195,000	£195,000
NHSE TOTAL		**£212,300**	**£212,300**
ALL TOTAL		**£2, 816,778**	**£2, 040 896**

DATA QUALITY
CLCH recognises that Information Governance which has as a component high quality data is essential for the effective delivery of patient care and to enable continuous improvements in care provision. This includes ensuring that personal data is treated in the strictest confidence, managed securely and is shared for the purposes of direct care in line with the Caldicott principles. The Trust is 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.

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 clinical and administrative 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 during the 2015/2016 year:

- The Data Quality Strategy was revised and re-issued in late 2015. This supports the already published Data Quality Policy
- A limited number of self-service data quality reports are now available on the CLCH Hub (intranet). These reports will increase in number during 2016/2017
- Additional reports covering specific areas of data quality are sent out on a weekly basis to service managers
- We have started to make use of third-party data quality reports from the Health and Social Care Information Centre (HSCIC) relating to submissions to the Secondary Uses Service (SUS)

In addition, a Performance and Information Data Quality Operations Group (PIDQOG) was established during the year, chaired by a Divisional Director of Operations. In the context of data quality this group has three specific aims:

- Support the Accountable Officer for Data Quality and Data Validation (the Chief Executive) and provide assurance that the quality of data within the Trust is of a high standard for accurate decision making and reporting
- To act as a central focal point for Data Quality matters within the Trust, from both a clinical and corporate services, including having ownership and responsibility for reviewing data quality issues and developing action plans to address those issues

To be responsible for supporting the development and implementation of corporate strategies, policies and procedures for data quality

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 94.6% for accident and emergency care. The percentage of records in the published data which included the patient's valid General Medical Practice code was 96.5% for accident and emergency care.

CLCH did not submit records during 2015/16 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 2015/16.

INFORMATION GOVERNANCE TOOLKIT AND REVIEW OF SERVICES

The Trust has maintained Level 2 compliance against the Information Governance Toolkit and achieved a score of 76%. This represents overall satisfactory compliance which has been confirmed by the Trust auditors.

REVIEW OF SERVICES

During 2015/16 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 2015/16 represents 100 percent of the total income generated from the provision of NHS services by CLCH for 2015/16.

STAFF SURVEY RESULTS[1]

Key Score 26 (KS19 in 2014 survey) – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

2014 Score – 28%
2015 Score – 24%

This represents an improvement of 4% but it is still above the national average for community trusts which is 21%.

(The figure above combines results from two separate questions as follows:
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from:

Managers	88% said “never”	Community Trust average: 89%
Colleagues	82% said “never”	Community Trust average: 86%)

Key Score 27– Percentage of staff believing the trust provides equal opportunities for career progression or promotion

In 2015 **83**% said yes. Community Trust average: 89%
In 2014: 82% said yes.

Our Plans for improvement:

We have identified bullying and harassment hotspots by looking at staff survey data at service level and we are offering workshops to those teams with scores significantly higher than the trust average. This has proved useful in the past because it has helped team members develop effective working relationships.

[1] (results for indicators KS19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KS27 (percentage believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard

Additionally we are looking at options to prevent bullying and harassment at an early stage. These include developing the mediation service and raising its profile. We are also recruiting and training additional mediators and anticipate that four new mediators will be trained in May. We are also encouraging the use of the *restorative practice* approach within teams, which again aims to repair relationships as an alternative to using the formal bullying and harassment policy.

Finally we are building management capability through a range of management training options such as the clinical team leaders' development programme as well as a course designed specifically for managers who are new to management. We are also looking at how to provide training for managers to help them promote health and wellbeing in their teams, with a particular emphasis on how to spot and handle mental health issues. While none of this is specifically about reducing bullying and harassment, we believe that it will help develop a constructive and supportive team environment which provides a good basis resolving concerns at an early stage.

A workforce race equality standard has been completed by CLCH and shared with BME Staff. A board seminar is planned for April 2016 and a work plan will be formulated following the seminar.

STATEMENTS

HEALTHWATCH
COMMISIONERS
HEALTH OVERVIEW COMMITTEE

(These will be added when received).

FEEDBACK AND FURTHER INFORMATON

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 few 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, please call our communications team on 020 7798 1420.

Further advice and information

If you would like to talk to someone about your experiences of CLCH services or if you would like to discuss 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)
Email pals@clch.nhs.uk
Tel 0800 368 0412
Switchboard for service contacts Tel 020 7798 1300
Local Healthwatch

Central West London Healthwatch

For Hammersmith and Fulham, Kensington and Chelsea and Westminster Email healthwatchcwl@hestia.org Tel 020 8968 7049

Barnet Healthwatch

Tel 020 8364 8400 x218 or 219
www.healthwatchbarnet.co.uk

Local Clinical Commissioning Groups
Barnet CCG
Tel 020 8952 2381 www.barnetccg.nhs.uk
Central London CCG
Tel 020 3350 4321 www.centrallondonccg.nhs.uk

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

Harrow CCG
Tel 020 8422 6644
www.harrowccg.nhs.uk

Merton CCG
Tel 020 3668 1221
www. mertonccg.nhs.uk

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

Local councils
Barnet
Tel 020 8359 2000
www.barnet.gov.uk

Harrow
Tel: 020 8863 5611
www.harrow.gov.uk

Hammersmith and Fulham
Tel 020 8748 3020
www.lbhf.gov.uk

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

Merton
Tel: 020 8274 4901
www.merton.gov.uk

Westminster
Tel 020 7641 6000
www.westminster.gov.uk

Healthcare organisations

Care Quality Commission
Tel 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.

National reporting and learning system (NRLS)
The NRLS receives confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.

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.

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.

10. APPENDICES

APPENDIX 1 – COMPLAINTS ANNUAL REPORT

(This will be attached to final Quality Account).

Quality Account 2015- 2016

DRAFT

Please note.

The content and illustrations used in this report may change in the final version.

world class expertise local care

Quality account 2015- 2016

Part One: Delivering on quality

Statement on Quality from the Chief Executive

Quality achievements made during 2015-16

Part Two: Priorities for improvement and Statement of assurance from the board

2015/16 quality improvement priorities

Priorities for improvement 2016/17

Statements of assurance from the board

Review of the core indicators

Part Three: Review of quality performance

Overview of the quality of care in 2015/16

Performance against key national indicators

Our improvement plans

Annexes

Annex 1: Statements from Commissioners, local Healthwatch organisations and Overview and Scrutiny Committee

Annex 2: Statement of Directors' responsibilities in respect of the Quality Report

Annex 3: Limited assurance Statement from External Auditors

Appendices

Appendix A Our Quality Strategy

Appendix B Actions undertaken as the result of a national audit

Appendix C Actions undertaken as the result of a local audit

Appendix D Glossary of Terms and Abbreviations

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Part One: Delivering on quality

Statement on quality from the chief executive

As one of the UK's first hospital offering treatment free at the point of need, the Royal Free London NHS Foundation Trust is committed to providing exceptional patient care, leading-edge research, excellence in teaching and a positive patient experience. Since our foundation in 1828, we have made significant contributions to the development of new and better therapies, to advances in medical procedures and to medical education. We are justifiably proud of our heritage, but we are also committed to the relentless improvement of our services.

It is therefore my great pleasure to once again introduce our annual Quality Report. The aim of this is to assure our local population, our patients and our commissioners that we provide high-quality clinical care to our patients. It also shows where we could perform better and what we are doing to improve.

Each year we set a number of high-level quality objectives for the upcoming 12 months. Part three of this report provides details of how we performed against last year's objectives. Personally I have been extremely impressed by the work of our Patient Safety Programme, whose work underpinned some of those objectives. One of the highlights of the year was a visit to the trust by Dr Don Berwick, founder of the Institute of Health Improvement (IHI), during which we presented some of the improvements achieved by this programme. Over the years the IHI has made a huge contribution to patient safety, initially in the USA but now internationally. Don met with members of our patient safety team and staff of ward 10N who presented their work on diabetes improvement. It was obvious that Don was extremely impressed by their work and that our staff were thrilled, and proud, to be able to showcase their improvements.

I am always aware that in addition to our overall quality objectives, a great deal of other improvement work goes on within the trust. This year, as part of the preparation for this report, I asked each of our four clinical divisions to highlight the quality achievements they are most proud of. Those achievements are listed immediately following this introductory statement together with some examples of the comments patients have made about using our services.

The last year has been our second year as an enlarged organisation following the acquisition of Barnet and Chase Farm Hospitals NHS Trust in July 2014. We have continued to make improvements across all our hospital sites, but I would particularly like to highlight the rebuilding of Chase Farm Hospital. Previously, I reported that we were busy developing plans for the new hospital. This year I am pleased to report that the funding for the new hospital has been fully approved, planning consent granted, and work is well underway on the foundations of the new hospital. Once completed in 2018, this will provide a state-of-the art healthcare facility which will deliver clinical services of the highest quality.

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In December 2015 our board approved a new quality strategy. The aim of this is to introduce large numbers of staff to methods of continuous improvement - in other words provide them with the skills they need to make things better. Components of this project are included in our objectives for the upcoming year, described in part two, and I will be particularly excited to see these come to fruition.

Finally, I should note that the trust underwent a major inspection by the Care Quality Commission at the beginning of February this year. This was part of the CQCs revised inspection programme introduced three years ago, and is the first time the trust has been inspected using this new methodology. Although we have not yet received the outcome of the inspection, including our ratings, I was so very proud of the welcome our staff gave to the inspection team. It was uplifting to witness just how many were keen to show the CQC what they do – in fact there was a real sense of disappointment in areas which the CQC were unable to visit. As chief executive, I could not have asked for a better response to the inspection and I am profoundly grateful to all our staff for this.

I hope you enjoy reading the rest of the report which I believe demonstrates our continuing commitment to providing high quality care.

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

David Sloman
Chief Executive

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Quality achievements made during 2015-16

This section of the report outlines some of the quality achievements that we have made during 2015-16 and a list of positive comments that we have received from our patients.

We have remained committed to provide patients with world class expertise and local care. Underpinned by our five governing objectives- Our four clinical divisions have made several key achievements of which we are proud and which supports our commitment to provide quality services to improve the experience and outcomes for our patients.

Our four clinical divisions are:

Name of division	Examples of services covered within each division
Surgery and Associated Services (SAS)	• Trauma and orthopaedics, ophthalmology, general, emergency and specialised surgery, pain management, therapy services, audiology, orthodontics.
Transplant and Specialist Services (TaSS)	• Nephrology, urology, diabetes and endocrine, haematology, oncology, liver transplant, hepatology, infection and immunity, gastronenerology, pathology, outpatient services.
Urgent Care (UC)	• Cardiology, pharmacy, acute respiratory, neurology and stroke, critical care, emergency department, North London Breast Screening Services (NLBSS).
Women's, Children's and Imaging (WCI)	• Children's services which includes paediatrics and neonatology, women services, imaging

Examples from our Surgery and Associated Services (SAS) division

Improvements made within our plastic surgery service

Our plastic trauma service is one of the specialized trauma centres in London. The service recognised that improvements could be made through the patients' pathway to reduce time from referral/injury to treatment and the length of stay for our patients.

what did we do?

- Appointed a locum to see patients who had been waiting a long time to been seen.
- Reallocated the threatre list if a consultant was away on leave.
- Appointed a trauma co-ordinator to manage the flow of patients through the plastics trauma clinic
- Moved the service to a dedicated ward (5NA) which has input from specialised medical and nursing teams to treat our patients.
- Our consultants currently work a six day routinue pattern with two elective operating lists on Saturdays.

what were the outcomes?

- Patients are waiting less time for their treatment.
- There is a dedicated registrar on the ward every day of the week and the nursing staff are specially trained to care for our patients.
- Our patients have a wider choice for their surgery dates , which also improves our 18 weeks target

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Improving our pain services

The pain team is a part of the Surgery and Associated Services (SAS) division and during 2015/16. The service has made significant improvements in the management of pain for our patients. This supports our aim to deliver better experiences and outcomes for our patients.

- Reviewed the triage and referral system for pain management physiotherapy, streamlining the process.
-
- Introduction of group work in pain physiotherapy and set up a physio led short intensity pain management programme
-
- Ran a 8 week programme and several workshops for staff on 'mindfulness' (stress reduction)

- Achieved a reduction in waiting times for pain management physiotherapy from 6 months to 4 weeks.
-
- A reduction in waiting list also released additional time for our physiotherapist to undertake more one-to-one sessions.
-
- Improved outcomes for some complex patients as a result of the peer support gained from being treated in a group setting.
- Introduced a greater variety of treatment options for pain management physiotherapy
-
- Supported staff, helping them to be able to deal with stress in their work and home lives.

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Examples from our Transplant and Specialist Services (TaSS) division

A new endoscopy unit

We built a new £2 million endoscopy unit which opened in December 2015 at Chase Farm Hospital. Our patients are offered a choice to use either our services at the Royal Free or Chase Farm hospitals. Our Barnet hospital site will continue to provide in-patient and emergency endoscopy services only.

what did we do?

- We built a dedicated building which has greater capacity than the previous unit
- The unit is the first in the country to use a tracking system.
- Provided twice as many treatment rooms as well as private recovery rooms each with en-suite facilities.

what were the outcomes?

- Provided an improved service to patients at Chase Farm Hospital
- Staff are able to monitor patients more closely with the tracking system
- shorter waiting times for our patients
- Increased privacy and dignity for our patients.

I am delighted that we have opened this new unit, which means we can offer a better service to our patients. We have more capacity, which means waiting times will be cut and we will also offer patients private recovery rooms. The new unit will have all the latest equipment and technology and will be more spacious and pleasant environment for our patients and staff.

Doug Thorburn, clinical director

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Examples from our Urgent Care (UC) division

Improving our dementia services

In 2015, we successfully appointment a dementia lead and have undertaken various initiatives to support dementia care across the trust. This has included the launch of our dementia strategy and our staff-led project on Larch ward at our Barnet hospital site.

what did we do?

- We transformed Larch Ward into a dementia friendly ward, helping to give patients a sense of place and creating a ward environment that is easier to navigate.
- The £330K project was inspired by an initial charitable donation from the Mayor of Barnet, who selected Barnet Hospital dementia care as one of his chosen charities.

what has improved for Larch ward?

- Each bed bay has its own theme to ensure patients have a sense of place within the bay and ensure they are able to easily locate their bay.
- The ward has enhanced lighting and signage, clearly visible calendars and clocks and positioned grab rails.
- New wood flooring enables patients to navigate around the ward with more independence.

"These changes will make a real difference to patients on Larch ward. Not all of our patients have dementia, but many of them do. We are making changes that research has shown will help patients feel less agitated, which will help their recovery and means they can return sooner."

Kate Hennessey, ward sister

Examples from our Women's, Children's and Imaging (WCI) division

Innovative approach to lung biopsy for early detection of lung cancer

The trust won an award from the NHS Innovation Challenge Prize for Cancer Care. The initiative aimed to improve patient experience and outcomes by eliminating delays in lung cancer diagnosis, whilst reducing time spent in hospital, and costing 90% less.

what did we do?

- Recognised that radiology-led management of lung biopsy could offer a solution, without the need for hospital beds.
- Created an innovative lung biopsy service in 2011 to reduce delay in diagnosis for our patients

what were the outcomes?

- Lung biopsies are performed using an early discharge protocol, without pre-emptively booking hospital beds.
- It has also enabled us to perform lung biopsies in patients declined elsewhere.
- The cost of an uncomplicated biopsy is significantly lower as the patient simply goes home after 30-60 minutes.

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Improving the safety culture on our children's ward

The quality improvement project was led by Dr. Jane Runnacles and our multidisciplinary SAFE team. The project was built on the background that children in the United Kingdom experience higher morbidity and mortality than those in comparable health systems.

Twice daily multidisciplinary ward safety huddles

what did we do?

- We implemented the Cincinatti children's "huddle" technique, a ten minute open exchange of information between all staff, to encourage information sharing and equip professionals with the skills to identify children at risk of deterioration.
- Using the model for improvement we designed and tested a safety huddle proforma to be completed by the nurse in charge during the huddle. In October 2014 we tested morning huddles and adapted the process before implementing evening huddles 6 weeks later.
- Since October 2014, morning ward safety huddles occur 100% of the time, and since January 2015, evening huddles also occur 100% of the time.

what did we do?

- We designed a "MONTY the penguin" acronym (inspired by a Christmas TV advert) to motivate the staff with credit card size reminders of our criteria.
- Our nurse champion re-designed our patient board for the ward with "watchers" highlighted.
- Monthly safety crosses are completed and entered onto the Institute for Health Improvement (IHI) extranet to produce run charts of cardiorespiratory arrests, transfers to High Dependency and transfers to Intensive Care

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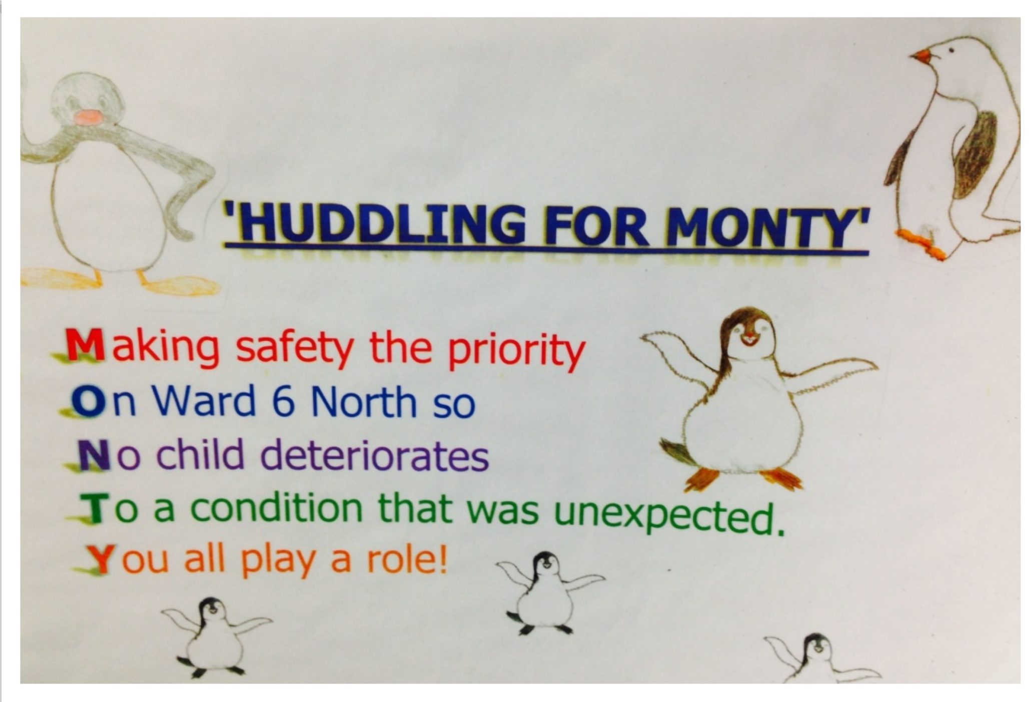
what were the outcomes?

- A survey of staff showed 100% found the huddle process useful, comments: ‘improved knowledge of patients on the ward’, ‘real sense of support’, ‘pre-empt problems’, ‘highlighting patients at risk’. Qualitative case studies have demonstrated the impact of our huddles (e.g. highlighting a safeguarding concern the medical team were not aware of).
-
- We review all cases of deterioration monthly using the Rapid Evaluation of cardiorespiratory arrests with Lessons for Learning (RECALL) tool and cross- reference to our safety huddle records.

what were the outcomes?

- The ward safety huddles have improved situational awareness and empowered all staff, however junior, to raise concerns.
-
- Having the sfety huddles has also improved team working with the opportunity to learn about each other, consistent with published findings that huddles lead to empowerment and sense of community, creating a culture of collaboration and enhanced capacity for eliminating harm.

‘MONTY’. Our Team metaphor



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Other measures that we have taken on 6N (our paediatric ward) includes the following:

what did we do?

- Quality Improvement (QI) champions to improve PEWs (Paediatric Early Warning Score) chart compliance

what were the outcomes?

- 6N ward has used PEWs charts since 2010 to help recognize the deteriorating child and escalate concerns
- A junior charge nurse on the ward has been a PEWs "champion" since January 2015, reviewing 20 charts/month as part of the SAFE project
- PEWs chart compliance has increased from 70% to 100% by engaging all nurses on the ward and training student nurses

what did we do?

- Since May 2015 bedside whiteboards have been introduced to improve communication with parents

what were the outcomes?

- A daily plan is agreed with patients and/or parents and listed on the whiteboard during the morning ward round (for example times of medication/tests and parent's schedules)
- The play specialists have engaged patients in the design of these boards and are champions for the daily plan boards on the ward

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what did we do?

- Engaging parents in ward safety culture, through leaflets and noticeboard specially designed for our parents.

what were the outcomes?

- Collaborative project with play specialists and patients to design a safety noticeboard for parents
- Information about the SAFE programme including data are displayed
- A "safety checklist" leaflet has been co-designed by a junior doctor with parents to educate them on recognising deterioration and empowering them to speak up if they are concerned

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what did we do?

- Learning from deterioration and disseminating to the team

what were the outcomes?

- Multidisciplinary notes of all patients who have required high dependency care or transfer to intensive care are analysed on a monthly basis using the RECALL tool.
- A junior doctor champion spreads learning via a new quarterly risk newsletter to all paediatric staff.

Innovation to reduce the risk of 3rd and 4th degree tears – OASIS

Background:

Between 2000 and 2012 there has been a threefold increase from 1.8% to 5.9% in the incidence in Obstetric Anal Sphincter Injuries (OASIS) in England and associated morbidity. This has led to an increased focus on possible preventative strategies.

Therefore, our project aimed to explore how we could achieve a slow delivery of the baby's head and shoulders through effective support, communication and perineal protection and therefore reduce the risk of 3rd and 4th degree tears.

what did we do?

- A multidisciplinary group comprising senior midwives, obstetricians, educationalists was convened to review current evidence, local practices and to formulate a strategy to address any issues identified.
-
- The rates are monitored monthly on the Barnet Hospital and Royal Free Hospital sites via the North Central London Maternity Dashboard.

what did we find?

- Antenatal perineal massage was not being routinely promoted
- Interventions that have significantly been shown to be associated with a reduced rate of OASIS including antenatal perineal massage, use of warm compress, hands on technique, slow delivery of the baby head, and correct technique of performing an episiotomy.
- Lack of consistency between midwives and doctors as to what they understood and practiced in relation to both "Hand's on" and "Hand's off".
- Midwives and doctors were poor in determining the correct angle for episiotomy.
- With exception of those birthing in our birth centres active pushing was been encouraged during the delivery of the head and shoulders.

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Innovations

Education	Mandatory workshop for all Midwives and Obstetricians
Practice changes	Antenatal perianal massage
	Use of warm compress in second stage
	Controlled delivery of the head and shoulders
	Introduction of epi-*scissors to facilitate accurate mediolateral episiotomy*
Supervision	Obstetricians Consultant supervision of Instrumental delivery between 08.00-23.00.
	Band 7 Supervision of Normal births against set audit tool
Audit	Instrumental delivery
	On-going OASIS
Information to women/training	Information for women on antenatal perineal massage and warm compress

Mandatory Workshops

A key component of the programme was staff education and all staff were mandated to attend a 3-4 hour workshop led by senior midwives and obstetrician's with respect to current trends in OASIS and preventative strategies.

Aim	**To promote evidence practice with respect to the delivery of the baby in an attempt to minimise the risk of severe perineal trauma**
Objectives	To share local and nation trends and practices. To review current evidence in relation to reducing risk of OASIS ○ Place of birth ○ Antenatal perineal massage ○ Perineal support (Hands on-Hands off) ○ Warm compresses ○ Position ○ Communication ○ Directed versus non-directed pushing ○ The use of episiotomy To provide a forum to undertake "practical hands on" support with a training model. To present future management at RFH in light of the current evidence and trends. To provide training and guidance for all staff on the use of Episcissors.

Results

To date approximately 90% of staff across the organisation have attended the mandatory programme. Feedback on the training has been extremely positive with staff proactively embracing and welcoming any practice changes that might help reduce OASIS rates. The rates of third and fourth degree tears among primiparous and multiparous women as reported on the dashboard and there have been significant improvements in the rates. This is monitored as part of our Maternity action plan.

Positive comments from our patients

During 2015/16 we received positive feedback from our patients which supports our values. Through our values we aim to ensure that we are welcoming, respectful, reassuring and communicative. Our values were chosen by our patients and staff and underpin all we do. The comments have been themed according to our values and were taken from our friends and family test and national inpatient survey.

positively welcoming | actively respectful | clearly communicating | visibly reassuring

Positively welcoming

- The nurses involved were very nice, caring and supportive, making me feel comfortable.
- The medical care from the doctors was exceptional.
- I'm happy. The doctors and staff are good to me. I'm happy with them. They look after me well, thank you very much.
- From the time I went in for my operation until I went home they were very caring and they also looked after my husband while he was waiting for me. The nursing staff was great!
- Had an accident and received very swift treatment, with the operation taking place the following day.
- I was much impressed by the high level of care I received from both them medical and domestic staff on my ward, it turned a stressful experience into a relaxed time.
- I was extremely well cared for by doctors and consultants. These services were world class and excellent.
- The care I received was the best. That includes nurses and doctors they were all wonderfully caring.

Actively respectful

- Nothing was ever too much trouble for the nurses. Didn't matter what time of the day or night you needed them, they were always there for you.
- Pleasant and helpful staff seemed to be very busy and in demand, but they appeared to cope well.
- Greatly impressed by the thorough and prompt attention.
- Nurses were very good, emotional support was given and they paid great attention to me. Doctors were reliable and trustworthy.
- I watched three nurses come to help a fellow patient who knocked the water jug over in the middle of the night. They didn't shout, just politely told her that they were there to help and told her not to worry when she got distressed.
- There was one nurse that was really nice and made all us patients laugh. Laughter is definitely good for the soul.

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Clearly communicating

- The staff and doctors were excellent. They answered all my questions.
- Everyone was very kind, even cleaners found time to say a few words and always had a smile.
- The surgeon was friendly and made me comfortable. All staff were polite, approachable and provided a good service of care.
- All staff: medical, nursing, catering and cleaning were polite, helpful and friendly. Most always had a smile on their face and asked "how I was".
- The kindness and understanding of the nursing staff was exceptional. They work such long hours with such responsibility – all praise and thanks to them.
- Nurses could answer the bell quicker, but this isn't a criticism – I know they are busy.

Visibly reassuring

- I'd had this type of operation before, so I knew what to expect, but was still kept informed about all aspects throughout my stay in hospital.
- The consultants took more care this time and communication with consultant in charge of care was fantastic.
- All information was fully explained and I was well looked after
- My surgery was fully explained to me by the surgeon, who was reassuring, kind and efficient. Equally, the anaesthetist introduced himself and after that I was totally unaware of anything and woke up on the ward.
- I attended a 'joint clinic; a few weeks before my surgery where I received information on exactly what would happen. There was plenty of time to ask questions too so I felt well prepared.
- I do not feel that I could have received better treatment anywhere else. From the consultant, to the nurses on the ward, everyone was very knowledgeable and knew exactly what to do to get me home as quickly as possible.
- During my stay I was treated both personally and medically with a very high degree of excellence.
- I am lucky to have such an amazing surgeon that I can put all of my faith into. I choose to have treatment at this particular hospital and am so glad I made this choice.
- The care, dedication and professionalism of the staff at every level cannot be praised too highly.

Comments taken from our friends and family test and national inpatient survey.

Part Two: Priorities for improvement and statements of assurance from the board

In this section of the quality report, we present a review of our performance and progress made during 2015/16 against the key areas that were identified for improvement in 2014/15 and how we have monitored and reported on the progress made.

We also provide data relating to our performance on specifically defined measures as presented within the section titled '*statements of assurance from the board*'.

2015/16 quality improvement priorities

In 2014/15, following consultation with our key stakeholders we agreed to focus on three key priorities for 2015/16. Progress was monitored and reported at our board level committees for patient safety, patient experience and clinical effectiveness.

Quality domain	Relevant committee	Chosen priorities for 2015/16
Patient experience	Patient and Staff Experience Committee (PSEC)	Priority one: Delivering world-class experience
Clinical effectiveness	Clinical Performance Committee (CPC)	Priority two: Improving in-patient diabetes
Patient safety	Patient Safety Committee (PSC)	Priority three: Improving our focus for safety

Table 1. Quality domains, associated committees and chosen priorities.

Priority one: Delivering world class experience

Our overall aim is to provide an excellent experience for our patients, which is intrinsically linked with our culture, the way we engage our patients, carers and staff and the improvements we prioritise. In autumn 2015, we published our four year patient experience strategy which focused on making improvements for those who use our services, their carers and families.

Specific areas identified were:

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.

What was our aim during 2015/16?	What did we achieve in 2015/16?
To appoint four patient experience champions from amongst our consultant surgeons and physicians.	We submitted a report to the Medical Director regarding the implementation of 'Patient Experience Champions from amongst consultant surgeons and physicians, and we are in the process of identifying champions.
To ensure that 100% of inpatient and day care wards respond to their patient experience data with publically displayed responses from staff	Each ward and department display 'you said, we did' responses to patient experience feedback which are updated each quarter.
To provide each inpatient and day care ward with improvement targets mapped to feedback from patients and carers	Each ward and department has a target for response rate and recommendation rate.
To develop and publish a list of patient experience never events (things that should never happen)	Discussions were held with staff and patients regarding 'never events' and 'always events' (This would differentiate from the safety never events and allow greater integration with our world class care values). We will continue to develop and publish the list during 2016/17 and this work will be done in partnership with NHS England
To train staff in advanced facilitation and feedback interpretation for patient and carer focus groups	This training is currently being evaluated
To achieve the Macmillan Quality Environment Mark ® across all our hospital sites.	We successfully appointed a patient information manager to support the information standard certification assessment
To establish a patient reference group for those with a cancer diagnosis; ensuring that service improvements are important to them and informed by their input.	A variety of support and reference groups were held in 2015/16 (These included renal cancer and prostate cancer groups); These provided a forum for patient support between service users and health care professionals as well as feedback for service improvement.
To produce and implement a specifically designed carers' point of information display at each hospital site.	Discussions were held with carer organisations and carers regarding the type of information that would be useful if displayed within each hospital. A carers card is being developed, this will help identify carers and will be coupled with training for staff. We will continue to develop this further during 2016/17

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During 2015/16 we also chose to focus on other key areas to support our aim to provide an excellent experience for our patients. These included:

Additional areas of focus:	What did we achieve?
Consulting with carers on whether and how they would wish to receive training on safeguarding adults.	Discussions were held with carer organisations and carers regarding what learning materials would be useful to support their awareness on safeguarding, deprivation of liberty and mental capacity.
Ensuring that 20% of our inpatient wards will have undertaken the Triangle of Care self-assessment.	We are designing a new protocol carers and people with dementia which includes access to professionals and appropriate information.
Producing a care and compassion film for staff as a training aide filmed from the perspective of a carer.	The film has been produced and is now being used in training for multidisciplinary staff groups.
Increasing the number of dementia awareness trainers.	We have introduced a new clinical teaching programme that equips frontline members of staff in role modelling and dementia clinical skills. The teaching programme is a move away from traditional classroom teaching towards training delivered in the relevant clinical areas.
In partnership with the Picker Institute develop and conduct surveys for carers of people with dementia.	The Picker Institute facilitated focus groups with carers to be enabled to design a survey to be delivered in May 2016.
Undertaking the eligibility and readiness assessment for the Information Standard Certification and set a timeframe for achieving certification	We successfully appointed a patient information manager to support the information standard certification assessment

What are our next steps?

- We will continue our work to deliver world class experience for our patients and have agreed priorities for improvement for 2016/7 which are outlined in the relevant section of this report.

Other measures undertaken to support dementia care.

Over 25% of all acute hospital beds across the NHS are occupied by a person living with dementia. These patients face unique and specific challenges when admitted into hospital, with statistics showing that they are more likely to stay in hospital longer, fall, die, develop delirium and frequently require residential care placements as a consequence of these factors.

Given the gravity and the complexity of the problem, any meaningful strategy required the following components; a comprehensive approach to reviewing and improving care structures, time-limited, achievable goals / milestones and a proactive group of professionals forming the Dementia Implementation Group who commit to work outside of the group to achieve goals with the support of the executive team.

This year a new 12 month strategy for dementia care was launched by the Dementia Implementation Group in December 2015. The new strategy comprises of 3 workstreams each focussed on one of the main stakeholders in world class dementia care; the patients and their carers, the staff and the organisation.

Among the achievements thus far:

Patients and carers

- We have launched John's campaign (the rights for carers of people with dementia to be welcomed onto wards outside of ward visiting hours) across our care of the elderly wards at Royal Free and Barnet sites.

- The development of a carer passport that entitles carers of people with dementia to staff reduction in the canteen, reduced parking costs, free massages and companionship by our dementia volunteers.

- We held the first of 3 "Living with dementia" events which took place at Royal Free Hospital in February. The event was designed as a drop in evening for carers with talks from the Chief Executive David Sloman, nurses and the dementia lead. Colleagues from various community groups including Alzheimer's Society, Age UK, Camden and Barnet Carers and advocacy services as well as hospital staff ran advice stalls and provided information to those in attendance. Further events are planned next year.

- We are building ever closer links with community dementia advisers in Camden and Barnet to establish a more integrated support system for carers to aid the transition from hospital to home and vice versa.

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Future actions;

- Development of a carer protocol for those caring for people with dementia in view of the specific challenges these carers face including information packs for carers
- Extending John's campaign to Chase Farm and additional wards outside of care of the elderly wards
- Designing and launching a "Carers Welcome" campaign across the trust to raise awareness of how valuable carers can be to us as an organisation, increasing empathy and improving the care delivered to carers when they visit

Staff

- Subsequent to the successful Dementia Discharge OT pilot (SHINE) and the permanent establishment of that service by the Trust, the Health Foundation awarded a grant to the project lead Danielle Wilde to disseminate and embed key learning points form the project
- Having reflected on the clinical experiences and analysing the data associated with the 18 month pilot, Danielle designed a protocol for replicating world class dementia care, "the CAPER toolkit", which stands for collateral, assessment, partnership, enablement and risk-positivity
- Owing to a surfeit of "Champion" schemes across the health sector, we decided upon the name "Anchor", the idea being that if there are enough "anchors" trained to allow one per shift, they will be the consistently high-quality dementia care on the ward
- The Anchor scheme identifies key frontline staff groups, many of whom have high levels of patient contact and low levels of training opportunity (domestics, nursing assistants and ward clerks) and provides them with a bespoke 6 week programme of training around dementia. This training is a departure from traditional classroom training in that it is delivered in clinical areas and focusses on the use of practical tools and strategies.
- In one example, a domestic assistant on one of our wards was able to correctly spot that a patient had developed delirium – something that the medics and nursing team had not picked up on.
- A key component of the Anchor training is the development of role-modelling skills. This organic method of spreading good practice has been found to be a more effective and sustainable way of affecting cultural change within clinical environments compared to classroom teaching and fosters a sense of achievement, pride and expertise in the Anchors, many of whom have never received any specialist training.
- We run a programme of drop-in teaching sessions across our wards in which our dementia lead runs a 15 minute teaching session 4 or 5 times over the course of an afternoon. This approach allows ward staff to cover each other for 15 minutes and therein have access to learning that rotas and staffing levels can sometimes make difficult
- The process and practice of "specialling" patients is being completely redesigned by a working party led one of our deputy directors of nursing. This piece of work seeks

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- to improve the experience of complex patients by driving up quality and redesigning the process to avoid unnecessary interventions
- A group of staff visited De Hogeweyk in Amsterdam which is the world's first dementia village. This trip was organised by the team at Chase Farm hospital looking for inspiration for their dementia garden. The team were struck by the success and relative inexpense of a "social approach" to care and now thinking how we can adapt this model to the hospital environment
- Training of our staff continues

Dementia training figures (tier 1 and 2) January 1st 2015 - April 1st 2016 – **842 people**

Future actions

- We will extend the Anchor training scheme across all our sites with 60 Anchors due to be trained at a special one off event at Chase Farm hospital in April
- Various Dementia awareness events organised across sites to celebrate Dementia Awareness Week 15 – 17 May

Organisational

- We are now able to flag that a patient has dementia on our electronic patient administration system and this is currently being piloted at front of house (TREAT, HOT clinics) and on two care of the elderly wards. As well as making sure that staff know a patient has dementia it will also allow us to collect more accurate and robust data
- A review of coding has been undertaken and the many-hundred-long coding list has now been distilled into a favourites list of 20 – alongside a doctor led review of codes disseminated to junior doctors which should also help improve the quality of our data
- The Forget-me-not scheme (a scheme in which staff are alerted to the specific needs of a person with dementia by the depiction of a forget me not by their name on the ward board) now fully operational across all elderly care wards and extensively throughout Barnet hospital and Chase Farm hospital
- We have designed an electronic system to translate the dementia flag from Cerner into a forget-me-not on the nursing handover sheets which will allow nurses to identify people with dementia on their wards and meet their needs better

Further actions

- Design and launch of a delirium pathway for use across all sites
- This work will involve a delirium awareness-raising campaign, a new protocol for the prevention, detection and treatment of delirium and a new MDT care bundle for those presenting with a suspected delirium

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Priority Two: Improving in-patient diabetes

Most patients with diabetes in our hospitals are admitted for reasons other than their diabetes. However, we made a commitment that every in- patient with diabetes should have a good *experience* of *safe*, *effective* diabetes care.

In 2014/15 we chose to continue with our diabetes improvement programme. We expanded the programme to include further elements of diabetes care and extended it to our three hospital sites.

What was our aim during 2015/16?	What did we achieve?
Reduce prescription errors by 20%	We were concerned that the incidence of prescription errors at our Royal Free site was high relative to other English hospitals. Compared to 2013, we have reduced prescription errors at the Royal Free Hospital site by 28%, and therefore achieved our aim. Compared nationally, our performance at the Royal Free site no longer lies in the lowest quartile. Barnet Hospital has fewer prescription errors than average.
Reduce severe hypoglycaemia episodes by 20%	We were concerned that the incidence of severe hypoglycaemia events at our Royal Free site was high relative to other English hospitals. Compared to 2013, we have reduced the incidence of severe hypoglycaemia events at the Royal Free Hospital site by 55.2%, and have therefore achieved our aim. This improvement means that the Royal Free Hospital was in the group of best-performing hospitals in the recent audit. The incidence of severe hypoglycaemia events at Barnet Hospital was 20%.

Prescription errors (Eng 22.0%)	2015	2013	Change
Royal Free Hospital	24.3%	33.8%	-28.1%
Barnet Hospital	15.6%		

Severe hypoglycaemia events (Eng 9.9%)	2015	2013	Change
Royal Free Hospital	6.5%	14.5%	-55.2%
Barnet Hospital	20%		

<table>
<tr>
<td>Achieving 30% foot assessments within 24hrs of admission</td>
<td>We were concerned that we did not perform timely foot assessments at our Royal Free site as well as other English hospitals. We aimed to improve to match the national average (2013).

We currently undertake foot assessments in 40% of in-patients with diabetes within 24 hours of admission to our Royal Free site. At our Barnet site, our performance on the same measure is 23%. Both sites perform above average for English hospitals.

<table>
<tr><th>Foot assessment on admission (Eng 28.7%)</th><th>2015</th><th>2013</th><th>Change</th></tr>
<tr><td>Royal Free Hospital</td><td>40%</td><td>6.5%</td><td>+515%</td></tr>
<tr><td>Barnet Hospital</td><td>23.1%</td><td></td><td></td></tr>
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<tr>
<td>Reduce hospital-acquired foot ulcers by 10%</td>
<td>Information to follow</td>
</tr>
<tr>
<td>Improve patient satisfaction scores by 10%</td>
<td>We were concerned that patient satisfaction at our Royal Free site falls below that of other English hospitals.

We are disappointed that the work we have done to improve diabetes care has not led to an improvement in reported patient satisfaction at the Royal Free site.

Satisfaction with our service at Barnet has improved by 17% compared to 2012.

We will undertake further work to understand the causes in order to inform further efforts (eg ability to take control of diabetes, meals and mealtimes, staff knowledge of diabetes). We will learn from the improvements made at Barnet.

<table>
<tr><th>Patient satisfaction (Eng 84.3%)</th><th>2015</th><th>2013</th><th>Change</th></tr>
<tr><td>Royal Free Hospital</td><td>73.1%</td><td>76.2%</td><td>-4%</td></tr>
<tr><td>Barnet Hospital</td><td>83.2%</td><td></td><td></td></tr>
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</td>
</tr>
<tr>
<td>To participate in the National Diabetes Inpatient Audit on all eligible sites</td>
<td>The trust successfully participated in a snap shot audit on the 21 – 25 September 2015. Collectively 154 cases were submitted from Barnet and Royal Free hospital sites to the National Diabetes Inpatient Audit. (Chase Farm hospital site did not participate in the audit as they did not meet the specified criteria for participation).</td>
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Improving Diabetes: A quality improvement project

As part of our patient safety programme (PSP), diabetes care is a key work stream and high priority for the Royal Free London. The 10 West diabetes improvement pilot began a year ago, following a serious incident on the ward.

Using a collaborative approach with improvement methodology, staff was empowered to help make changes to their clinical area. Recommendations were then made to address issues from the serious incident including improved recognition and escalation treatment of hyperglycaemia (high blood sugars levels).

We have developed a hyperglycaemia management pathway which was tested using improvement science methodology plan, do, study, act (PDSA), and small tests of change on the ward. As part of the pathway, clearer guidance around increasing diabetes medications, including insulin, was created. A separate pathway focusing on recognition and treatment of low blood sugars (hypoglycaemia) was tested in a similar format. Other key improvements from the pilot include:

- testing of a hypoglycaemia box
- new dosing guidance for increasing diabetes medication
- new insulin table guidance
- new colour coded blood sugar charts
- a new diabetes in-patient booklet
- new simplified alerts from glucometers to help staff recognise and escalate patients for early review.

Data so far has demonstrated that there is increasing compliance with using both pathways and patients are having more timely control with abnormal blood sugars. The next phase of work is reviewing the impact of the pathways on patient outcomes such as length of stay reduction, and also capturing patient feedback on their experience. With ward data now being collected by the diabetes nurse champions, instant feedback is being used to plan further changes.

The multi-disciplinary approach has shown earlier identification of high risk patients, better recognition, escalation and management by ward staff and improved diabetes awareness and safety on 10 West

What are our next steps?

- We will continue to work towards providing every patient with safe and effective diabetes care; however we have chosen to change this priority for improvement for 2016/17. These have been agreed and are outlined in the relevant section of this report.

Priority Three: Improving 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.

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 *(this is explained in our glossary of definitions and terminology).

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Identification of process issues to enable surgeons to attend the first and fifth step • Identification of clinical leaders in all our hospital sites • Review of solutions to staff flow and challenges • Consolidate the World Health Organisation (WHO) policy across all our hospital sites • Review and Refresh workshop to use successes and failures to identify how to move to 95% compliance in all five steps	During 2015/16, we identified that compliance to safer surgery was only measured consistently for steps 2, 3 and 4 and that data for steps 1 and 5 were poor and unreliable. So in order to take this work stream forward we have developed ways to measure and improve compliance with all 5 steps, and so we have amended our timeframe to allow these developments to embed. Unfortunately, we have reported 7 never events during 2015/16, 5 of which relate to surgery. Therefore, our new goal is to improve compliance with the 5 steps to safer surgery to 95% and to reduce the number of surgical never events by 31 March 2018. In September 2015, new guidance on National Safety Standards for Invasive Procedures (NatSSIPs) was published, to help trusts implement safer surgery checklists in non-surgical areas. We are therefore intending to include this within our approach as we develop our Safer Surgery improvement plan over the next 2 years.

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Falls

Our goal is to reduce falls by 25%, as measured by incidents reported on Datix (our electronic database) 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.

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Set-up trust-wide 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 trust-wide Multi-Disciplinary Team (MDT) falls study day • Initiate falls podiatry assessment pathway	We have achieved all our 2015/16 milestones. Following the publication of the 2015 National Audit Falls (England and Wales) audit, there are now data on both the rate of falls and the rate adjusted measure of harm from falls. We have used this information for comparison which shows the RFL rate of falls per 1000 bed days (8.4) compared to combined national rate for acute trusts, where the mean is 6.63/1000 bed days. We are worse than the average, so there is room for improvement. During 2015, we updated our goal to reflect the amended the Royal college of Physicians national falls measurement. Therefore, we have reset the goal to a 20% reduction of falls per 1000 bed days, as measured by incidents reported on Datix, by 31 March 2018.

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Acute Kidney Injury (AKI)

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

What was our aim during 2015/16?	What did we achieve?
We aimed to 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	During 2015/16, the initial quality improvement work with AKI has focused on setting up the learning sets with trust wide participation and engaging with an analytical provider to start to review and analyse the data needed to identify the patients.

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Patient Deterioration

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

What was our aim during 2015/16?	What did we achieve?
We aimed to 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	The measurement of the number of cardiac arrests has been an integral part of the Royal Free Hospital data submission to the National audit ICNARC; however, this data collection was only initiated at the Barnet Hospital from the first quarter of 2015/16 and is only available to the trust retrospectively once analysed by ICNARC, so only partial data are currently available for the year. The data indicates that RFH has significantly higher cardiac arrest rates than other trusts (about 2.5/1000 in comparison to 1.5/1000 nationally). The higher figure is in part due to the reporting of cardiac arrests in A&E, ICU and Theatres, which are not commonly reported as part of this audit in other trusts. However, we still have some significant work to do to decrease our rate. Therefore, the deteriorating patient work stream has been subject to a review in the last six months and its milestones have been significantly amended. A new innovative IHI Improvement Collaborative approach is now being implemented by using the IHI Break through series collaborative model.

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Unborn baby deterioration

Our goal is to reduce the number of claims relating to deterioration of the unborn baby to two claims per year, between January 2015 and March 2018.

We have introduced the "Risky Business" newsletter within our maternity department that shares lessons learnt from incidents across both hospital sites.

What was our aim during 2015/16?	What did we achieve?
We aimed to 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	Our work to identify baseline data required at ward level and create process to feedback to staff in a timely manner remains in progress
Determine CTG interpretation skills baseline by staff survey	We have also increased our K2 training for midwives, so that this is now an integral part of skills training across both sites and includes CTG interpretation skills. However, we have not yet clarified all the key drivers for change within this work stream and so this will be part of our on-going work throughout 2016.
Identify champions	We are also in the process of identifying champions to support this initiative

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Sepsis

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

What was our aim during 2015/16?	What did we achieve?
We aimed to 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	We have achieved all our 2015/16 milestones. During 2015/16, we joined the UCLP Patient Safety Sepsis Collaborative to share ideas and provide opportunities for further learning. Staff training in sepsis recognition was undertaken in maternity and the emergency department at Barnet Hospital, and the sepsis improvement tools introduced in May and August 2015 respectively. The compliance data show significant improvements.

What are our next steps?

- Our quality improvement priorities are supported by the Patient Safety Programme team. The team was fully recruited from December 2015 and it is expected that significant improvements within all the work streams will occur during 2016/17. We have agreed priorities for improvement for 2016/7 which are part of our three year plan and are outlined in the relevant section of this report

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Priorities for improvement 2016/17

In order to provide the best possible care to our patients, each year we set three quality improvement priorities for the year ahead which will be reported and monitored at our board level committees and our trust board throughout 2016/17. The priorities fall within the three quality domains, patient experience, clinical effectiveness and patient safety was drawn from our intelligence, performance and discussions.

Building on the progress that we have made during 2015/16, our priorities for improvement for 2016/17 will continue to support the values, governing objectives and our underpinning quality strategy.

Our consultation process

As part of our consultation process, external stakeholders, the council of governors, patients and staff were invited to share their views on our proposed priorities and were also given the opportunity to indicate if there were any other priorities that the trust should consider for 2016/17. (We did not include any new proposal for patient safety as we set out in our last accounts our safety priority over a three year period).

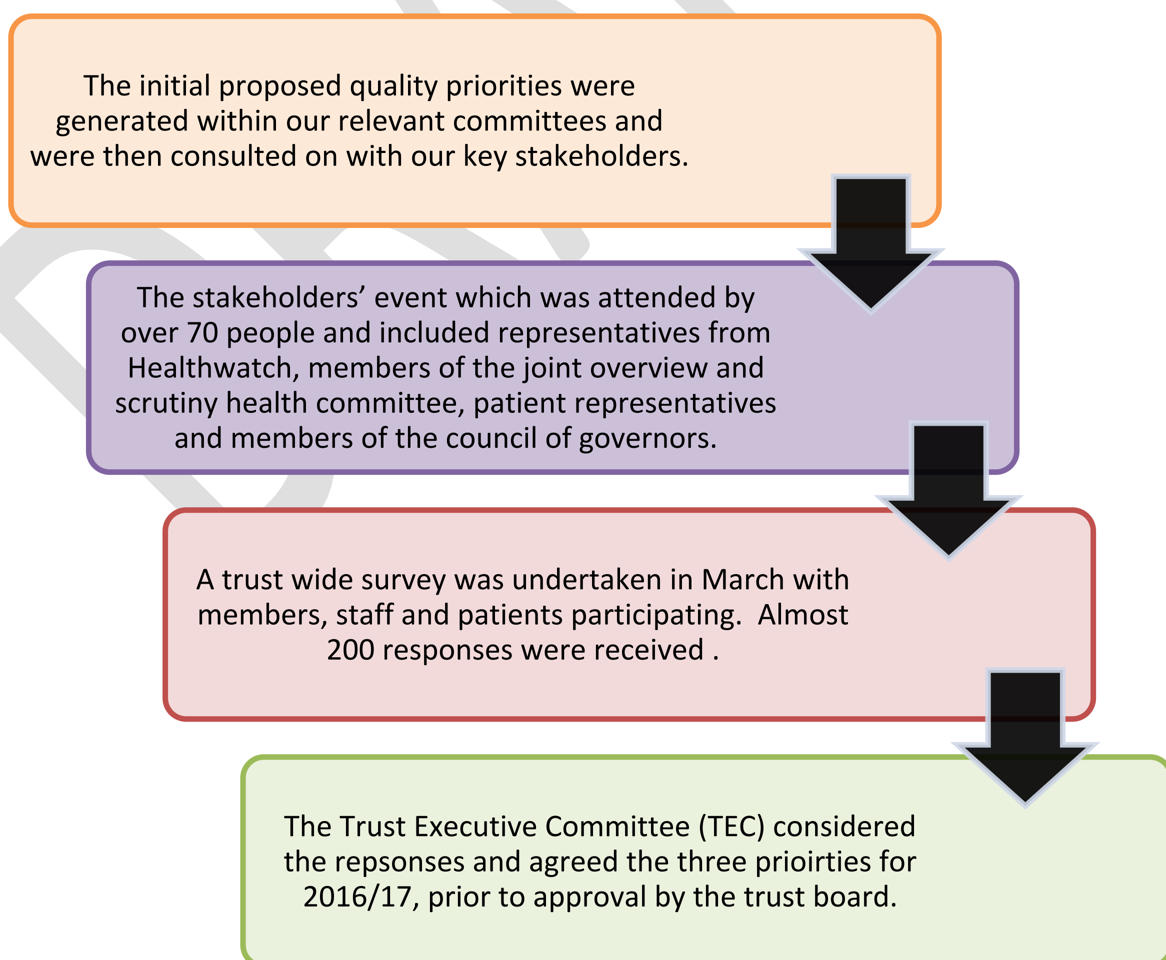

Figure1: Overview of our consultation process

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Our quality strategy

Our new quality strategy was approved by the trust board in November 2015 and spans all three domains of quality: patient experience, clinical effectiveness and patient safety. This year we are therefore including priorities spanning all three domains focused on key initial steps for implementation of the quality strategy itself (See Appendix A- Our quality strategy).

The strategy centres on equipping large numbers of staff with the capabilities they require to make continuous improvement core to their daily work, and to ensure the organisation supports them in their improvement efforts. This will ensure the trust's improvement work energises staff and has maximum impact for patients and families:

Our overarching chosen priorities for 2016/17 are:

- For the Trust board and senior leadership to work on their collective development, enabling them to provide effective leadership for improvement across the Trust.

- To develop and use a diagnostic which enables us to understand the readiness for implementing an improvement-focused approach across the Trust as a whole and for different parts of the organisation, helping us prioritise and target our work.

- To begin to build our trust-wide improvement team and faculty whose job is to support quality improvement work at the front-line across the trust.

Priority one: Patient experience priorities for improvement 2016/17

During 2016/17 we will continue to deliver on our mission and principles as outlined within our Patient Experience strategy and to support this we have agreed on a number of initiatives.

Through our Patient and Staff Experience Committee (PSEC) we will monitor and report progress.

Our chosen priorities for 2016/17 are:

- To publish an annual report; to include statement of dementia care on progress against the Trust Dementia Strategy and Fixed Dementia Care (Alzheimer's Society report) metrics.

- To allow flexible visiting times for carers of people living with dementia on 100% of inpatient wards.

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- To achieve trust certification for ‘The Information Standard’ by 2018.
- To ensure that 95% of patients (identified as end of life) have an end of life care bundle in place.

Priority two: Clinical effectiveness priorities for improvement 2016/17

Improving clinical effectiveness – outcomes for patients – is core to the Trust’s quality strategy and improvement work; as highlighted in our overarching quality priorities for 2016/17.

We have selected one additional aim in this area, on our dementia care priority:

Our chosen priority for 2016/17 is:

To further enhance and support dementia care initiatives across the trust, as previously identified in the National Audit of Dementia (NAD) 2013 and more recently in the pilot for national dementia 2015/16.

Linked with our patient experience priorities on dementia, we will work to improve our discharge co-ordination for patients with dementia and their carers.

We know from the results from the National Audit of Dementia that this is one of the areas for improvement. Therefore a priority within our quality improvement strategy will be to develop those metrics which will enable us to measure improvements in dementia care.

Priority three: Patient safety priorities for improvement 2016/17

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 and we will be delivering key milestones along the way,

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.

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Our chosen priorities for 2016/17 are:

Safer Surgery

- To improve compliance with the five steps to safer surgery to 95%.
- To reduce the number of surgical never events.

Falls prevention

- To achieve a 20% reduction of falls per 1000 bed days.

Acute Kidney Injury (AKI)

- To increase the number of patients who recover from AKI within 72
- hours of admission by 25%.

Deteriorating patient (DP)

- To reduce the number of cardiac arrests to less than 1 per 1000 admissions
- To reduce the number of incidents of deterioration relating to unborn babies

Sepsis

- To reduce severe sepsis-related serious incidents by 50% across all sites.

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Statements of assurance from the board

This section contains eight statutory statements of assurance from the board, regarding the quality of services provided by the Royal Free NHS Foundation Trust. This includes services provided across Barnet and Chase Farm hospitals.

Where relevant we have provided additional information that provides local context to the information provided in the statutory statements.

Review of Services:

Quality is monitored in each of our four clinical divisions; with regular review of safety, clinical effectiveness and patient experience. Assurance is provided from each division to our strategic quality committees.

During 2015/16, the Royal Free London NHS Foundation Trust provided; either directly or sub-contracted **(tbc)** relevant health services

The Royal Free London NHS Foundation Trust has reviewed all the data available on the quality of care in **(tbc)** of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents **(tbc)** of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2015/16

Participating in Clinical Audits and National confidential enquires

The Trust continues to participate in clinical audit programmes and steps are taken to review our processes; ensuring that we have demonstrable evidence of changes made to practice.

During 2015/16 44 national clinical audits and 2 national confidential enquiries covered relevant health services that the Royal Free London NHS Foundation Trust provides.

During 2015/16 the Royal Free London NHS Foundation Trust participated in 98% (43/44) of national clinical audits and 100% (2/2) of national confidential enquiries of the national clinical audits and national confidential enquiries that we are eligible to participate in.

The national clinical audits and national confidential enquires that the Royal Free London NHS Foundation Trust was eligible to and participated in, and for which data collection was completed during 2015/16 are listed in table 2

The national clinical audits and confidential enquires that the Royal Free London NHS Foundation Trust participated in during 2015/16 are listed in table 2

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 2015/16, are listed in table 2, 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.

Participation in national clinical audits and national confidential enquiries

Table2. Participation in national clinical audits and national confidential enquires

National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
British Thoracic Society (BTS): Adult Community Acquired Pneumonia Audit - BTS 2014/15	√	√	√ BH	n=33/30 (110%)
		x	x CFH	N/A
		√	√ RFH	n=40/30 (133%)
BTS: Emergency Use of Oxygen	√	√	√ BH	n=48
		x	x CFH	N/A
		√	√ RFH	n=46
BTS: Paediatric Asthma	√	√	√ BH	n=40/20 (200%)
		x	x CFH	N/A
		√	√ RFH	n=14/20 (70%)
Cancer: National Bowel Cancer Audit 2013/14	x	√	√ BH	n=199/208 (96%)
		x	X CFH	N/A
		√	√ RFH	n=98/90 (109%)
Cancer: National Lung Cancer Audit 2014	x	√	√ BH	n=106
		x	x CFH	N/A
		√	√ RFH	n=113
Cancer: National Oesophago-gastric Cancer Audit 2012-2014	x	√	√ BH	n=112 (71-80%)
		x	x CFH	N/A
		√	√ RFH	n=67 (81-90%)
Cancer: National Prostate Cancer Audit 2014/15	x	√	√ BH	n=91 (21%)
		√	√ CFH	
		√	√ RFH	n=19 (90%)
College of Emergency Medicine (CEM): Procedural Sedation in Adults - RCEM	√	√	√ BH	n=42
		x	x CFH	N/A
		√	√ RFH	n=46

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
CEM: VTE Risk in Lower Limb Immobilisation	√	√	√ BH	n=12
		x	x CFH	N/A
		√	√ RFH	n=45
CEM: Vital Signs in Children	√	√	√ BH	n=101
		x	x CFH	N/A
		√	√ RFH	n=42
Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary Rehabilitation	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=10
Diabetes: National Diabetes Audit (NDA) 2014/15	√	√	√ BH	n=371
		√	√ CFH	n=626
		√	√ RFH	n=1533
Diabetes: National Foot care in Diabetes Audit 2014/15	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=41
Diabetes: National Diabetes In-patient Audit (NaDIA)	√	√	√ BH	n=55
		x	x CFH	N/A
		√	√ RFH	n=103
Diabetes: National Paediatric Diabetes Audit (NPDA) 2014/15	√	√	√ BH	n=69
		√	√ CFH	n=57
		√	√ RFH	n=48
Diabetes: National Pregnancy in Diabetes 2014	x	√	√ BH	n=17
		x	x CFH	N/A
		√	√ RFH	n=20
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of In-patient Falls	√	√	√ BH	n=32/30 (107%)
		x	x CFH	N/A
		√	√ RFH	n=33/30 (110%)
FFFAP: Fracture Liaison Service Database - Patient audit	x	√	√ BH	N/A
		x	x CFH	N/A
		x	x RFH	N/A
FFFAP: National Hip Fracture Database 2015	√	√	√ BH	n= 370
		x	x CFH	N/A
		√	√ RFH	n= 196
Heart: National Audit of Percutaneous Coronary Interventions 2014	x	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=829
Heart: Cardiac Rhythm Management 2014/15	x	√	√ BH	n= 295
		x	x CFH	N/A
		√	√ RFH	n= 267

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
Heart: Myocardial Infarction National Audit Project (MINAP) 2014/15	x	√	√ BH	n=254
		x	x CFH	N/A
		√	√ RFH	n=561
Heart: National Heart Failure Audit 2014/15	x	√	√ BH	n=402
		x	x CFH	N/A
		√	√ RFH	n=260
ICNARC: National Cardiac Arrest Audit (NCAA) 2014/15	x	√	x BH	n=0
		x	x CFH	N/A
		√	√ RFH	n= 251
ICNARC: Case Mix Programme: Adult Critical Care 2014/15	x	√	√ BH	n = 813
		x	x CFH	N/A
		√	√ RFH	n = 1104
Inflammatory Bowel Disease (IBD) Biological Therapy Audit (Adult)	√	√	√ BH	n= 47
		x	x CFH	N/A
		√	√ RFH	n=0
IBD Biological Therapy Audit (Paediatric)	√	x	x BH	N/A
		x	x CFH	N/A
		√	x RFH	n=0
National Complicated Diverticulitis Audit (CAD)	√	x	x BH	N/A
		x	x CFH	N/A
		√	RFH	n=16/15 (107%)

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
National Elective Surgery PROMs: Four Operations	x	√	√ BH	n=532 (43.6%) *(Apr-15 to Sep-15)*
		√	√ CFH	
		√	√ RFH	
National Emergency Laparotomy Audit (NELA)	√	√	√ BH	n=10 (5%)
		x	x CFH	N/A
		√	√ RFH	n=100 (83%)
National Joint Registry 2015	√	√	√ BH	n= 42
		√	√ CFH	n=573
		√	√ RFH	n=427
National Neonatal Audit Programme (NNAP) 2014	x	√	√ BH	n=1082
			x CFH	N/A
			√ RFH	n=309
National Pulmonary Hypertension Audit 2014/15	x	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=1080
NHS Blood and Transplant (NHSBT): Audit of Lower Gastrointestinal Bleeding and the Use of Blood	√	√	√ BH	n=15 (100%)
		x	√CFH	
		√	√ RFH	n=8 (100%)
NHSBT: Audit of Patient Blood Management in Scheduled Surgery	√	√	√ BH	n=23 (100%)
		√	√CFH	n=8 (100%)
		√	√ RFH	n=30 (100%)
NHSBT: Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	√	√	√ BH	n=32 (100%)
		√	√CFH	n=15 (100%)
		x	x RFH	N/A
NHSBT: UK Transplant Registry Elective: 2014/15 Superurgent: 2010/15	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=106 (100%)
Ophthalmology: Adult Cataract Surgery	x	√	√ BH	N/A
		√	√ CFH	N/A
		√	√ RFH	N/A
UK Parkinson's Audit: Neurology	√	√	√ BH	n= 33/20 (165%)
		x	x CFH	N/A
		√	√ RFH	n= 20/20 (100%)

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
UK Parkinson's Audit: Elderly Care	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n= 20/20 (100%)
UK Parkinson's Audit: Physiotherapy	√	√	√ BH	n= 20/10 (200%)
		x	x CFH	N/A
		√	√ RFH	n= 10/10 (100%)
UK Parkinson's Audit: Speech Language Therapy	√	√	√ BH	n=0
		x	x CFH	N/A
		√	√ RFH	n=0
UK Parkinson's Audit: Occupational Therapy	√	√	√ BH	n=0
		x	x CFH	N/A
		√	√ RFH	n=0
Renal Replacement Therapy (Renal Registry) 2014	x	x	x BH	N/A
			x CFH	N/A
			√ RFH	n=2239
Rheumatoid & early inflammatory arthritis	√	√	√ BH	n=33
		√	√ CFH	n=10
		√	√ RFH	n=7
Sentinel Stroke National Audit Programme (SSNAP) 2014/15	x	√	√ BH	n=167 (90+%)
		√	√ CFH	
		√	√ RFH	n=147 (90+%)
Trauma Audit Research Network (TARN) 2014/15	x	√	√ BH	n=78 (29.4%)
		x	x CFH	N/A
		√	√ RFH	n=193 (100.5%)
National Vascular Registry 2014	x	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=246

National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
Adult Asthma (BTS)	x	√	N/A	N/A
Adult Cardiac Surgery	√	x	N/A	N/A
Chronic Kidney Disease in Primary Care	√	x	N/A	N/A
Congenital Heart Disease (Paeds)	√	x	N/A	N/A
Cystic Fibrosis Registry	√	x	N/A	N/A
Head and Neck Cancer Audit (DAHNO)	x	x	N/A	N/A
Mental Health Clinical Outcome Review Programme	√	x	N/A	N/A
National Audit of Dementia	x	√	N/A	N/A
National Audit of Intermediate Care	√	x	N/A	N/A
Non-invasive Ventilation Audit - BTS	x	√	N/A	N/A
Paediatric Intensive Care (PICANet)	√	x	N/A	N/A
Paediatric Pneumonia Audit - BTS	x	√	N/A	N/A
Prescribing Observatory for Mental Health	√	x	N/A	N/A

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The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2015/16

National Audit Title
End of Life Care Audit
British Association of Urological Surgeons: Nephrectomy Audit
British Association of Urological Surgeons: Percutaneous Nephrolithotomy Audit
British Association of Urological Surgeons: Stress Urinary Incontinence
National Audit of Cardiac Rehabilitation
British Association of Endocrine and Thyroid Surgeons: Thyroid and Parathyroid Surgery
NHSBT: Kidney Transplantation Audit
NHSBT: Potential Donor Audit
Royal College of Anaesthetists: National of Perioperative Anaphylaxis

Clinical Outcome Review Programme (previously the National Confidential Enquiries, and Centre for Maternal and Child Death Enquiries):				
NCEPOD: Acute Pancreatitis	√	√	√ BH	n= 10/10 (100%) Clinical Questionnaire n=10/10 (100%) Case notes n= 3/3 (100%) Organisational Audit
		x	x CFH	
		√	√ RFH	
NCEPOD: Mental Health Acute	x	√	√ BH	N/A
		√	√ CFH	N/A
		√	√ RFH	N/A
NCEPOD - Non Invasive Ventilation	x	√	√ BH	N/A
		x	x CFH	N/A
		√	√ RFH	N/A
NCEPOD: Young People's Mental Health	x	√	√ BH	N/A
		√	√CFH	N/A
		√	√ RFH	N/A
Maternal, Newborn and Infant: Maternal Programme 2014	√	√	√ BH	n=1
		x	x CFH	N/A
		√	√ RFH	n=2
Maternal, Newborn and Infant: Perinatal Programme 2014	√	√	√ BH	n=TBC
		x	x CFH	N/A
		√	√ RFH	n=TBC

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The reports of 44 national clinical audits were reviewed by the provider in 2015/16 and Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

Actions to improve the quality of healthcare provided:

- We are working towards the outcomes from the national clinical audits being presented at our strategic Clinical Governance and Clinical Risk Committee (CGCRC).
- We are working with our four clinical divisions to ensure that any key findings are reviewed and raised within the relevant divisional forum.

(A full list of specific actions are presented in Appendix B)

Clinical Audit remains a key component of improving the quality and effectiveness of clinical care; with the aim to ensure that safe and effective clinical practice is based on nationally agreed standards of good practice and evidence-based care.

The Trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research. Through our four clinical divisions work is in progress to dovetail our clinical audits and quality improvement initiatives. This will provide better outcomes for our patients.

The reports of **(tbc)** local clinical audits were reviewed by the provider in 2015/16 and Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Actions to improve the quality of healthcare provided:

- To ensure that all local audits are monitored effectively throughout our clinical divisions, with an increased focus on identifying what were the outcomes and embedding recommendations.
- To ensure that any key themes which cross divisions are addressed appropriately

(A full list of specific actions are presented in Appendix C)

Participating in clinical research

Involvement in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of health care both nationally and internationally. Our participation in research helps to ensure that our clinical staff stays abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes.

Our reputation attracts outstanding staff and researchers from many different countries. The close collaboration between staff and the research department of the medical school is one of our unique strengths, enabling patients to be involved in research allowing our staff to provide patients with the best care available whilst working to discover new cures for the future.

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2015/16 that were recruited to during that period to participate in research approved by a research ethics committee was 8420

The figure includes 2348 patients recruited into studies on the NIHR portfolio and 6072 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year.

CQUIN Payment framework

The Royal Free London NHS Foundation Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the trust chose to opt for the Default Tariff Rollover (DTR) rather than the Enhanced Tariff Option (ETO).

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Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Royal Free London NHS Foundation Trust during 2015/16.

Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period

Information on the quality of data

This section refers to data that we submit nationally

Royal Free London NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data that included the patients' valid NHS numbers was:

% of records	2014/15	2015/16
For admitted patient care	98.8%	98.6%
For outpatient care	99.2%	98.62%
For accident & emergency care	92.6%	94.36%

Table 3: Percentage of patient records with a valid NHS data

Data which included the patients valid General Medical Practice Code was:

% of records	2014/15	2015/16
For admitted patient care	99.8%	99.95%
For outpatient care	99.9%	99.96%
For accident & emergency care	99.9%	99.94%

Table 4: Percentage of patient records with a valid GP Practice Code

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 72% and was graded satisfactory.

	2014/15	2015/16
Information Governance Assessment Report score	70%	68%
Overall grading	**satisfactory**	**satisfactory**

The data for 2015/16 shows a slight 2% increase in comparison to our 2014/15 data.

Payment by Results

The Trust was not subject to a ‘payment by results’ clinical coding audit under the Audit Commissions Assurance Framework during 2015/16.

Data Quality

The Trust continues for focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services. A data quality improvement plan was undertaken in February 2016 and approved by KPMG (internal audit)

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

We will ensure that key factors identified within our data quality improvement plan are reviewed and monitored.

This includes:

- Ensuring that regular meetings are held with our clinicians and clinical coding teams to review the data.
- Ensure that effective feedback is provided to the coding team following audits.

Review of Core indicators

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. Prior to this date the Royal Free London NHS Foundation Trust was not accountable for the performance of the Barnet and Chase Farm Hospitals NHS Trust.

The data and commentary in the following tables presents the most recent data available from the nationally prescribed data source (Health and Social Care Information Centre, unless stated otherwise) however in accordance with NHS conventions data prior to the acquisition has now been merged, effectively combining the Royal Free London NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust for the periods both before and after 1 July 2014.

There are a number of exceptions to this position which include the following metrics:

1) Patient reported outcome measures which presents Royal Free London NHS Foundation Trust excluding Barnet and Chase Farm Hospitals NHS Trust data for the periods 2013/14 and 2014/15

2) The trust's Commissioning for Quality and Innovation indicator score which presents Royal Free London NHS Foundation Trust excluding Barnet and Chase Farm Hospitals NHS Trust data for the period 2013/2014 and Royal Free London NHS Foundation Trust including Barnet and Chase Farm Hospitals NHS Trust data for the period 2014/15

Details are presented on the following core indicators:

- Summary hospital-level mortality indicator (SHMI)
- Palliative care coded
- Patient Reported Outcome Measures (PROMS)
- Re-admission within 28 days of discharge
- Responsive to personal needs of our patients
- Recommending friends and family to use our services (staff)
- Recommending friends and family to use our services (patients)
- Venous thromboembolism (VTE)
- Clostridium difficile
- Patient safety incidents

Summary hospital-level mortality indicator (SHMI)

SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. It includes the majority of hospital admitted activity, takes into consideration mortality that occurs up to 30days post discharge and additionally does not adjust for palliative care episodes; it is therefore a more comprehensive indicator than HSMR.

Indicator	Jul 13 – Jun 14 (RFL)	Jul 14 – Jun 15 (RFL)	National performance	Highest trust	Lowest trust
The value and banding of the summary hospital-level mortality indicator for the trust	88.69 (15th out of 137)	85.25 (8th out of 136)	100*	66.05	120.89
Actions to be taken to improve performance					
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, referenced by Dr Foster Intelligence in Mortality Comparator. The latest data available covers the 12 months to June 2015. During this period the Royal Free London NHS Foundation Trust had a mortality risk score of 85.25, which represents a risk of mortality 14.75% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free London NHS Foundation Trust ranked 8th out of 136 non-specialist acute trusts. Consistent and equitable standards of care are confirmed by site analysis of the SHMI score which is significantly better than expected at the trust's three main acute sites (Royal Free hospital site, Barnet hospital site and Chase Farm hospital site). 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.					

*SHMI is a case mix adjusted relative risk, each organisation is compared with itself where a score of 100 would indicate performance exactly as expected

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Palliative care coded

Indicator	Jul 13 – Jun 14 (RFL)	Jul 14 – Jun 15 (RFL)	National performance	Highest trust	Lowest trust
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	28.4%	25.4%	26.0%	52.9%	12.4%

Actions to be taken to improve performance

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.

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Patient Reported Outcome Measures Scores (PROMS)

Patient Reported Outcome Measures 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 improves the quality of care provided.

Indicator	2013 – 2014 (RFL)	2014 – 2015 (RFL)	National performance	Highest trust	Lowest trust
Patient reported outcome measures scores for:					
(i) groin hernia surgery	Low Number rule Applies	Low Number rule Applies	0.08	0.15	-1.94
(ii) varicose vein surgery	Low Number rule Applies	Low Number rule Applies	0.10	0.15	0.00
(iii) hip replacement surgery	0.38	0.37	0.44	0.52	0.33
(iv) knee replacement surgery	0.30	0.28	0.32	0.42	0.20

Actions to be taken to improve performance

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.

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 and knee replacement surgery patient feedback was identified as a risk in May 2015 by the Care Quality Commission (CQC) in their Intelligent Monitoring Report based on the 2013/14 data.

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

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Re-admissions within 28 days of discharge

Indicator	2013 – 2014 (RFL)	2014 – 2015 (RFL)	National performance	Highest trust	Lowest trust
The percentage of patients readmitted to the trust within 28 days of discharge for patients aged:	**Note: Trusts with zero readmissions have been excluded from the data**				
(i) 0 to 15	8.3%	10.1%	9.6%	4.4%	16.4%
(ii) 16 or over	6.4%	9.0%	9.9%	6.5%	16.8%
Actions to be taken to improve performance					

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 Intelligence, 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 (specialist providers whose data is not unavailable are excluded).

The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care.

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.

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Responsiveness to personal needs of our patients

Indicator	2013 – 2014 (RFL)	2014 – 2015 (RFL)	National performance	Highest trust	Lowest trust
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.	67.4	68.6	68.9	86.1	59.1

Actions to be taken to improve performance

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 just 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 2016 the trust was inspected by the Care Quality Commission. The inspection was designed to assess the trust services against the following key questions:

1) Are they safe?

2) Are they effective?

3) Are they caring?

4) Are they responsive to people's needs

5) Are they well-led?

Once the Care Quality Commission inspection report is received the trust will identify which service elements require strengthening or improvement with the Trust Board and Patient and Staff Experience Committee overseeing targeted action including improvements in its responsiveness to the personal needs of patients should this be required.

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Recommending friends and family to use our services

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

The data below show information for staff and patients who would recommend their friends and family to our trust.

Staff who would recommend their friends or family the trust

Indicator	2014 (RFL)	2015 (RFL)	National performance	Highest trust	Lowest trust
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.	71.0%	72.1%	69.1%	85.4%	45.9%
Actions to be taken to improve performance					
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.					

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Patients who would recommend their friends and family

Indicator	November 2015 (RFL)	December 2015 (RFL)	National performance	Highest trust (Dec 2015)	Lowest trust (Dec 2015)
Friends and Family Test scores for inpatients and patients discharged from Accident and Emergency departments.	85%	84%	88%	100%	58%

Actions to be taken to improve performance

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 Royal Free London NHS Foundation Trust intends to take the following actions to improve its Friends and Family Test rating:

- There has recently been a strong push from the trusts frontline services for additional information on results. On reading their weekly scores and comments clinical and support staff often wish to put in place improvements or more often why a failing might be being reported.
- As a learning tool for teams and departments the Friends and Family Test continues to be increasingly used.

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Venous thromboembolism

Venous thromboembolism (VTE) is the formation of blood clots in the vein. 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 95% of patients to be assessed in relation to risk of VTE.

<table>
<tr><th>Indicator</th><th>April 2015-June 2015</th><th>Jul 2015 – Sept 2015</th><th>National performance (Jul- Sep 2015)</th><th>Highest trust (Jul – Sep15)</th><th>Lowest trust (Jul – Sep15)</th></tr>
<tr><td>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.</td><td>97.0%</td><td>96.3%</td><td>95.8%</td><td>100.0%</td><td>75.0%</td></tr>
<tr><th colspan="6">Actions to be taken to improve performance</th></tr>
<tr><td colspan="6">The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

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 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 clinical performance committee at its next meetings.
• The Thrombosis Unit also conduct a detailed clinical audit into each reported case of HAT with findings shared with the wider clinical community.</td></tr>
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Clostridium difficile (C.diff) infection

C. 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 C. difficile infections is a key government target.

Indicator	RFL (2014/2015)	RFL (2015)	National performance (2015)	Highest trust (2015)	Lowest trust (2015)
The rate per 100,000 bed days of cases of C. difficile infection that have occurred within the trust amongst patients aged 2 or over	17.5	20.4	15.5	1.12	65.4
Actions to be taken to improve performance					

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 and Social Care Information Centre.

Royal Free performance was higher (worse) than the national average during 2014/15. However from April 2015 the trust's regulator, Monitor, assesses performance in relation to those infections deemed to result from "lapses in care". Against this measure of performance the trust has been compliant with its national trajectory for the entirety of 2015/16. However comparative data is not available for "lapses in care" infections.

The Royal Free London NHS Foundation Trust intends to take the following actions to reduce its rate of C. difficile infection:

- In order to demonstrate robust governance and ensure performance improvement during 2015/16 the trust provides detailed C. difficile infection data to both the monthly trust board and quarterly clinical performance committee meetings
- The data provides a view of all infections as well as the subset relating to "lapses in care". In addition the trust also provides comparative views of the infection data comparing the rate at the Royal Free London NHS Foundation Trust against teaching trusts and all acute providers.

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Patient safety incidents

Indicator	RFL (April 14-Sept 2014)	RFL (Oct 2014-March 2015)	National performance Oct 2014-March 2015)	Highest trust	Lowest trust
The number and rate of patient safety incidents that occurred within the trust during the reporting period	5,614 (31.4)	5,734 (34.7)	4,539 (37)	12,784 (62.5)	443 (3.75)
The number and percentage of such patient safety incidents that resulted in severe harm or death.	40 (0.71%)	43 (0.75%)	22.7 (0.37%)	2 (0.11%)	128 (5.2%)

Actions to be taken to improve performance

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 data presents both total patient safety incidents as well as the rate of per 1,000 bed days. In relation to patient safety incidents resulting in severe harm and death the data presented is both the total number of such incidents and the rate against total patient safety incidents.

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 a similar rate of incidents to the national average for the period October 14 to March 15.

The Royal Free London NHS Foundation Trust has taken the following actions to improve its reporting rate:

- 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.
- 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. Review of quality performance

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2015/16 against indicators and national priorities selected by the board in consultation with our stakeholders.

The indicators also follow the three quality domains: patient safety, clinical effectiveness and patient experience

Overview of the quality of care in 2015/16

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. As a consequence the trust inherited a number of deep seated challenges particularly in relation to meeting our regulators standards for cancer and 18-weeks waiting times.

During the course of 2015/16 significant progress has been made in terms of validating historically poor data. During June 2015 we re-established national reporting for 18-weeks, and modernising cancer tumour site pathways, particularly in relation to Urology.

This winter has seen unprecedented pressure on accident and emergency departments and urgent care pathways. At the Royal Free hospital site there was a 16.7% growth in all attendances and a 22.7% growth in ambulance attendances during January 16 compared to January 15. Looking at the Barnet hospital site there was a 12.8% growth in all attendances and a 12.7% growth in ambulance attendances.

Despite this extremely challenging operating environment for the period April 15 to December 15 the Royal Free London NHS Foundation Trust achieved 95.4% compliance against the 95% 4 hour standard. Over this period, the trust's three emergency departments recorded the third highest performance against the standard when compared with the eighteen London non-specialist acute providers.

In addition we continue to record some of the lowest mortality rates in the country and are ranked 7th and 5th best performing against the two main measures or mortality risk (HSMR and SHMI) compared to our peer group of 26 English Teaching trusts.

We continue to develop our world class care programme, which is designed to improve patient and staff experience and we have retained our focus on safety by continuing to promote our patient safety programme.

We have also concentrated our efforts on modernising our services and upgrading our estate. 2015/16 has seen a huge emphasis on cancer tumour site modernisation with many high-risk patients now able to receive diagnostic tests and biopsies on the same day as their first outpatient appointment. In terms of the estate we are now well on the way to rebuilding the Royal Free hospital A&E department with the planning application for the new hospital build on the Chase Farm site recently approved. These projects, and many

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others, will ensure we continue to deliver world class care for our current patients and generations to come.

Our focus for 2016/17 is in ensuring that all parts of our diverse trust reach and maintain the standards of the best performing hospital sites. Key challenges will include returning to compliance with the A&E 4-hour standard, Cancer 62 Days from GP referral target and 18-weeks from referral to treatment.

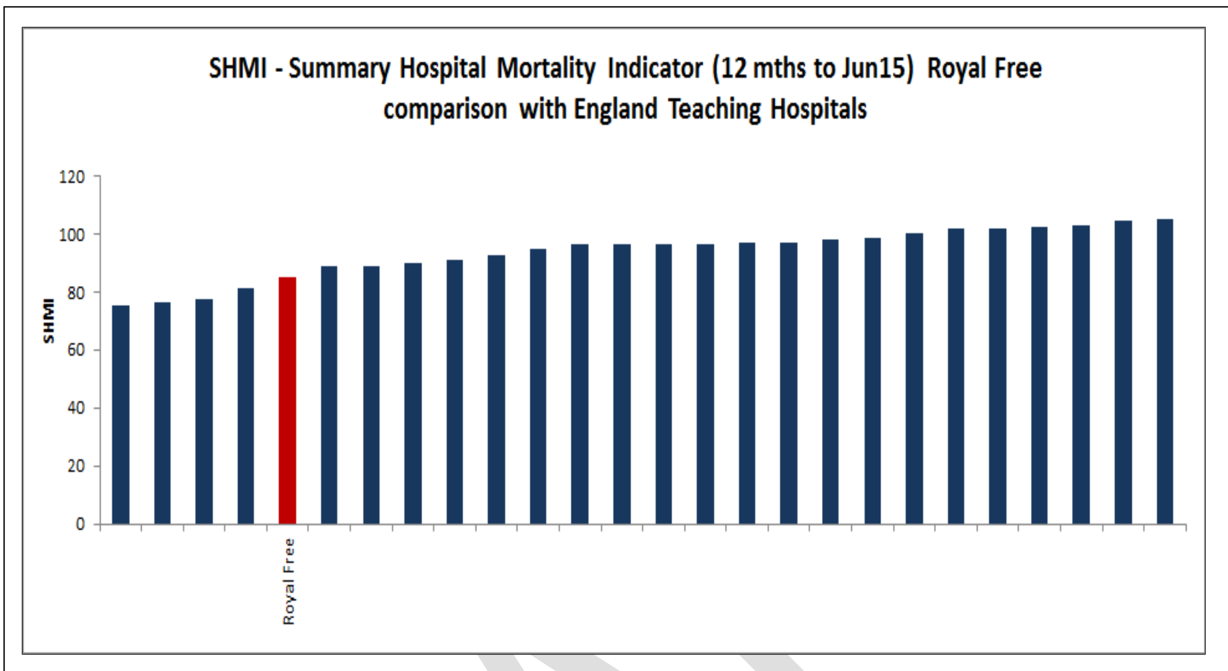
Performance against key national priorities

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. The charts and commentary contained in this report represents the performance for the combined organisation (i.e. including the performance in aggregated form across all sites where services are provided by the Trust. This approach has been taken to ensure consistency with the prescribed indicators the trust is mandated to also include within the Quality Account. The prescribed indicators data are sourced via the Health and Social Care Information Centre where in the majority of cases data are also aggregated.

Where possible, performance is described within the context of comparative data which illustrates how the performance at the Trust differs from that of our peer group, English Teaching hospitals.

Relevant Quality Domain	Quality performance indicators
Patient Safety	• Summary Hospital Mortality Indicator (SHMI) • Hospital Standardised Mortality Ratio (HSMR) • Methicillin-resistant Staphylococcus aureus (MRSA) • C. difficile
Clinical Effectiveness	• Referral to treatment (RTT) • A&E performance • Day case rate • In- patient length of stay • Cancer waits • readmissions
Patient experience	• Last minute cancellations • Delayed transfer of care • Friends and family test

Patient Safety Indicators

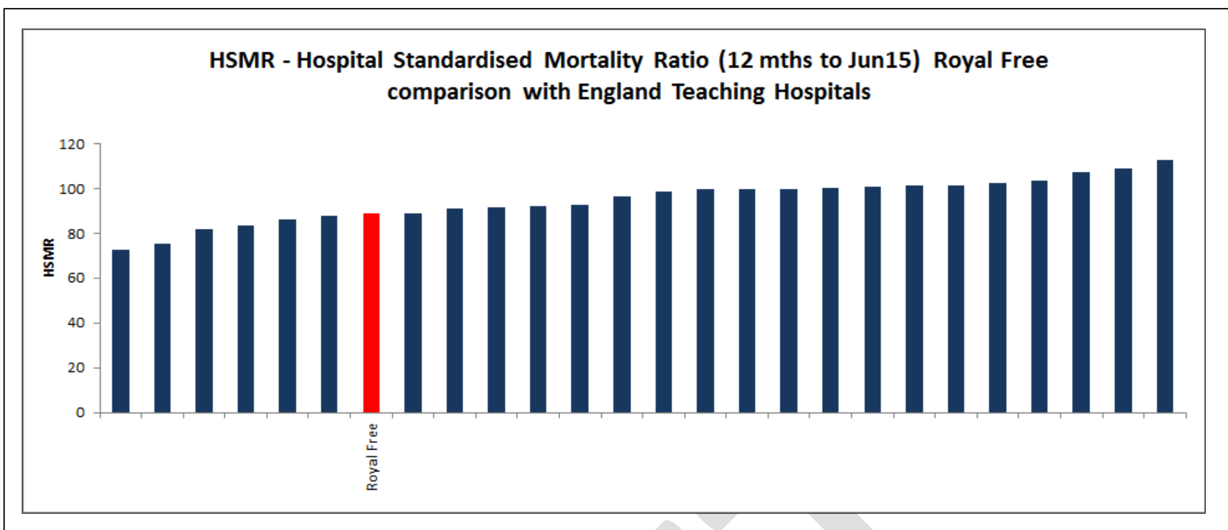


SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. This expression of mortality risk includes all diagnoses groups and mortality occurring up to 30 days post discharge.

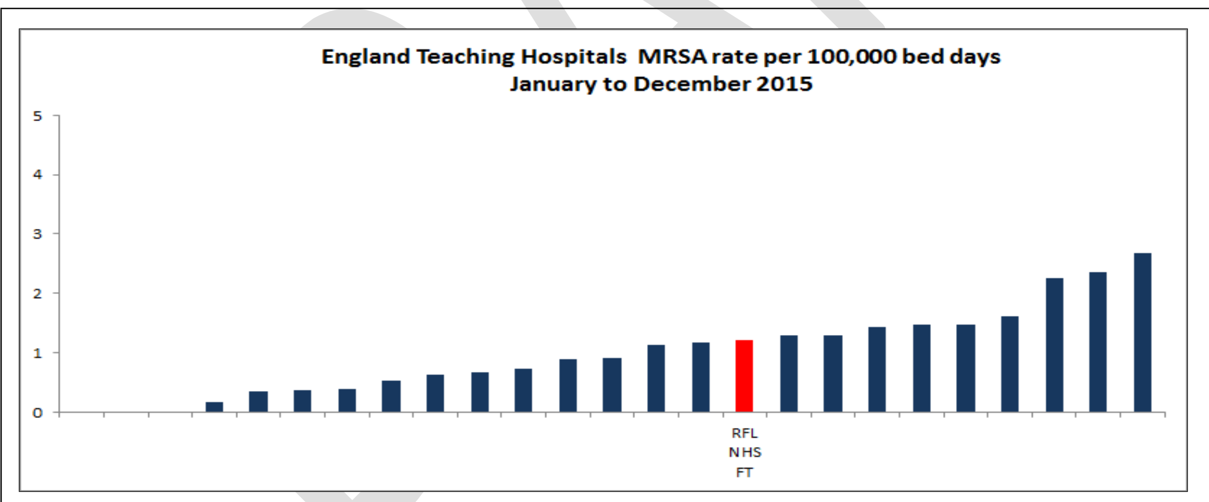
The observed volume of deaths is shown alongside the expected number (case mix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better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

SHMI data is presented for the twelve month period ending June 2015 and therefore covers the twelve month period post-acquisition of Barnet and Chase Farm Hospitals NHS Trust. For this period the Royal Free London NHS Foundation Trust SHMI ratio was 85.25 or 14.75% better than expected. For this period the Royal Free had the 5th lowest relative risk amongst the 26 large England Teaching Hospitals.

(Data source: Dr Foster Intelligence/Health and Social Care Information Centre)

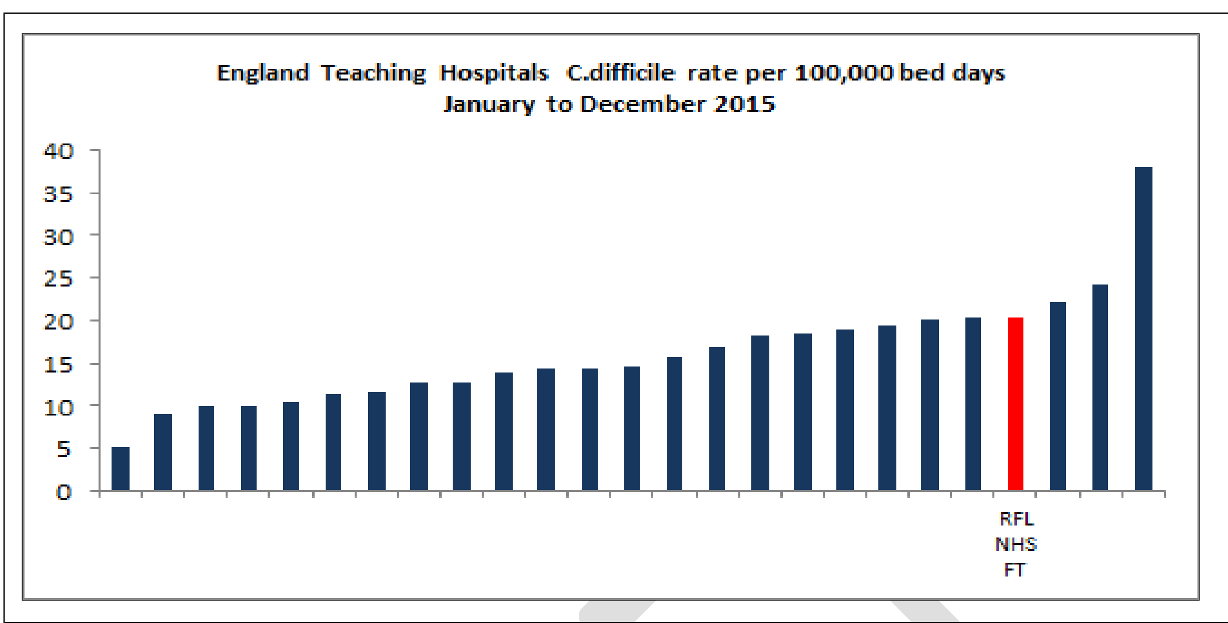


The HSMR (Hospital Standardised Mortality Ratio) includes 56 diagnoses groups responsible for 80% of deaths and only includes in-hospital mortality. Data shows that for the 12 months to the end of June 2015. The Royal Free London NHS Foundation Trust recorded the 7th lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 88.8 which is 12.2% below (statistically significantly better than) expected.
(Data source: Dr Foster Intelligence/Health and Social Care Information Centre)



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 key in ensuring patient safety 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 twelve months to the end of December 2015 the Royal Free reported 4MRSA bacteraemias. Against the 25 teaching trusts, the Trust is ranked 16th with a rate of 1.22 bacteraemias per 100,000 bed days.



In relation to **C. difficile** the trust's regulator, Monitor, assesses performance in relation to those infections deemed to result from "lapses in care". Against this measure of performance the trust has been compliant with its national trajectory for the entirety of 2015/16.

However comparative data is not available for "lapses in care" infections, looking therefore at all infections, including those not resulting from "lapses in care", the Royal Free London NHS Foundation Trust is ranked 22nd out of 25 English Teaching Hospitals for the period April to December 2015 with a reported position of 20.4 per 100,000 bed days.

(Data source: Public Health England)

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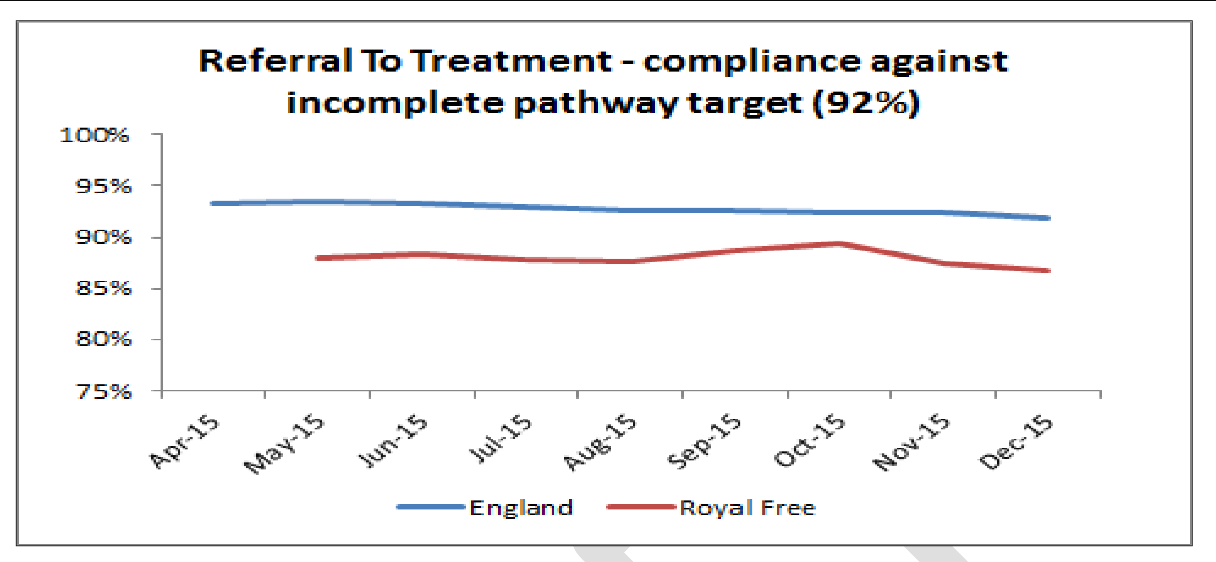
Clinical Effectiveness Indicators



Prior to the acquisition of Barnet and Chase Farm Hospitals NHS Trust the Royal Free London NHS Foundation Trust identified significant data quality and accuracy issues in relation to Barnet and Chase Farm Hospitals NHS Trust **referral to treatment** 18 weeks data.

One of the largest data validation exercises in NHS history was commenced resulting in 1.9m pathways being extracted from the Barnet and Chase Farm Hospitals Trust Patient Administration System of which 75,090 required manual validation to determine true referral to treatment status and waiting time. During this process it was not possible to report performance against the referral to treatment indicators.

In May 2015 reporting resumed, however from September 2015 onwards, the NHS decided to focus reporting on pathways where the patient has yet to receive treatment and is actively waiting as the single measure of compliance with the NHS Constitution. For incomplete (open) pathways the national standard requires that no more than 8% of patients should be waiting longer than 18 weeks for treatment, or put another way 92% should be waiting less than 18 weeks.

Following the data validation and recovery exercise described a significant volume of long-waiting pathways were identified at the former Barnet and Chase Farm Hospitals site. A significant recovery project structure and trajectory were put in place with the aim of ensuring compliance with the 92% standard is achieved by September 2016. The trust is making good progress in delivering the recovery programme.

However, for the 8 month period for which data exists, the Royal Free reported a greater proportion of patients waiting longer than 18 weeks at the end of each month when compared to the average performance of English acute trusts.

(Data source: National Health Service England)

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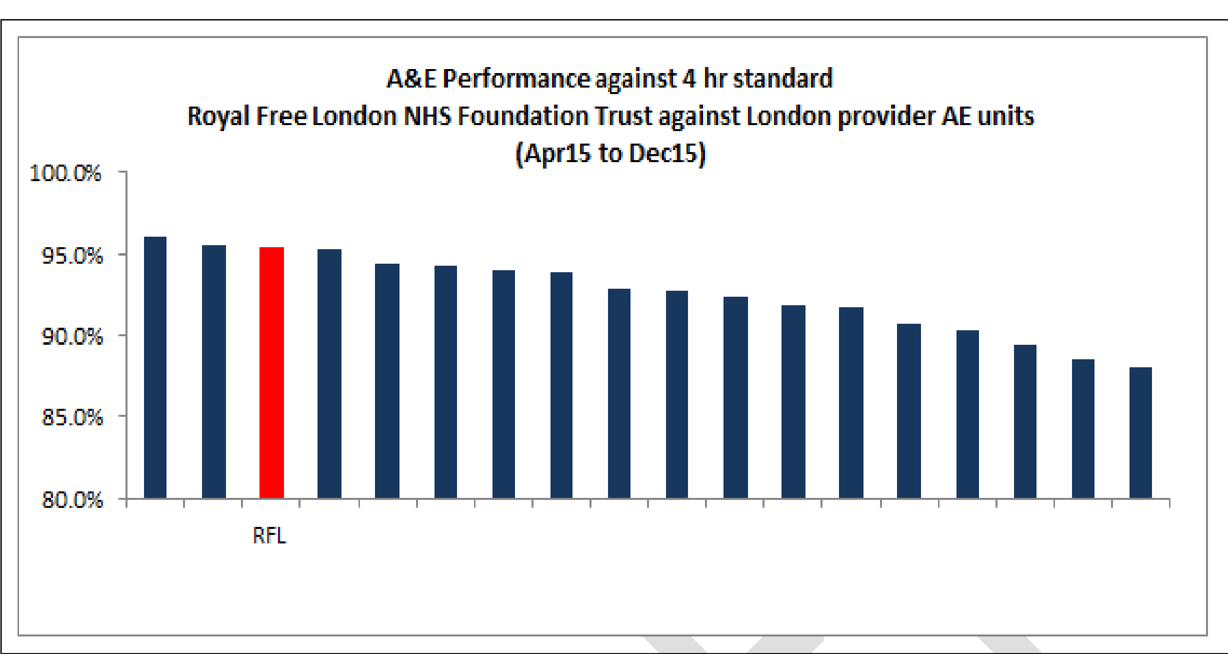

The **Accident and Emergency Department** is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment.

The graph summarises the Royal Free's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of London A&E departments.

The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within 4-hours of arrival. A higher percentage in the graph is indicative of shorter waiting-times. During the period April 15 to December 15 the Royal Free London NHS Foundation Trust achieved 95.4% compliance against the 95% 4 hour standard.

Over this period, the Royal Free London NHS Foundation Trust's three emergency departments recorded the 3rd highest performance against the standard when compared with the 18 London non-specialist acute providers.

Pressure on A&E's has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare.
In response the trust has invested heavily in modernising and extending its emergency service, this includes completely rebuilding the Royal Free hospital site A&E department now well underway.

(Data source: National Health Service England)

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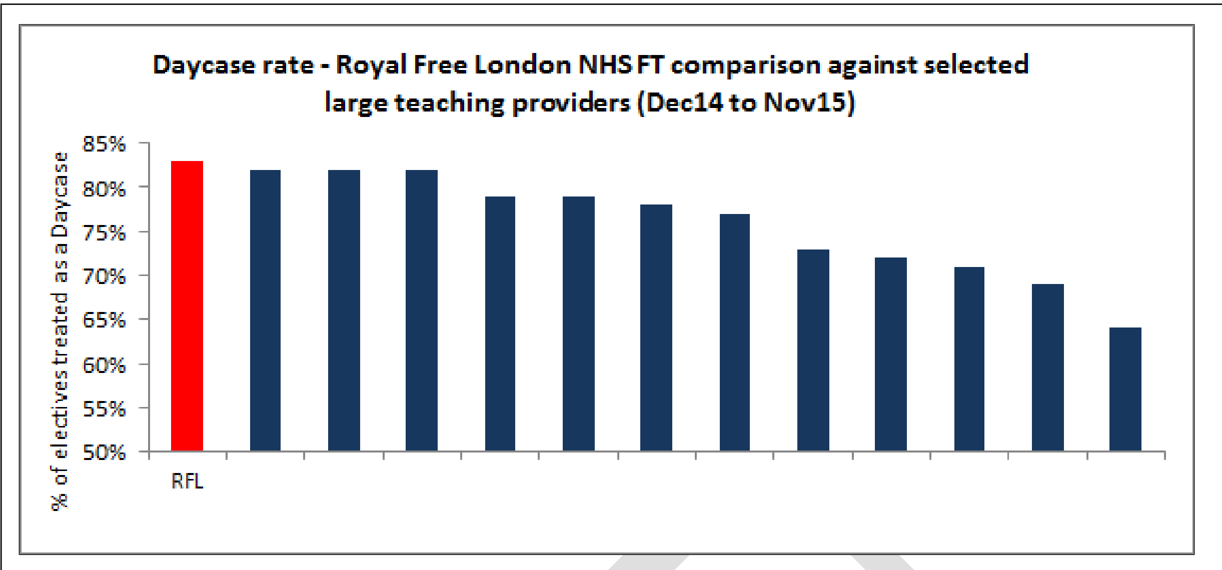
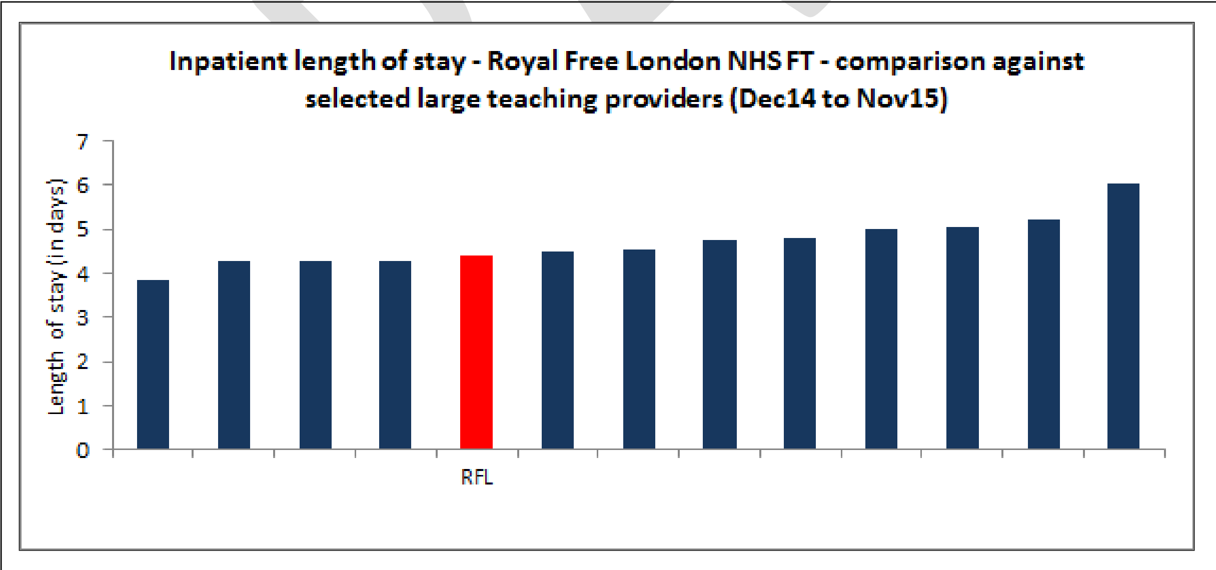


Day cases are procedures that allow you to come to hospital, have your treatment and go home, all on the same day. A high day case rate is seen as good practice both from a patient's perspective and in terms of efficient use of resources.

During the period covering December 14 to November 15, the Royal Free London NHS Foundation Trust treated 83% of elective admissions as day cases, this was the highest proportion across the group of large teaching providers.



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 December 14 and November 15 the Trust reported the 5th lowest average length of stay across the large teaching provider peer group.

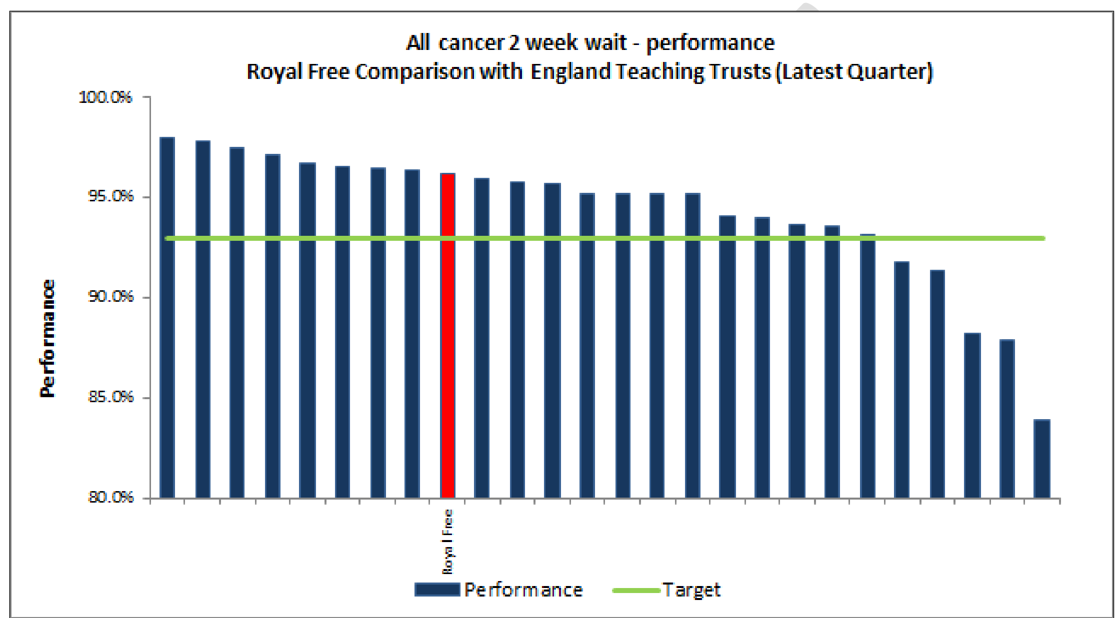
It is important to note that when producing comparative data of this type a variety of data quality issues will influence all trusts data and operational models will differ significantly between trusts as well as between trust sites.

(Data source: Dr Foster Intelligence Ltd)

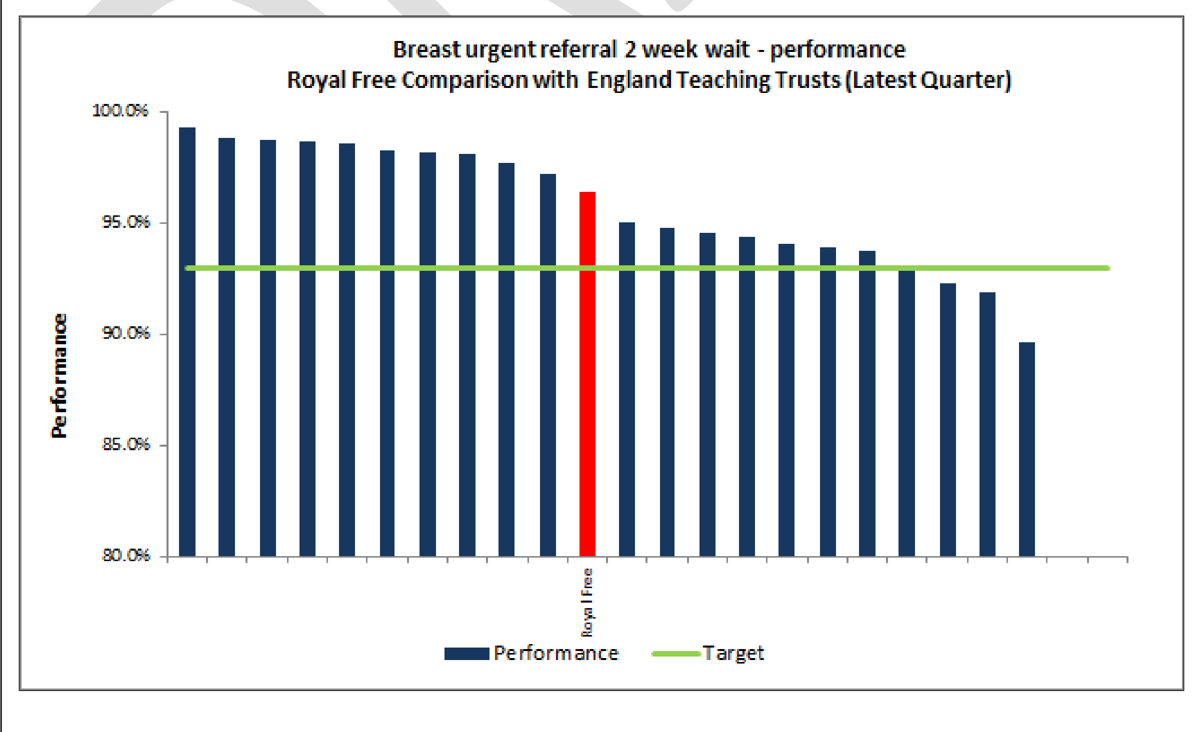
Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed diagnosed and treated the better the clinical outcomes and survival rates.

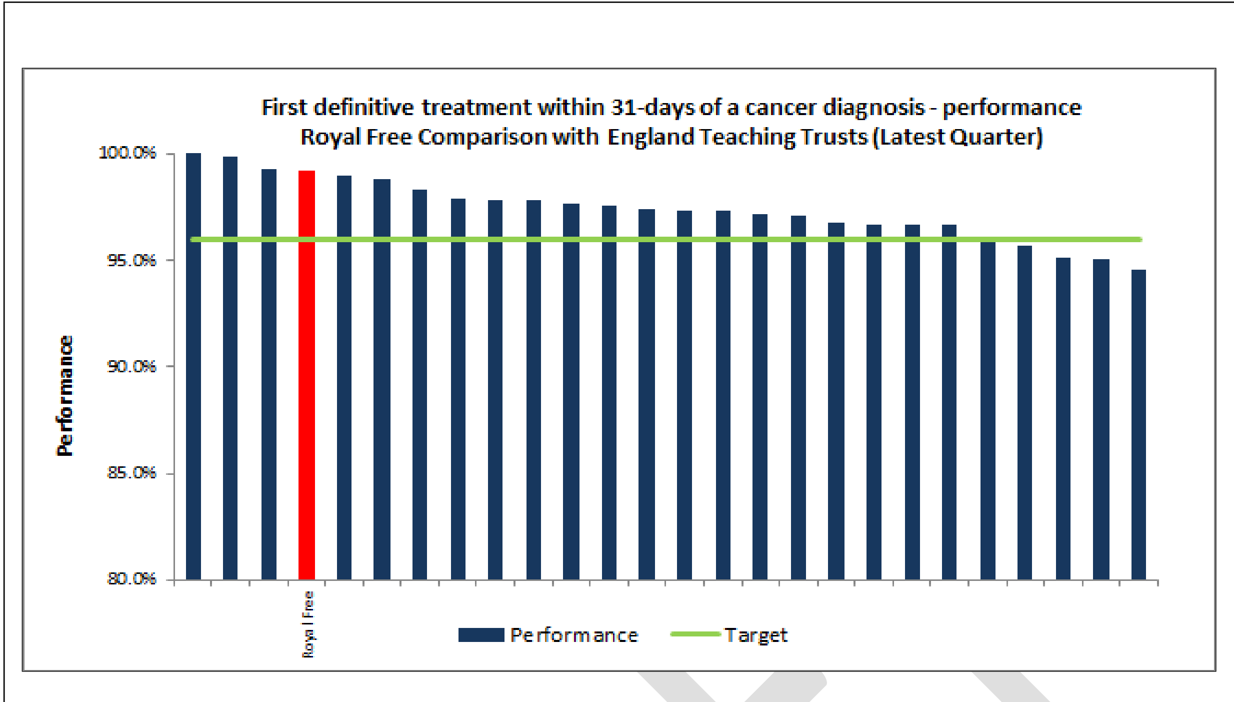
National targets require 93% of patients urgently referred by their GP to be seen within 2 weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

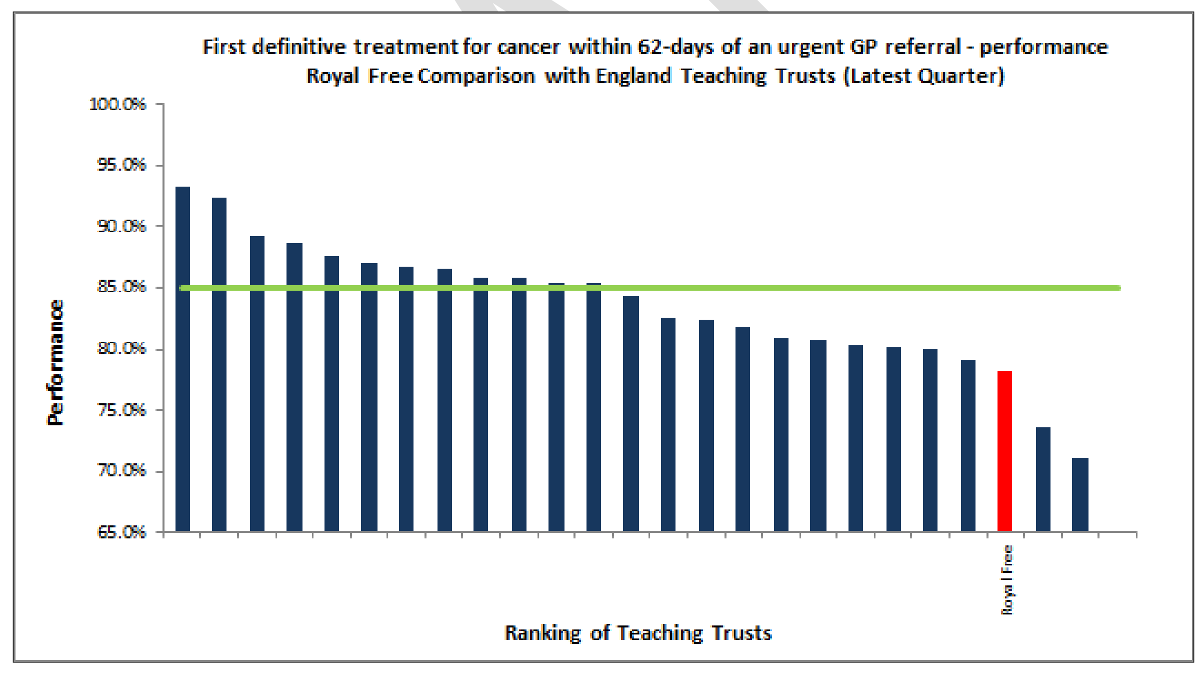
National data is provided for the period October 15 to December 15, the most recent available.



Over this time series the Royal Free London NHS Foundation Trust performed better than the national targets in relation to the two week wait and 31 day standards.







The trust underperformed against the 62 day standard. Underperformance is being driven by a build-up of breach backlog pathways across a number of tumour sites, most notably Urology where there have been significant capacity issues in the diagnostic and tertiary centre surgical stages of treatment, Skin and Upper Gastrointestinal.

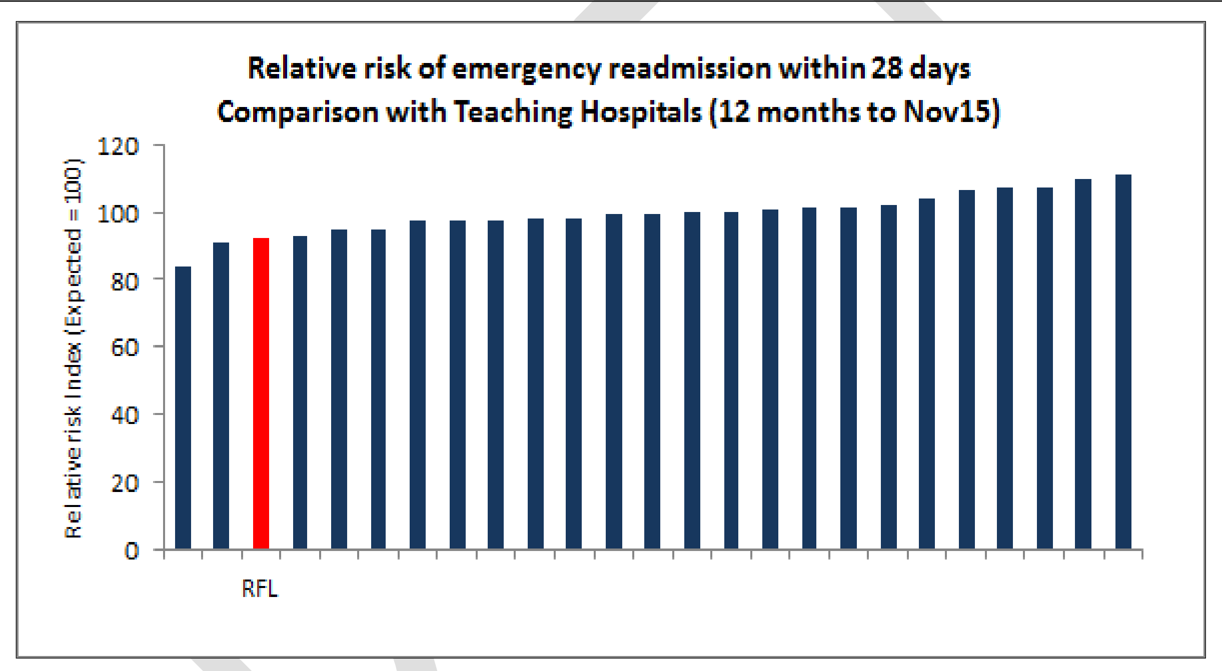
Specific issues in both the Urology and Skin pathway, such as imaging and biopsy diagnostic clinics, have been addressed, as have extended waiting times at tertiary treatment centres. Waiting times at the front end of tumour site pathways, such as initial referral to first appointment two week waits and waits for diagnosis are improving as a result.

However the trust is still working through considerable volumes of breach backlog pathways which built up prior to the implementation of the improvement programmes.

In response the trust has set out a detailed recovery plan to deliver a sustainable waiting list by end of March 2016 and a return to national target compliance from April 2016.

The graphs present the Royal Free London NHS Foundation Trust performance relative to English teaching trust performance and the relevant national target.

(Data source: National Health Service England)



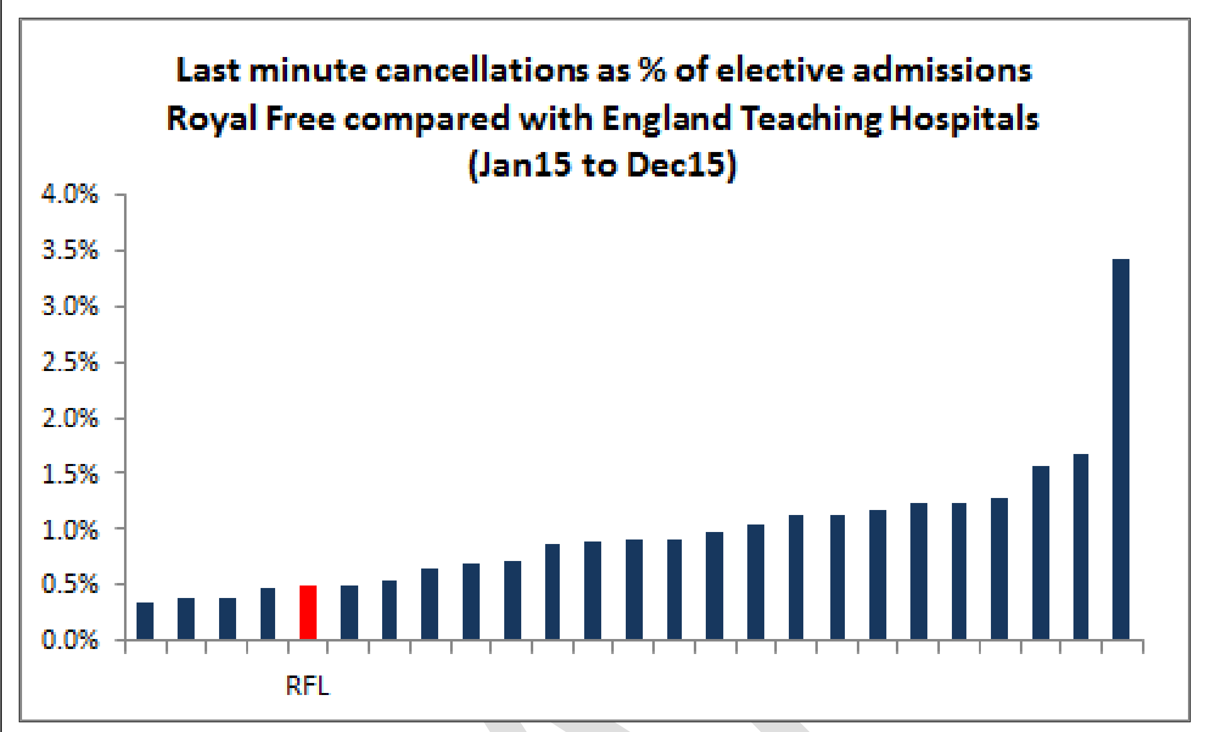
The Royal Free London NHS Foundation Trust carefully monitors the rate of **emergency readmissions** as a measure for quality of care and the appropriateness of discharge. The hospital is working with Commissioners, GPs and local authorities to provide enablement and post discharge support in order to reduce the rate of readmissions.

A low, or reducing, rate of readmission is seen as evidence of good quality care.

The chart presents the rate over the 12 month period shown; over this period the Royal Free London NHS Foundation Trust had the 3rd lowest relative risk of readmission across the English teaching hospital peer group of 25 providers.

(Data source: Dr Foster Ltd)

Patient Experience Indicators



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

For the 12 months reported, from January to December 2015, the Trust cancelled admission for 459 patients at the last minute for non-clinical reasons. This translates into a rate of 5 cancellations per 1,000 admissions.
As a ratio, the Trust rate of 0.5% is the fifth lowest rate of cancellations across the English Teaching hospitals peer group.

Internal analysis shows that the cancellation rate was highest at Royal Free Hospital site at 0.7% and lowest across the Barnet and Chase Farm hospital sites (0.3%).

(Data source: NHS England)

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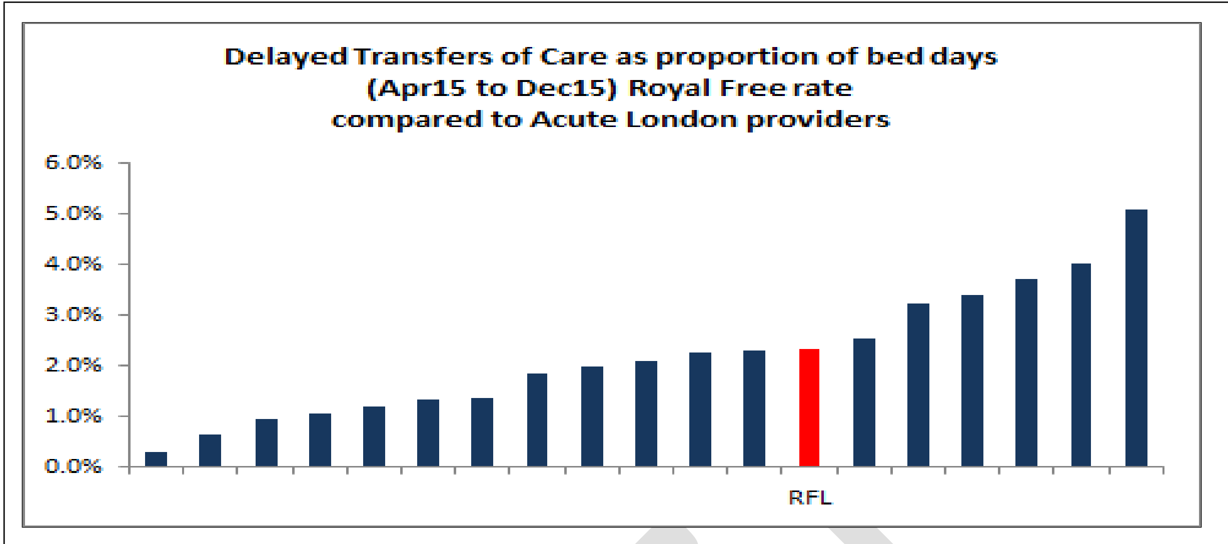
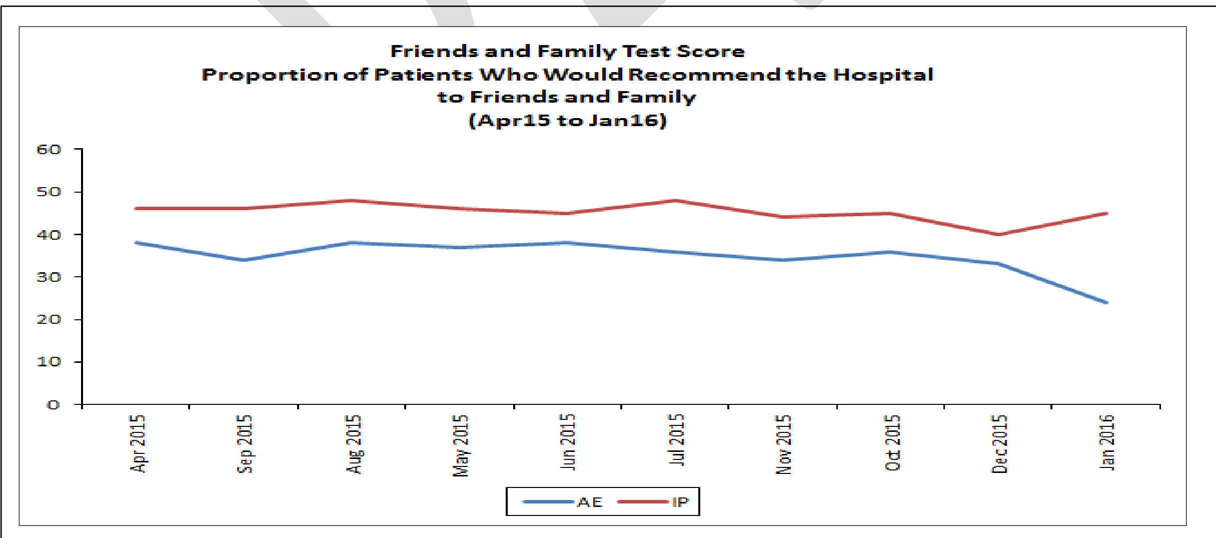


Delayed transfers occur when patients no longer need the specialist care provided in hospital but instead require rehabilitation or longer term care in the community. A delayed transfer is when a patient is occupying a hospital bed due to the lack of appropriate facilities in the community or because 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.

(Data source: National Health Service England)



The Friends and Family Test (FFT) was introduced in April 2013. Its purpose is to track and therefore improve patient experience of care.

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 chart describes the Friends and Family Test responses in 2015/16 YTD and relates to A&E and Inpatient wards.

Our local improvement plans

This section contains our local improvement plans additional areas which includes Care Quality Commission (CQC), patient safety and complaints and our most recent NHS staff survey. Throughout 2015/16 we have undertaken additional measures to support our delivery of world class expertise and local care and plans are in place to drive this.

Care Quality Commission

This year we had our planned comprehensive hospital inspection in February 2016 across our three main hospital sites of Barnet, Chase Farm and the Royal Free. The inspection report is anticipated later in the year and at the time of our inspection the CQC has not requested that we undertake any immediate actions.

Ahead of the inspection process the CQC asked us to tell them about our performance against each of the five key questions, summarising this at overall trust level as well as providing detail to highlight areas of good and outstanding practice, as well as telling them about where the quality of services is less good, and in these cases, what action we are taking. Below is the information provided to the CQC setting out our own view of our performance.

Which services or areas of the trust do you consider to be good or outstanding?	
Safe	Strong patient safety programme, an example of its work is the award winning Sepsis 6 quality improvement programme, designed by clinical staff in response to a series of serious incidents.
Effective	We have maintained a strong ED performance across the Trust despite the challenging operational environment. We have low mortality rates with no weekend variation. We regularly participate in around 50 national audits with outcomes reviewed at Board level.
Caring	We have hundreds of comments from patients on a week basis telling us our staff are caring.
Responsive	The Trust inherited a large RTT waiting list issue when we acquired Barnet and Chase Farm NHS Trust (BCF) in July 2014 which we have systematically addressed and our approach, particularly the clinical harm review process, has been held up by NHS England as best practice. We have successfully led the national NHS response to Ebola while facing significant operational challenge.
Well- Led	We have a stable senior leadership team with a strong record of delivery of clear strategic objectives, board governance is well established with clear strategy and set of values, developed by staff and patients and embedded throughout the Trust. We acquired BCF 18 months ago with no serious issues - widely recognised as one of the most successful recent NHS mergers. We buddied Basildon and Thurrock University Hospitals NHS FT to assist it out of special measures; asked to buddy other struggling trusts. There is strong commitment to clinical leadership supported by robust leadership programmes.

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Which services or areas of the trust do you feel are your weaker areas?	
Safe	Post acquisition there is a new clinical governance structure with a significant investment which is beginning to embed. However we acknowledge this has been challenging for staff at Barnet and Chase Farm we have restructured. There are differential IT platforms in the organisation which are now in the process of being standardised resulting in some change management issues.
Effective	Work is continuing post acquisition to harmonise clinical policies and guidelines and our approach to NICE guidance, but work is not complete.
Responsive	We have been working on improving our complaint response time. We are currently not meeting 18 weeks RTT or 62 day cancer targets, largely due to inherited issues from acquit son of BCF however clear trajectories are in place to achieve targets (62 day target within next 2 months and RTT by quarter 2 2016/17)
Well- Led	The clinical leadership model is still embedding at Barnet hospital and Chase Farm hospital where it is a new structure.
Please describe what actions you are taking to address these weaker areas, Please include any support that you feel the trust may need (or has already sought) to address the challenges it is facing in ensuring the quality of care and patient safety.	
Safe	Our recently approved quality strategy to a significant upskilling of frontline staff in improvement methodology. This will support existing clinical governance structures and the already established patient safety programme. The impact of IT platform changes is reviewed weekly by the Trust executive committee.
Effective	We are working through our new clinical governance structures to complete harmonisation of policies and NICE guidance.
Responsive	We have strengthened the complaints team and increased monitoring including a weekly review. RTT and 62 cancer targets are reported and discussed at the weekly Trust executive committee in addition to monthly project boards. Both these projects have had external validation from the Intensive Support team.
Well- Led	The regular review of Board governance through Monitor well led framework is due in 2016. Recently approved as one of the 3 national acute care collaborative vanguards to develop a Royal Free group model; this involves a detailed review of our current clinical leadership model. There is continuous emphasis on leadership development through and internal programme run by Professor Richard Bohemer (Harvard Business School).

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Patient safety

As shown through our quality account priorities, patient safety remains integral to the delivery of safe and effective care for our patients. The current data for our patient safety incidents (as previously reported) covers between 01 October 2014 to 31 March 2015. However there will be a 6 month update in April 2016.

The following information outlines the additional measures that we have undertaken:

Implementing the duty of candour

We have been implementing Being Open across the Trust for many years, and approved our Duty of Candour policy in November 2014, to clarify the updated processes for staff. We have developed a monthly training package aimed at all levels of staff that has been delivered across all sites.

We have set up our incident reporting system (Datix) to enable us to monitor Duty of Candour compliance for those incidents that have resulted in moderate harm or above. We provide monthly reports to the Patient Safety Committee and our Commissioners detailing our compliance with duty of candour.

Patient safety improvement plan as part of the Sign up to Safety campaign

The Trust formally signed up to the NHS England's sign up to safety campaign in April 2015 to develop our Patient Safety Programme. We have committed to deliver a detailed improvement plan through building strong organisational relationships and engaging clinical and non-clinical staff to work together for shared purpose.

The patient safety programme has monthly collaborative meetings where clinical leads and safety champions come together to share learning and experiences around driving safety improvements.

As part of this work we are actively involved in our academic health science network, UCL Partners, safety collaborative, where we contribute to sharing and learning around safety issues, with many other organisations.

Learning from mistakes

From our Patient Safety Programme strategy launched in October 2014,we started our three year Patient Safety Programme in April 2015, with the aim 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 by 50% by 31 March 2018.

The key areas of focus have been determined following review of the serious incidents, incident trends, complaints and claims across the trust in the last 5 years and are listed in table five:

Table Five: Actions to support patient safety

Phases	Actions to support
Phase 1	1. Falls Prevention 2. Acute kidney injury 3. Deteriorating patient 4. Deteriorating unborn baby 5. Safer Surgery 6. Sepsis 7. Acute diabetic management
Phase 2	8. Missed and delayed diagnoses 9. Action on abnormal images 10. Medicines management 11. VTE prevention and inpatient anticoagulation management
Phase 3	12. Hospital associated infections, including catheter-related infection 13. Hydration and nutrition 14. Pressure ulcers

In March 2016, the NHS published a league table of "Learning from mistakes", where the trust was ranked 190 / 230 and labelled as having "significant concerns about openness and transparency".

This ranking was based on 2 questions on the 2015 Staff Survey which were significantly worse than expected:

Question 7. Percentage of staff able to contribute towards improvements at work
Question 26. Percentage of staff experiencing harassment, bullying or abuse from staff

We are currently reviewing the results of the annual staff survey in order to identify ways we can further improve our processes and are committed to creating an atmosphere of openness and transparency in which all staff feel able both to raise and respond to concerns.

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Learning from complaints

Feedback from patients, relatives and carers provides the trust with a vital source of insight about people's experiences of healthcare at our hospitals, and how our services can be improved. The aim of the trust's complaints process is to listen and respond to the issues being raised and use the information received to improve services and, in turn, the experience of our patients.

Complaints data is reviewed monthly by the trust executive committee alongside other data, including patient surveys, infection, falls, pressure ulcers and incidents. Complaints data, including lessons learnt and actions taken is included in:

- The divisional monthly quality & safety boards.
- The quarterly report taken to the patient and staff experience committee.
- An annual complaints report taken to the trust Board.
- The quarterly CLIPS (complaints, litigation, incidents, PALS and safety) report taken to the patient safety committee.

Themes and actions taken:

The table below shows the primary subjects from the complaints received in 2015/16 and is followed by some example actions taken in response to those issues.

1	**Clinical treatment**
2	**Communication**
3	**Appointments**
4	**Values and behaviours (attitude)**
5	**Car parking**

- Following review of an ENT complaint at the ENT audit and governance meeting, there was agreement that any patient presenting with a traumatic perforation should be followed up by the ENT team until the perforation has healed and there should be early referral for formal hearing testing via an audiologist. This should not be left for the GP to action.

- To improve the support that amyloidosis patients and families have, we have appointed a cardiac amyloidosis link nurse for 10 West ward – someone with a keen interest in this very specialist area who has spent time with senior doctors to learn about the disease but also to learn about what specific nursing needs this group of patients have and what input the family require. This nurse's role will also support the discussions around prognosis. Although we have a dedicated specialist haematology nurse for myeloma and amyloidosis, this nurse is part of the 10 West ward team and we hope that this new role will greatly improve communication with families and help address any concerns they may have as early as possible.

- We are looking at extending our ophthalmology clinic times into the early evening and have opened a further eye clinic at St Pancras Hospital, helping us to meet the ever increasing demand for ophthalmology services.

- The doctor concerned has reflected on her consultation with the patient and accepts that she need not have been so direct with the patient which, in hindsight, caused the patient stress. The clinical director has also taken the opportunity to review doctor's communication skills and has offered her advice on how best to discuss this element of care in future.

- Explanations and updates have been provided to visitors and blue badge holders with regard to the new parking arrangements on the Barnet and Chase Farm Hospital sites, and some penalty charge notices have been cancelled as a gesture of goodwill or as a result of the extenuating circumstances explained by the complainant. In addition, the reception staff and PALS team are very well versed in the parking arrangements are on hand to provide help and advice whenever required.

Actions taken by the complaints team

Two batches of the complainant questionnaire were sent out to complainants who had received responses from the trust in April 2015 and October 2015.

An overview of the key questions is provided in the table below:

Question asked?	April 2015	October 2015
Was your complaint treated seriously and with sensitivity?	Yes = 42% No = 58%	Yes = 62% No = 38%
Were all points raised in your complaint addressed by the response?	Completely or mostly = 50% Partially or not at all = 50%	Completely or mostly = 61% Partially or not at all = 39%
Was the response letter clear and understandable?	Yes = 58% N0 = 42%	Yes = 82% N0 = 18%
Were you kept updated about any delays with the investigation?	Yes = 9% No = 62% N/A = 29%	Yes = 61% No = 25% N/A = 14%
Overall, how well do you think your complaint was handled?	Very well or well = 33% Average 17% Poor or very poor = 50%	Very well or well = 50% Average 297% Poor or very poor = 21%
Was your disability taken into account during the process?	Yes = 0% No = 8% N/A = 82%	Yes = 18% No = 3% N/A = 79%

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The results are reflective of a period in which our complaint investigations were taking longer than expected and updates to complainants about those delays were not happening routinely and proactively. Change-over of staff and sickness within the divisional complaints teams had an impact but this has been resolved and, as of January 2016, all divisional complaints roles are filled with permanent full-time staff.

Overall, there is a positive trend in every question with October's data, which it is felt is largely reflective of the improvements that have been made since October 2015 with regard to turnaround times for completion of investigations and updates to complainants about delays. Our performance will continue to be monitored during 2016/17.

In an attempt to make our services and information more widely available, the trust's complaints and PALS posters were updated and revamped and displayed prominently on wards, in outpatient clinics and throughout our hospital buildings.

Feedback from our maternity action plan

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NHS Staff survey results 2015

For the national staff survey 2015, 3184 (38%) of 8347 eligible staff completed the Survey between 28th Sept and 10th Dec 2015. The response rate was 6% lower than 2014 (44%). Across the NHS the response rate in 2015 was 41%, 1% lower than in 2014 (42%).

For 2015 there was a substantial revision in the questionnaire, which means that some questions and key findings are not directly comparable to 2014 results. The survey comprised 30 questions (plus sub questions) and 3 local questions which the NHS analyses into 32 key findings.

This section outlines the most recent NHS staff survey results for indicators:

- KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion).
- KF27 (percentage of staff reporting most recent experience of harassment, bullying or abuse).

KF21- Providing equal opportunities for staff

76% of staff felt that the trust provides equal opportunities for career progression or promotion, in comparison to 87% which was the national 2015 average for acute trusts.

KF27- staff reporting harassment, bullying or abuse

34% of staff/colleagues have reported most recent experience of harassment bullying or abuse, in 2014 the trust score was 38% (the higher the score the better).

Suggestions to improve the staff experience include five high priorities based on the analysis of results. These include:

1. A strong campaign on bullying and harassment.

2. Working closely with those leadership teams in units with the worst outcomes from the staff survey – developing locally owned plans and monitoring delivery.

3. Setting clear expectations of managers in relation to appraisal, staff engagement and team communication activity – measuring and monitoring as part of their management.

4. Progressing rapid delivery of the improved intranet with clear and easy to find policy procedures and forms etc.

5. Delivering leadership training and support to managers – with an expectation that those in poorer performing areas will complete it.

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Annexes

Annex 1. Statements from Commissioners, Healthwatch organisations and overview and scrutiny committees

Annex 2: Statement of directors' responsibilities for the quality report

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2015 to [the date of this statement]

- papers relating to Quality reported to the board over the period April 2015 to [the date of this statement]

- feedback from commissioners dated XX/XX/20XX

- feedback from governors dated XX/XX/20XX

- feedback from local Healthwatch organisations dated XX/XX/20XX

- feedback from Overview and Scrutiny Committee dated XX/XX/20XX

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX

- the [latest] national patient survey XX/XX/20XX

- the [latest] national staff survey XX/XX/20XX

- the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX

- CQC Intelligent Monitoring Report dated XX/XX/20XX

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

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The performance information reported in the Quality Report is reliable and accurate

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

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

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

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

By order of the board

NB: sign and date in any colour ink except black

.............................Date...Chairman

............................Date...Chief Executive

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Annex 3 Limited assurance Statement from External Auditors

This will be added in the final version of the report.

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Appendices

Appendix A: Our quality strategy

Our new quality strategy was approved by the trust board at a public meeting in November 2015 and spans all three domains of quality: patient experience, clinical effectiveness and patient safety.

1.1 External context

Three 2013 reports on quality and safety in NHS – the Francis report, Keogh review and the Berwick report – stressed the need for NHS to prioritise patients and quality above all else, and to develop organisational cultures which relentlessly strive for higher quality through continuous improvement and learning.

Continuous improvement, and the leadership and care redesign associated with it, offer a route to higher quality care – often at lower cost – by motivating and empowering front-line staff to explore, test, discover and implement changes which improve quality and efficiency. An increasing number of NHS trusts are discovering that carefully-planned, multi-year efforts to embed continuous improvement into routine practice can deliver sustainably better performance on several dimensions[1]. Success requires this is designed and owned by organisations themselves; it cannot be led from outside.

1.2 Characteristics underpinning cultures of improvement in other organisations

Empirical evidence from NHS trusts supports placing primary emphasis on quality and building capacity in continuous quality improvement. Michael West[2] found that trusts which put into practice an inspirational, quality-focused vision and narrative, and those which deploy continuous learning and quality improvement outperform others on outcomes, patient-experience and staff experience.

Over the past two decades, drawing on experience from UK and internationally, three core characteristics for successful improvement can be identified, as follows (see Figure 1 for more detail):

1. Building will and a sense of purpose, resonant with people's professional values
2. Building alignment and ensuring focus, while enabling staff to focus on their priorities
3. Building capability, in people and in systems.

Crucially, successful organisations have gone beyond an "initiative" or "programme": they align the organisation's overall strategy with making improvement business as usual – governance, reporting, leadership, organisational development and operations. The "programme" to embed improvement as normal business is 5 years minimum, around a robust business case and sustainability plan, harnessing both existing in-house expertise and usually also working with an external partner.

[1] See for example East London NHS FT's QI programme evaluation published October 2015: *Successes and lessons from the first year of ELFT's Quality Improvement Programme*; available at https://elftqualityimprovement.files.wordpress.com/2015/10/elft-qi-programme-evaluation-2015.pdf

[2] NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data (2013), M West et al; available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215455/dh_129656.pdf

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Figure 1. Characteristics of successful quality improvement programmes

Building will and a sense of purpose, resonant with people's professional values

- Framing and communicating an overarching purpose, relevant and inspiring to all staff, in terms patients can understand
- Listening widely to understand staff priorities, opportunities and concerns
- Focusing simultaneously and explicitly on improving staff experience and well-being
- Involving patients and families directly in improvement work
- Celebrating success

Building alignment and ensuring focus, while enabling staff to focus on their priorities

- Ensuring tight alignment between organisational strategy and the improvement programme: e.g., aims, structures, performance management arrangements, related initiatives
- Having sustained, visible and unambiguous senior leadership and board commitment to the work. At every level, improvement is championed by the most credible leaders
- Linking the vision to a small number of organisation-wide priorities while simultaneously encouraging staff to translate these priorities into what matters most their local context
- Adopting a consistent core improvement method, organisation-wide – and using the same method across clinical, clinical support and non-clinical areas

Building capability, in people and in systems

- Building board/senior leader understanding and capability
- Investing in capability-building across the workforce, learning in teams addressing real-work challenges
- Developing internal coaching resource (to support delivery by the operating line)
- Fostering informal learning, and making it "OK to fail" (fail fast and at small-scale, and learn from it)
- Developing data capture, reporting and analytic infrastructure and support.

1.3 The financial case and business rationale for investing in quality and continuous improvement, and the concept of "value"

Better quality must be achieved within increasingly constrained resourcing and growing demand: financial and operational pressures are relentlessly rising. Focus on financial savings and operational performance is essential, but risks negative impact on staff morale and quality. Further, the areas of greatest inefficiency and waste often lie within the clinical processes themselves, and can only be addressed if clinically-led teams are motivated, skilled and supported to address them[3].

A business rationale for investing in quality and continuous improvement does exist (see Appendix 1 for further details). Best available evidence suggests well-executed improvement programmes can yield a financial return of 2 to 10 times their cost of investment[4]. The rationale centres on systematically reducing waste, reducing opportunities for harm and improving process efficiency. Success requires clinical teams themselves to own the realisation of gains and for the organisation to support them. The same methods can be used to address waste in non-clinical areas.

It may be beneficial to bring cost and quality together under the framing of "value"[5]. This emphasises the shared responsibility of everyone working in health care (in whatever role, profession or setting) to maximise the outcomes delivered and patient experience per pound spent. Improvement work can focus on maintaining quality while removing cost, or disproportionately improving quality for resources invested. Over time, we may wish explicitly to frame our quality and improvement work under the banner of "value".

1.4 RFL context

We employ over 10,000 dedicated and talented staff who strive to deliver outstanding results and experience for the 1.6m patients we serve each year. We have made substantial progress in quality and safety outcomes over recent years (for example, in falls, infection, sepsis and patient experience). Our current performance as defined by national metrics and standards is generally good or excellent, with some areas of challenge (such as MRSA and, historically, patient satisfaction and staff turnover/feedback). There is substantial variability of performance in most areas (e.g., by site, ward, over time and across services) which we are working to reduce.

We have a growing reputation as a strong organisation which delivers what it sets out to do. Having achieved FT status, we have focused over 2014 and 15 on effective integration to create "one trust" across multiple sites, investing to develop robust governance and risk management and reporting systems. We have developed and embedded the four WCC values and launched major programmes in safety and staff and patient experience, reinforcing and accelerating work at Divisional level.

This provides the basis on which to move forward and make continuous improvement a core part of RFL's ways of working. Developing a single trust-wide approach to quality improvement is one of our corporate strategic objectives for 2015-16. There is widespread recognition that RFL cannot consistently provide high-quality, efficient care across its services without a new approach to continuous improvement, which unleashes the energies and creativity of front-line staff at scale. Furthermore, a well-embedded, consistent operating model for existing sites is an essential foundation from which to move toward greater scale through our RFL Group aspirations and work as an NHS England Vanguard and through the Enterprise Group.

[3] Swensen, Kaplan et al (2011) Controlling healthcare costs by removing waste, BMJ Qual & Saf
[4] Swensen, Meyer et al (2010) From cottage industry to post-industrial care, NEJM
[5] Porter (2010) What is value in health care, NEJM

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Continuous improvement should be central to delivery against each of our 5 governing objectives, as follows:

Objective	Continuous improvement
1. Excellent outcomes – to be in the top 10% of our peers on outcomes	• Clear focus on continuous improvement of outcomes that matter most
2. Excellent user experience – to be in the top 10% of relevant peers on patient, GP and staff experience	• Equal focus on continuous improvement of patient and staff experience • Link to WCC values
3. Excellent financial performance – to be in the top 10% of relevant peers on financial performance	• Continuous improvement of value (through removal of waste) as the most reliable route to financial health
4. Excellent compliance with our external duties – to meet our external obligations effectively and efficiently	• Applying continuous improvement to the trust's 'must-dos'
5. A strong organisation for the future – to strengthen the organisation for the future	• Raising morale, cohesiveness and enhancing reputation; quality and continuous improvement underpinning recruitment and retention • Contributing to a strong local health economy

Diagnostic on current approach to quality

The iQuasar programme undertaken in 2014-15 offers insight into leadership perceptions regarding quality improvement. Executive and Non-Executive Board members and senior clinical/divisional leads' survey responses suggested that areas for development include:

- Linking staff at all levels who are interested in getting involved with QI with relevant trust expertise and resources
- Linking the learning from different QI projects, and providing staff with opportunity for reflection on QI and integrating QI into educational activities
- Working with patients to identify and address QI priorities.

Additionally, iQuasar highlighted the need for a narrative around quality and improvement, and making QI "business as usual" across the trust, by defining and codifying a methodology that the trust chooses to adopt. Responses also highlighted the need for investment, including in a coordinated improvement function to train and support staff and in data/analytic infrastructure.

Interviews across clinical directors, service line leads and others to inform development of our quality strategy revealed five main themes (set out in greater detail in Appendix 2):

1. There is no widely-understood definition of quality, or a clear narrative to guide services
2. In general, although executives' commitment to quality is acknowledged, the "voltage-drop" into directorates and services is substantial. People aren't clear what is required or expected
3. There is less emphasis on the management and governance of quality vs. operational targets and money. Reporting "by exception" means that what matters most to services is often lost. Delivery is achieved through performance management, rather than by enabling improvement

4. Many change projects and programmes are ongoing, which creates some confusion. More clarity is also needed on what change support is available, and on how best to access and use it
5. Despite substantial investment in overall support to services, creating a "RFL-way" which includes continuous improvement will require addressing substantial gaps in capability and infrastructure.

2. Scope of the quality strategy

Quality for NHS was defined by the 2012 Health and Social Care Act as having 3 basic dimensions: safety, effectiveness and patient experience. While some organisations have chosen one dimension within quality around which to focus their strategy (must usually patient safety) the focus for our quality strategy should encompass all three dimensions of quality: this will allow it to dovetail with and accelerate delivery of the Safety and Patient & Staff Experience strategies, and help re-energise the work on service-specific effectiveness metrics. It will also make the quality strategy directly relevant to the work of each board committee focused on quality. Further, it links the quality strategy to addressing key operational challenges (e.g., those along CQC's responsiveness domain, such as RTT) since these each impact one or more of the three dimensions. It also provides the best platform from which to link quality improvement to quality governance, risk management and audit, and allows broadening to a focus on quality and resource together – i.e., the continuous improvement of value.

3. Building-blocks of our strategy: the PDSA model, capability-focus and getting to scale, measurement, leadership and learning

3.1 The "PDSA" model for improvement

Numerous improvement models are available and can be effective in a wide range of contexts. Each is associated with a set of technical/analytic and behavioural tools. Evidence suggests key to success is less which model is chosen and rather its consistent application and reinforcement over time. The best-known model for improvement both in RFL today and the NHS is the "PDSA Model for Improvement", used by the Institute for Healthcare Improvement (IHI) – see Figure 2. A key benefit of it is its simplicity: "Plan, Do, Study, Act" represents a cycle of designing and testing a change, measuring its impact and reflecting on the result. This discovery and learning cycle is re-run iteratively.

As such it is an extension of audit and evaluation with which clinicians are familiar. The key differences lie in the size of the measurement samples and the linking of cycles together in a way which rapidly delivers improved results. After successful tests under a wide range of conditions, the PDSA cycle is used to hardwire changes into the organisation's infrastructure for sustainability.

The PDSA model will be at the heart of RFL's approach to continuous improvement. The method is powerful since it provides a structured, iterative way for front-line teams to test possible solutions to key challenges in their daily work, and to obtain rapid feedback on these changes' effectiveness, enabling successes to be built on and scaled up and tests which didn't work to be stopped. As such, front line staff discover routes to better performance and sustainability, and have full ownership of the solutions.

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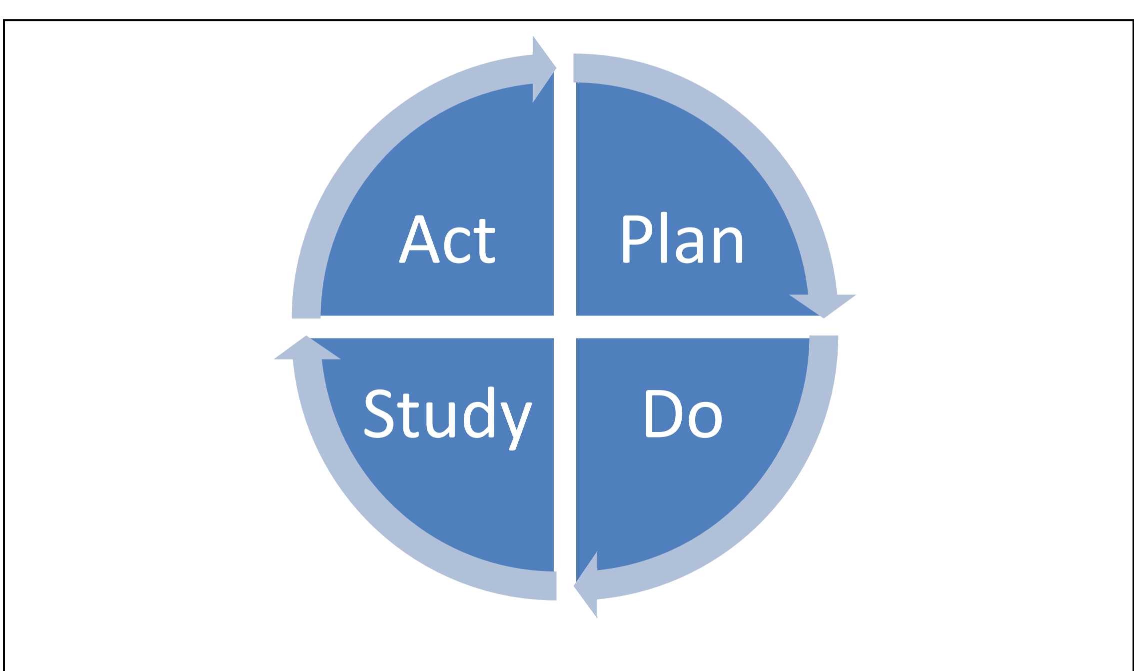
The model is equally applicable to work which spans different departments and multiple services as to work within one service; as such, “improvement” can be used to address complex challenges such as flow and safety. It is also equally applicable to clinical support services and non-clinical services as to clinical services: as such, it offers an unusual opportunity for staff of all backgrounds and departments to learn and deliver together.

Figure 2: The PDSA model for improvement



3.2 A capability-building focus for the strategy, and getting to scale

RFL’s quality strategy should not be about coordinating and resourcing a large portfolio of quality-improvement projects. We aim for the number of these to grow over time, but these will be primarily owned by the operating line. Rather, our quality strategy’s central theme should be **capability-building at scale** which embeds our approach to continuous improvement into staff’s daily work, and which also **supports learning and knowledge transfer** across the organisation. Without staff who have the capability, capacity and motivation to find, sustain and spread improvements we cannot deliver the strategy since today the great majority of staff do not have experience of the science and methodology of improvement.

Consequently a major capability-building exercise over several years is required. We will focus capability-building efforts on equipping staff with a method for systematically driving continuous improvement, and providing support in using that method. This support will include developing coaches and other experts to support teams undertaking improvement. We must ensure that the method is widely applied and adopted across professional groups and services. This applies to non-clinical and clinical support functions just as it does to clinical services. Additionally, senior leadership must have the understanding and skills to lead for improvement**.**

Achieving the coverage required will take several years even with rapid roll-out. Capability-building is needed both for front-line teams and for leaders, to include at minimum:

- Fundamentals of improvement thinking and improvement-centred approaches
- Patients' and families' roles in improvement
- Strategies for developing change ideas
- Systems thinking
- Measurement for improvement, and concepts of variation and reliability
- Flow
- Understanding of human factors
- Study-designs for testing changes
- Coaching and promoting learning
- Spread and scale-up.

These domains will be included in a variety of capability-building formats which we will develop through implementing this strategy. These formats range from introductory learning (for example at induction and as part of mandatory training for all staff) to generate basic awareness, to in-depth learning over time in real teams where learning is paired with application to address important challenges faced by the teams. We also need to tailor, scale-up and spread useful innovation from single contexts to greater scale – potentially trust-wide and beyond. We will deploy an approach to spread and scale which draws on proven methods[6] as we scale-up as rapidly as possible from small local tests of change to implementation at scale (as, for example, the patient safety programme is already doing).

Experience suggests for a trust of 10,000 staff, several hundred (including those in leadership roles) need deep applied knowledge of and commitment to QI to truly embed improvement into routine working. Overall we aim to create a movement for quality across the trust, which a "Quality Champions" concept (see Appendix 3) would support.

Staff will need dedicated time to learn and space to apply learnings in their everyday work. Implementing the strategy will establish trust-wide a common language and standard set of tools for improvement and learning. It is crucial we also establish tight alignment across the different elements of support and major initiatives which exist across the trust today.

3.3 Measurement for improvement, and analytic/information systems support

All improvement work must be underpinned by rigorous time-series measurement, tracking reliability on key inputs/processes and required checks and balances which inform and drive the outcomes we care about. Our measurement approach should enable services to answer the following deceptively simple questions:

1. *Do you know how good you are?* – which requires services to have defined by what metrics they are defining success
2. *Do you know where you stand relative to the best?* – where the relevant peer comparison may be local, national or international, depending on the nature of the service
3. *Do you know where and how much variation exists?* – toward reducing inappropriate variation, whether variation by different site, different teams, times of day or day of week

[6] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement* (2003) IHI Innovation Series white paper, Institute for Healthcare Improvement, Boston (available at www.IHI.org); Massoud MR et al *A Framework for Spread: From Local Improvements to System-Wide Change* (2006). IHI Innovation Series white paper, Institute for Healthcare Improvement, Boston (available at www.IHI.org)

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4. *Do you know your rate of improvement over time?* – often the most important comparison of all, to oneself over time.

To implement the strategy we will need to invest in measurement, and the support for measurement and data management. Planning for this is being embedded into the trust's concurrent IMT strategy review, and two key areas include:

- Systems to capture key data required by teams in a time-efficient way, and to produce time-series data (eg SPC charts) directly to ward/clinic-level which provide the basis for interpreting PDSA cycle measurement
- Measurement and analytic expertise to support teams in their work.

3.4 Leadership for quality improvement

Successfully embedding improvement into daily work requires sustained and strong leadership and reinforcement at all levels, from "Board to Ward". As above (section 1.2), successful improvement efforts are characterised by sustained, visible and unambiguous senior leadership and board commitment to the work, with improvement championed by the most credible leaders at every level. We will need to consider how senior leaders build their own collective and individual capabilities to lead for improvement, and what leadership practices may best support delivery.

3.5 Learning from ourselves, and others

A culture of continuous improvement goes hand-in-hand with continuous learning – for individuals, teams and the whole organisation. Learning from one's own operational experience, and that of others, is a characteristic of excellent organisations, and is (strangely) not consistently present in health care. We will design-in mechanisms to maximise learning across professions, sites, services and divisions. Beyond RFL itself, the Enterprise Group represents an obvious channel for learning (Salford Royal and Northumbria FTs being well-known improvement-focused organisations). Other potential channels include UCLPartners and potentially joining NHS Quest, a national network of FTs focused on collaborative learning and improvement, convened by Salford Royal.

4. Alignment with existing major initiatives and the trust's organising principles

There is much work already underway across RFL to improve quality, efficiency and access. This takes a variety of forms, uses a variety of methods, and is anchored in various locations within the trust. The trust is aiming to streamline its approach to change and maximise synergies between initiatives, including through establishing a Change Board.

On this background it is especially important the quality strategy is executed in a way which builds alignment, reduces complexity and complements existing initiatives and workstreams – creating a "quality" or "improvement" silo would not be helpful. Successful delivery of the quality strategy will enable us to progress faster and more sustainably on existing priorities and daily work rather than charter multiple new initiatives.

To avoid creating additional complexity the quality strategy must be linked to the existing building blocks around which the trust is led and managed. Of three potential options (the trust strapline,

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WCC values and governing objectives), TEC's view was the most logical connection would be via the values. Recognising that the values have traction because they represent the voice of staff, we intend to explore with staff whether we should introduce a 5th value centring on "continually improving"[7].

By focusing the strategy on capability-building for improvement and by ensuring the detail of the strategy and its implementation are co-developed by those leading current, people with existing expertise and representatives of major professional groups, we will minimise the risk of developing something which does not dovetail with other initiatives or fails to meet the needs of front-line staff. Table 1 illustrates some ways in which the quality strategy will reinforce and support existing initiatives.

5. Principles underpinning RFL's quality strategy and tests of success

RFL's quality strategy aims to increase the likelihood that every patient receives the best possible care, in line with the trust's mission and values. We suggest the following **five principles to underpin the quality strategy**:

1. Everyone's primary goal and duty is improvement on things that matter to patients. Patients, families and carers will genuinely and consistently be at the centre of the work
2. We will constantly deploy iterative, reflective cycles of planned changes, linked to measurement over time, led by the multiprofessional teams which serve patients (or other 'customer')
3. We will build capabilities in continuous improvement, build capacity in coaching for improvement and build a learning organisation
4. Our approach will focus on equipping front-line staff to gain greater control of the systems that they work in – this is not about asking staff to work harder. This strategy will not increase the current number of centrally-driven initiatives: rather, it will focus on building capability and capacity better to deliver existing priorities across clinical care, clinical support and non-clinical support services
5. All trust initiatives and strategies (for example, patient safety & patient experience) and service support (for example, leadership/OD, Vision 2020/QIPP, pathway and service redesign, governance and audit) will dovetail and pursue the same goal of quality and continuous improvement. We will use formal mechanisms (such as job planning, recruitment and appraisal, committee and meeting agendas) to reinforce our approach and signal our priorities.

We will build evaluation into our delivery. The success of the strategy will primarily be determined by the number of staff who apply what they have learned to key improvement opportunities in daily work, and by overall staff feedback. While we expect the trust's "hard" quality – and efficiency – metrics to improve over time, these are driven by many internal and external factors. We therefore suggest the following **five tests of success of the strategy** for 2020**:**

- That critical numbers of staff have been trained in and meaningfully use RFL's approach to quality improvement in daily work. For example, at least 400 staff have completed the team-

[7] In current documentation accompanying the values (the "Living our values" Behaviour framework pamphlet), improvement is highlighted as one of three sub-elements under 'Visibly Reassuring': Prioritising safety, Speaking up, and Keep improving.

based, applied learning offer, and there are at least 200 Quality Champions across professions (and that this status is seen by staff as a 'badge of honour')
- That patients and carers are pleasantly surprised by how well their needs and preferences are anticipated and acted on – reflected in increased positive feedback and fewer complaints
- That all staff can articulate the quality metrics most relevant to the context in which they work, and are aware of current performance level and trend
- That staff morale, recruitment and retention rise. Over time, that people choose RFL as a place to work because of its reputation for embedding continuous improvement into routine practice
- That RLF's performance on "hard" system quality metrics and efficiency is exemplary and improving over time: for example, patients report greater satisfaction through better access and find services more responsive to their needs and preferences; staff report greater satisfaction from greater support and enhanced capabilities, reflected in national surveys.

6. Delivery of the strategy and next steps

The level of investment required and delivery plan are in development. Since this strategy represents an essential part of the operating model for RFL Group, we are seeking investment from NHS England through the Vanguard programme.

This is a major undertaking whose development will need at least 5 years trust (or Group)-wide. Our twin aims are: (i) to accelerate delivery of the highest quality, best value care, and best staff experience across RFL group by 2020, and (ii) to embed continuous improvement into daily operations at RFL and to ensure best support to services across RFL group. We plan to accomplish these aims through activities grouped into four themes – (a) building will, (b) creating alignment and deploying infrastructure, (c) building improvement capability, and (d) applying improvement to daily work. Application will be through two main tracks: first, major trust initiatives, including the Patient safety programme, Patient and staff experience programme and Transformation work (Vision2020: Wave1/2, QIPP, service/pathway redesign); second, through local priorities: each service/ward and non-clinical service to work to at least one local QI objective.

Governance: A programme of this strategic importance to the Trust should be sponsored by the Trust Board. Several choices exist for both Board-level and Executive-level reporting. Especially given the nature of the programme, it is important that patients/service users (potentially Governors), staff and non-executive directors are represented in the governance arrangements.

Structure: A core support team will be required, whose size and composition will depend in part on our ability to align across existing functions and initiatives, and with the operating line. We envisage internal secondments into this team for clinical and other staff not only to maximise efficiency but also to emphasise the relevance of improvement to mainstream daily work across professions.

We have set up a **working group** chaired by the Director of Quality, which includes membership from:

- Transformation (incl. Vision2020, QIPP, service and pathway redesign) and OD/LD
- Major quality initiatives already underway: safety and patient/staff experience
- Clinical audit and risk
- IMT and analytic services, and other key functions incl. finance and internal communications
- Professional education
- Medicine and nursing
- Operations: Divisions and service-lines.

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This approach will ensure that what we develop complements existing initiatives and functions, harnesses existing improvement expertise, and builds-in the "customer perspective" from medicine, nursing and operations. It also enables additional work to be done pending staffing the core support team.

Key activities for the next 6 months include:

- Listening to staff and patient priorities, and developing and deploying our quality narrative
- Agreeing the detailed components of our model, including links to existing functions and initiatives
- Determining the level of investment required, securing funding, and developing a full implementation plan
- Staffing the core support team
- Building an initial faculty and determining its capability-baseline and gaps
- Selecting a strategic partner for delivery.

7. Conclusion

An increasing number of leading NHS organisations are investing to create their "way" of continuous improvement. Investing over the coming five years to build our "way" for quality, centred on continuous improvement and learning will:

- Place relentless focus across the trust on the critical challenge of: "Are we improving on things that matter most to patients and staff?"
- Put patients and families ever-more at the heart of how we design and deliver care
- Provide the platform from which to deliver the highest possible quality of care, while also enabling RFL to meet ever-more challenging financial and operational hurdles. The result will be higher value care – delivered by front line staff through continuous removal of waste rather than cost-cutting
- Establish an operating model with greater ownership for delivery by front-line teams, supported by central structures and leadership
- Unleash and motivate staff of all types and in all departments, increasing RFL's attractiveness as a place to work
- Serve as an important enabler of successful integration to create "one organisation" across multiple sites, and provide a strong base to underpin further increases in scale through a Group model, as well as working with other organisations locally at whole system/pathway level.

TABLE 1: **How the quality strategy will reinforce and support existing initiatives**

Initiative (examples, not exhaustive)	How delivery of the quality strategy will support the initiative
Patient safety programme, and Patient/Staff experience programme	• Accelerate spread - & de facto expand capacity - by embedding the core methodology in front line staff, creating "pull" and capability for delivery
Vision 2020: e.g., Flow and discharge, Outpatients, Clinical Services Strategies	• Add to skillset of change agents and front-line staff • Increase ownership of front-line staff in change process – enabling functional teams to work on more 'fertile' ground; Create front-line "pull" and greater co-development with service lines
Service-line leadership programme (Bohmer programme)	• Complement leadership development and service operations work with front-line capabilities and coaching support to bring about change
Workforce	• Add important new skills into routine skillset across staff groups and increase attractiveness of RFL as a place to work; develop coaches drawn from various professions
24/7 patient	• Equip front-line teams with new methods and skills to find and implement practical solutions
IMT/analytics strategy	• Increase IMT/analytical experts' measurement-for-improvement capabilities (and skills/demands from services) • Focus analytic/data systems further on front-line team's requirements
RFL Group model	• Contribute to the more stable, codified operating base on which greater scale can be built (and which is championed by clinicians) • Develop a service-line/offer in QI, analytics and capability-building which RFL makes available to organisations joining the RFL Group.

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APPENDIX 1: **Financial case and business rationale for investing in quality and continuous improvement**

Providers exist to provide high quality care, and so investing in quality and continuous improvement can be seen purely as an ethical and practical imperative. Happily, this is there is increasing evidence these investments *also* make sound business sense, delivering measurable return on investment and showing how the disciplined application of continuous improvement techniques can systematically remove waste.

Greatest waste in healthcare is typically found within the clinical processes themselves, and can only be addressed if clinically-led teams are motivated, skilled and supported to address it[8]. High-quality, patient-centred care happens when processes have minimal waste and high reliability: removing waste reduces cost; high reliability means less frustration and wasted effort for staff, thereby improving staff satisfaction. This in turn has direct impact on outcomes and financial performance.

The best-documented evidence to date comes from USA where wasted spend has been estimated at 14-40% of total spend[9]. Reducing waste can be categorised in two main areas: (i) preventable harm and (ii) process inefficiency. Systematic re-engineering of care to achieve reliability against agreed standards has been shown across multiple US organisations to lead to sustained operating cost savings measured in millions of dollars per year, often with the additional benefit of avoiding the need for capital purchases or investments, revenue benefits, and better patient outcomes and staff/patient experience[10]:

(i) Preventable harm: Taking healthcare associated infections (HCAIs) as an example: Mayo clinic reduced central line infection rate by 50% from 2009-12, and calculate a $30k margin improvement per patient when complications are avoided (even allowing for additional revenue from treating complications). They also calculate that each bed is 3-4 times more productive without complications. Similarly, Cincinnati Childrens' hospital found work which reduced infections by 60% over two years also saved $11m in cost and released capacity equivalent to 5 beds due to reduced length of stay. Each bed generated $1m additional revenue/year when complications were avoided.

(ii) Process inefficiency: Various studies estimate that front-line staff spend around one-third of their clinical time and effort on non-value-adding activities (such as locating missing items, waiting, addressing defects and recovering errors)[11]. This reduces staff morale and can be addressed by applying improvement techniques. Work at Mayo Clinic to standardise hip and knee replacements across Mayo's 22 hospitals led to annualised cost savings of over $2.5m, driven by 40% reduced use of blood products, 30% reduction in LoS, 10% reduction in readmissions. Many of these also represent tangible improvements in quality for patients.

Overall, Mayo clinic calculate a typical 5:1 to 10:1 return from investments in quality improvement. Other US organisations report at least a 2:1 return[12]. Mayo has developed a structured tool with which to track financial return which distinguishes between "hard" financial impact (characterised by direct, short-term and quantifiable impact on cash flow) and "soft" impact (which may increase capacity, raise productivity without reductions in staffing, avoid future costs, and lower malpractice costs).

[8] Swensen, Kaplan et al (2011) Controlling healthcare costs by removing waste, BMJ Qual & Saf
[9] Swensen, Meyer et al (2010) From cottage industry to post-industrial care, NEJM
[10] Swensen, Dilling et al (2013) The Business case for health-care quality improvement, J. Patient Safety
[11] Spear & Schmidhofer (2005) Ambiguity and workarounds as contributors to medical error, Ann Internal Med
[12] 2012 Institute of Medicine discussion paper "A CEO Checklist for High-Value Health Care". This contains numerous examples and is authored jointly by CEOs of Cincinnati Childrens' Hospital, Cleveland Clinic, Denver Health, Geisinger, HCA, InterMountain, Kaiser Permanente, Partners Health Care, ThedaCare & Virginia Mason

The business case in NHS is less well documented, but evidence is emerging – taking 3 examples:

- Sheffield Teaching Hospital's Flow, Cost and Quality programme realised £3.2m annual cost saving in care of the elderly. Reduced length of stay enabled closure of two wards[13]
- Salford Royal estimate their safety work has saved £5m in cost & 25,000 bed days/year[14]
- Locally, East London FT have found work to reduce violence on one ward has generated annualised staffing cost savings of over £70,000 from reduced staff turnover and absenteeism[15].

Success is not guaranteed of course – many quality programmes have failed both on quality and return on investment. But as the examples above show, organisations are finding that a 'virtuous circle' of improvement in cost and quality can be realised. The same methods can be used in work on both cost and quality, and by teams working in non-clinical services.

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[13] Health Foundation newsletter, September 2014: available at http://www.health.org.uk/newsletter/eight-case-studies-show-you-can-improve-quality-while-also-saving-money
[14] HSJ The Case for Patient Safety, 2015
[15] ELFT verbal communication

APPENDIX 2: Messages from the organisation to inform RFL's Quality Strategy

To inform development of RFL's Quality Strategy, conversations were undertaken with clinical directors, divisional leadership, AMDs and others regarding current practices and how delivery could be better supported.

Despite substantial pressures, there is a sense that much is going right in the trust and a sense of optimism and excitement regarding opportunities ahead – people are restless to do better. Senior leadership is largely seen as authentic, focused on maximising quality for patients, and trying to be helpful to staff – wanting the same things that patients and staff care about. People throughout the trust are highly motivated to improve quality, balanced with to concern that capacity and focus may fall short when competing priorities bite. There is little appetite for "another initiative".

Five key messages emerged, as follows:

- **There is no widely-understood definition of quality, or a clear narrative to guide services**
    - People's definition of quality (and of "improvement") vary
    - There is clarity on and strong support for the WCC values – widely seen as translating positively into daily attitudes and behaviours. However, the five governing objectives do not provide similar clarity or inspiration – they are seen as "managerial"
    - A narrative on quality which people own and can interpret locally is lacking. Below the headline of "top 10%", people are not clear what the Trust's quality priorities are, or how their actions contribute to delivering against the Trust's priorities. We lack the clarity and immediacy found at Salford Royal[16]: "We aim to be the safest organisation in the NHS…we will continue relentlessly to pursue giving our patients, families and carers Safe, Clean and Personal care every time".

- **In general, although execs' commitment to quality is acknowledged, the "voltage-drop" into directorates and services is substantial. People aren't clear what is required or expected**
    - There is variable ownership regarding quality measurement and reporting beyond external requirements. The most advanced services typically have particularly effective leader(s) and external goals or reporting – which create focus, profile and urgency
    - There is variable level of ownership on national audits. Some see these as aligned with their aims, others as an unhelpful burden and distraction from what matters most to patients
    - There is variable understanding of what skills and actions are required to drive quality, and the capability/capacity requirements
    - Accountabilities and expectations are unclear and overlapping: e.g., division vs. service, and roles within each (nurse, clinician, manager).

- **There is less emphasis on the management and governance of quality vs. operational targets and money. Reporting "by exception" means that what matters most to services is often lost. Delivery is achieved through performance management, rather than by enabling improvement**
    - Overall, more is reported and more time spent discussing operations and finance (e.g., in divisional committees) than quality, so the subtext is: "these really matter the most"
    - Quality metrics which are not externally-mandated can appear neglected. For services with advanced local ownership and ambition, this can be frustrating: these locally-determined quality metrics often better capture what matters most to patients

[16] Salford Royal Quality Improvement Strategy, 2015-2018

- Positive outlier results only variably reach senior leaders'/governance attention: "If it's not externally mandated, it's not an exception, so however good it is, it doesn't get up the chain"
- Features of performance management are more prominent than those of continuous improvement. Planned tests of change and reflection, encouraging local experimentation, understanding variation and exchange of learning are not prominent in the current approach. (There are a few notable exceptions to this, for example the "Sepsis 6" work)
- There is generally high appetite to learn more effectively from units' own experience, and from others – people want mechanisms for transferring learnings within/across divisions and services.

- **Many change projects and programmes are ongoing, which creates confusion. More clarity is also needed on what change support is available, and on how best to access and use it**
    - Programmes/initiatives underway include: QIPP, service redesign, pathway work, Wave1, PMO/integration; safety strategy and patient experience strategy
    - Both the people working in these functions, and their "customers" in the services are confused by the range and scale of activities (though customers are positive about the people providing support)
        - Services are not clear where to go for support, or "what we use when". There is demand for "how-to" guides and a single 'key account' interface (offering guidance on what to access and how)
        - People based in functional support teams equally want to understand better what others do
    - It is not clear on what basis support is allocated/prioritised: "Does it go to those who shout the loudest?"
    - It is not clear how these functions do (or should) dovetail with OD/Leadership and professional education.

- **Despite substantial investment in overall support to services, creating a "RFL-way" which includes continuous improvement will require addressing substantial gaps in capability and infrastructure**
    - Most trust capacity for change is currently in larger-scale change – transformation and care redesign, rather than continuous improvement (more incremental change). Pockets of continuous improvement expertise do exist–e.g., PARRT team frequently cited—but these are often localised and/or not recognised for the methods they use. These provide a basis from which to build
    - Capability gaps include: training in and applying a model for improvement (at various levels of seniority); developing and deploying experts/trainers in improvement; coaching skills; giving and receiving feedback; measurement and analytics
    - Gaps in infrastructure centre on data and analytics, and include:
        - Systems to capture and report locally-relevant quality metrics
        - Measurement for improvement (currently people need to purchase their own software)
        - Analytic capacity to support services' work.

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APPENDIX 3: **The "Quality Champions" concept**

There is substantial will and motivation across staff groups to improve care and to gain more control over the systems in which they work. To build skills and participation rapidly and at scale so that people apply improvement to their real-work challenges, we will establish a "Quality Champions" programme. This will be designed to harness and generate energy and excitement among those who get involved in improvement. Drawing on social movement and large scale change theory, design principles include:

- Open to all staff members across all grades and professions, and potentially patients and carers
- People can focus their work on any area within the broad umbrella of the quality strategy. Staff will be encouraged to work in multiprofessional teams and to involve patients wherever possible
- Personal commitment is key – participants must be self-nominating
- People will gain tiered accreditation – for example, "bronze" to "gold" as follows:
    - *Bronze*: with a relatively low bar for entry, such as participation in introductory training and application to a challenge relevant to the person's work area
    - *Silver*: with some evidence of sustained commitment over time and implementation of successful improvement work within the trust
    - *Gold*: with substantial evidence of sustained commitment over time and driving successful improvement work in multiple settings across the trust, and supporting others to improve.

Carefully-chosen features will enhance the visibility & cachet of the programme – for example:

- Active sponsorship from CEO/executive and divisional leadership – e.g., regular opportunities to present work and receive feedback
- Creative internal communications – building awareness, sharing learnings and celebrating successes
- Visible markers to identify Quality Champions – e.g., modified ID badges displaying the tier achieved.

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Appendix B.

Details of specific actions undertaken as the result of a national clinical audit

National clinical audit	Actions to improve quality
NNAP Audit: In November 2015, the National Neonatal Audit programme 2015 report covering 2014 clinical data was published.	The NNAP data for Royal Free Hospital neonatal unit to be reviewed to check the validity of the audit results with the relevant stakeholders and an action plan to be developed to address any identified gaps/deficits.
The National Diabetes (core) adults	The Diabetes team are working with the database provider 'Diamond' to improve data collection for the 2016 audit.
The National Audit of Diabetes Inpatients (NaDIA) 2013	The NaDIA report for the 2015 audit has been recently published and currently under review. Improvements noted for foot assessments
The National Prostrate Cancer audit 2014-15 has published its Organisational report and First Year Annual Report.	Full compliance recorded against audit report findings. Actions to improve data entry for performance status and to consider increasing joint clinics to improve patient access, as recommended by NICE.
BAUS Audit data by individual surgeon	Reflecting the overall figures for the centre there were no individual outliers for the safety parameters.
Safeguarding- Section 11 Children Act Audits completed for Enfield, Barnet and Camden Safeguarding Children Boards.	On-going monitoring against section 11 continues to be led by the LSCB. The trust is compliant with section 11 of the Children Act. Most recent Section 11 audit completed and returned to BSCB 19.1.2016 with actions to improve effectiveness where identified.
Benchmark of recommendations from MBRRACE-UK 2015 Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enq Maternity services	Plans are in place with our maternity service in taking this forward.
Benchmark of recommendations from MBRRACE-UK 2015 Perinatal Confidential Enquiry Term, singleton, normally-formed, antepartum stillbirth.	The Maternity services benched marked itself against the report's recommendations and gaps were identified across the sites in Maternity and Paediatrics. A detailed action plan is in place.

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National clinical audit	Actions to improve quality
The National Oesophago-cancer audit report published in December 2015	The NOGCA report has shown a deficit in case ascertainment. An amber for case ascertainment (71-80% range) against expected HSCIC HES-based estimate. However, the HES data has been reported to be out of date. The deficit has been raised with the clinical area for feedback.
Rheumatoid and Early Inflammatory Arthritis report (1st cohort) published Jan 2016.	There have been issues with resource for recruitment and data entry at both RFH and BH, achieving only 6 at RFH and 24 at BH. The action plan includes a business case for an additional CNS, to improve patient flow into EIA clinics, patient education and assistance with audit.
Patient Report Outcome Measures (PROMS):	Actions to support this will include: • Obtaining data of actual number of procedures undertaken to compare with figures • Amending process at Barnet Hospital and Chase Farm Hospital for all submissions to come through governance team • Reviewing where pre-operative questionnaires are completed
CQC Maternity Survey- In December 2015, the CQC Maternity Survey was published.	The following actions are to be put in place: • The promotion of normality and the range of choice for women with regard to maternal positions in labour. • The promotion of the full range of communication strategies/media including the use of interpreting/translation services to facilitate women's understanding. • To ensure women receive consistent support and encouragement for infant feeding by promoting staff awareness via departmental meetings. • The Maternity services are working toward UNICEF Level 3 accreditation with an assessment due in April 2016.
Trauma Audit Research Network	Areas in the lowest quartiles for improvement: The quality of data submission was 94.6%.
National BTS COPD 2014 Audit	Improving referral for Pulmonary Rehabilitation-11% of patients are not being assessed for PR (better than the 44% national figure) but can be improved. This demands access to patients who are short-stay, especially at weekends, who do not see a member of the team. Again, the Camden process will consider this. Imperative to retain a PR class at RFH to facilitate this.

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Appendix C

Details of specific actions undertaken as the result of a local clinical audit

Local clinical audit	Actions to improve quality
Audit on Pain Management on the wards	Recommendations include; use of Abbey pain scale, implementation of verbal rating scale for cognitively intact, presentation to ED, meeting with ward managers to discuss.
To compare local practice to hospital guidelines for the need for thromboprophylaxis	Actions taken since have included: Consultants reminding junior staff, liaising with Pharmacy/Thrombophilia: Drug chart VTE section to be placed next to Tinzaparin prescribing section, and review dates to be placed within VTE prescription section.
NICE IV Fluids guidelines compliance audit (CG174)	Audit showed high compliance with some standards (prescription, rate, volume) but lower compliance with other standards (fluid management plan, fluid restriction, appropriate re-assessment). We have used these findings to improve fluid prescribing section of drug chart in conjunction with Pharmacy, and to design teaching, with plans to re-audit after new pan-RFH drug chart is introduced (currently expected June 2015).
Improving patient experience of cannulation/phlebotomy using USS guidance	To improve the technical ability of junior doctors in venepunture and cannulation by utilising ultrasound guided techniques, subsequently improving patient experience.
Use of PET in the investigation of paraneoplastic neurological syndromes.	Local guidelines formulated for more judicial use of investigations including CT and PET imaging in suspected paraneoplastic disease.
ITU Audit: Delirium	Actions include: • ITU staff educated in the importance of assessing delirium using CAM-ICU • Delirium levels to be re-audited in 2016 • Including auditing of how often delirium assessments are carried out.
Intensive Care Unit NG position testing policy	Actions include: • Improve supply/availability of stickers • New staff to be made aware of sticker in induction • Original length and current length to be recorded daily to ensure constant comparison

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Appendix D: Glossary of definitions and terms used within the report

Five steps to safer surgery

Steps	Timings of intervention	What is discussed at this step
1.Briefing	Before list of each patient (if different staff for each patient e.g. emergency list)	Introduction of team/individual roles. List orde . Concerns relating to equipment/surgery. Anaesthesia.
2. Sign in	Before induction of anaesthesia	confirm patient/procedure/consent form Allergies. Airway issues. Anticipated blood loss. Machine/ medication check.
3. Timeout (stop moment)	Before the start of surgery Team member introduction. Verbal Confirmation of patient Information. Surgical/anaesthetic/nursing issues. Surgical site infection bundle. Thromboprophylaxis. Imagining available.	In practice most of this information is discussed before, so this is used as a final check. Surgeons may use this opportunity to check that antibiotics prophylaxis has been administered.
4. Sign out	Before staff leave theatre	**Confirmation of recording of procedure:** Instruments, swabs and sharps correct Specimens correctly labelled. Equipment issues addressed. Post-operative management discussed and handed over.
5. Debriefing	At the end of the list	Evaluate list Learn from incidents. Remedy problems, e.g. equipment failure. Can be used to discuss five – step process.

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Term	Explanation
Care Quality Commission (CQC)	The independent regulator of all health and social care services in England.
Clostridium difficile	A type of bacterial infection that can affect the digestive system
CQUIN – Commissioning for Quality and Innovation	CQUIN – Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work.
Multi-Disciplinary Team (MDT)	A team consisting of staff from various professional groups i.e. Nurses, therapist, doctors etc.
NHS NCL-	NHS- North Central London Clinical Network
NICE- National Institute of Clinical Excellence	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
PEWS - Paediatric Early Warning Score	A scoring system allocated to a patient's (child) physiological measurement. There are six simple physiological parameters which are: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
SBAR- Situation, Background, Assessment, Recommendation	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.
Summary Hospital-level Mortality Indicator (SHMI)	The SHMI is an indicator which reports on mortality at Trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
University College London Partners (UCLP)	UCLP is organised around a partnership approach: developing solutions with a wide range of partners spanning universities, NHS Trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).
Venous Thromboembolism (VTE)	A blood clot that occurs in the vein

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Appendix 4 – Barnet Health Overview and Scrutiny Committee Minute Extract from the meeting on 11 May 2015

1. NHS TRUST QUALITY ACCOUNTS 2014-15 (Agenda Item 7):

Central London Community Healthcare NHS Trust:

The Committee scrutinised the Central London Community Healthcare NHS Trust Quality Account 2014/15 and wish to put on record the following comments:

- The Committee noted that the Trust had undertaken their external Monitor Quality Governance Assurance Framework (QGAF) assessment in September 2014 as part of the application for Foundation Trust status. The Committee was pleased to note that the Trust was required to achieve a score of 3.5 in the assessment and actually achieved a score of 3.0. The Committee commented that it would be helpful for the Trust to explain within the Quality Account that a score of 3.0 was actually better than a score of 3.5.

However:

- The Committee felt it would be beneficial to include maps within the final draft of the Quality Account.
- The Committee felt that given that the Trust had received 44 complaints in 2012/13 regarding communication / staff attitude, which reduced to 29 complaints for 2014/15, that an objective of a 10% reduction in complaints of this nature was not ambitious enough.
- The Committee noted the objective in relation to the Quality Strategy Campaign – Preventing Harm - which aimed to ensure that 95% of incidents will be reviewed by the handler within 7 days, and 100% within 14 days. The Committee commented that this target should be made more ambitious.
- The Committee noted that the target of training 80% of staff to be able to give smoking cessation education was an NHS target and suggested that this should be made clearer.
- The Committee noted the current goals for the Trust's participation in research for 2014/15 and suggested that completion dates for each research goal should be included.
- The Committee commented that it would be helpful to include the actions that the Trust had taken in response to the patient story and to include that within the Quality Accounts.
- The Committee considered the Trust's performance in relation to Incident Reporting and expressed concern that severe harm cases were "CLCH attributable grade 3 and 4 pressure ulcers". The Committee was pleased to note that, whilst pressures ulcers were a problem for the Trust, the Trust had a task force in place to address the issue.
- The Committee noted that the Trust had included milestones in last year's Quality Accounts and noted that this was an effective way to draw attention as to whether they were being achieved and to provide an explanation if not. The Committee suggested that milestones be included in next year's Quality Account.

Following consideration of the Quality Account, the Committee also requested that the Trust provide the Committee with the following:

1. Information on the services that CLCH provide within Barnet

2. Information as to what would happen to people requiring care at weekends, as set out in the "Patient Story – Continuing Care Team"

Royal Free London NHS Foundation Trust:

The Committee scrutinised the Royal Free London NHS Foundation Trust Quality Account 2014/15 and wish to put on record the following comments:

- The Committee noted that it had been an exceptionally busy year for the Trust, and wished to congratulate the Trust in taking a successful lead role in the UK management and treatment of the Ebola virus.
- The Committee congratulated the Trust on successfully combining three hospitals and 10,000 staff as a result of the acquisition of the Barnet and Chase Farm Hospitals NHS Trust and highlighted the role that staff played in achieving this success.
- The Committee welcomed the news that Enfield Council had given Planning Permission for the redevelopment of Chase Farm Hospital.
- The Committee welcomed the work done in relation to falls and, in particular, to setting the following milestones:-
  1. Identifying a falls Champion in each clinical service line across all sites.
  2. Introducing a Falls Screening Tool and Falls Prevention Plan by Division across all sites.
  3. Continuing staff education and development on falls prevention.
- The Committee welcomed the fact that falls had been reduced by 25% but requested that the actual figure for the number of falls be included in the final draft of the Quality Account.

However:

- Whilst the Committee welcomed the fact that a Patient Information Manager post had been created, the Committee expressed concern that, despite three recruitment campaigns, the Trust had not been successful in making an appointment.
- The Committee expressed concern that the most recently published report from the National Inpatient Diabetes Audit demonstrated that whilst 78% of patients were always, or almost always, able to choose a suitable meal at the Chase Farm site, only 64% of patients had reported that they were able to do so at the Hampstead Site. The Committee was also concerned that just 62% of patients reported that meals were always, or almost always, provided at a suitable time at Royal Free Hampstead, compared to 80% at Chase Farm.
- The Committee expressed concern in relation to performance for patients with diabetes receiving a documented foot risk assessment within 24 hours to assess the risk of developing foot disease. The Committee noted that whilst Chase Farm had improved the number of patients undertaking a foot risk assessment from 25.6% to 41.9% (a 63% increase) between the two audit periods, the performance at the Royal Free Hospital site had deteriorated from 24.2% to 6.5% (a 73% decrease). The Committee also noted that the Trust has made the improvement in the use of foot risk assessment a priority for next year.

- The Committee welcomed improvements in medication management for diabetes at both the Hampstead and Chase Farm sites but again expressed concern that the National Diabetes Inpatient Audit Report reported that, in 2014, the Royal Free site reported errors in medication management of 27.5%, whereas across England, Trusts reported an average of 22.3% errors in diabetes medication management.
- The Committee noted that whilst ward movement can be more complex at the Royal Free Hospital, the number of specialist units within the Hospital meant that a high proportion of patients with diabetes were treated on a variety of wards. On this basis, the Committee felt that further attention should be given to diabetes and the management of foot assessments, meal appropriateness and timeliness and medicine management.
- The Committee expressed concern that in 2014 a local audit identified that 30% of discharge summaries contained some incorrect information regarding the patient's medication list. The Committee noted that the Trust was undertaking work to address the issue.
- The Committee expressed concern about the figures for MRSA being five cases in total, one at the Royal Free and four at Barnet and Chase Farm.
- The Committee noted that the Royal Free had a very significant reduction in C. Diff. compared with the previous year, whilst the number of cases at Barnet and Chase had increased.
- The Committee welcomed the fact that the Trust has asked for an independent review to take place by a national expert on infection control processes.
- The Committee commented that the Key Quality Objectives for 2015/16 were inconsistent in the way that they were written and suggested that it would be helpful to set more specific targets within each objective in next year's Quality Account.
- The Committee suggested that the phrase *"deterioration of the unborn baby to 2, between 01/01/15 and 31/03/18"* be changed.
- The Committee expressed concern that staff working in hospitals at the Trust were not screened for MRSA.
- The Committee expressed concern that the Quality Account highlighted that the Acute Stroke Unit at Barnet had admitted an unexpectedly high number of patients. The Committee welcomed the fact that the Trust was investigating why some of these patients had not been referred to the relevant Hyper Acute Stroke Unit and would be working with external partners to ensure patients were referred to the appropriate unit in the first instance. The Committee also noted that the Sentinel Stroke National Audit had applied many of the standards applicable to Hyper Acute Stroke Units to the Acute Stroke Unit at Barnet and that the Trust believes the deterioration in their performance reflects these inappropriate standards and incorrect referral patterns for these patients.
- The Committee expressed disappointment that they had raised a number of issues when they had considered the 2013/14 Quality Accounts which had not been specifically referred to when the 2014/15 Quality Accounts had been drawn up (including the issues of staff feeling bullied, stressed or discriminated against).
- The Committee expressed concern that there was a lack of information about complaints and no analysis of complaints, which they would have liked to have seen within the report.

- The Committee noted the position of the Trust in comparison to other teaching hospitals in England regarding the percentage of last minute cancellations. The Committee commented that last minute cancellations contributed adversely to the patient experience. Members requested that the actual number of cancellations was shown, rather than just the percentage.
- The Committee noted that the performance against the “Friends and Family Test” was slightly down from last year and that they would hope to see an improvement next year.
- The Committee commented that car parking was an extremely important part of the patient experience. The Committee noted that the Chairman had written to the Chief Executive of the Trust in November 2014 expressing the Committee’s concerns about the new automated parking system at Barnet Hospital. The concerns included whether disabled badge holders were aware that they had to register their number plate at reception in order to park in the hospital car park and also whether the signposts were clear and also at an appropriate height. The Committee expressed their dissatisfaction that, despite being informed that these concerns would be rectified by the end of December 2014, the work was still outstanding.

Following consideration of the Quality Account, the Committee also requested that the Trust provide available data for Barnet and Chase Farm Hospital on the 62 day wait target for cancer diagnosis and for the Trust to confirm if the “Forget Me Not” scheme for dementia is used at Barnet Hospital.

<u>North London Hospice:</u>

The Committee scrutinised the North London Hospice Quality Account 2014/15 and wish to put on record the following comments:

- The Committee commended the positive impact of the “Living Room Project” on the experience of patients.
- The Committee welcomed the work that had been done to develop the garden, which has improved patient experience and suggested that this should be included within the Quality Account. The Committee also complimented the bedrooms that looked out onto the gardens.
- The Committee welcomed the decrease in the number of falls at the Hospice.
- The Committee noted that the hospice now had 18 bedrooms, compared to 17 last year and welcomed the refurbishments that had been made such as new hard floors which allow for a faster turnaround of rooms.
- The Committee commended the success of the “Fund a Bed” campaign which had provided both new beds and new linen.
- The Committee noted that the community teams cared for a total of 1299 patients in their own homes and welcomed the fact that 59% of these patients were supported to die at home where this was their preferred place of care.
- The Committee were pleased to note that a new caterer who also provides meals for other hospices was now being used by the North London Hospice. The Committee commented that the caterer had experience in producing meals suitable for the client group and welcomed the increased menu now being offered.
- The Committee noted that this year, the Hospice had joined a newly formed partnership to provide specialist palliative care services to people living in Haringey and that as part of this, the Hospice now employ the Haringey Community Specialist Palliative Care Team and provide a triage service for referrals. The Committee

welcomed the fact that the North London Hospice's education department has trained 223 staff of external organisations including Care Homes, Community Nursing Services and trainee Doctors. The Committee was pleased to note that this year it has provided new training in communications skills and as part of Hospice's Dementia Care Project, has delivered dementia training to 83 staff.

However:

- The Committee commented that they would like to see further benchmarking data in the final draft of the Quality Account, especially in relation to pressure sores and falls.
- The Committee expressed concern at the results of the hand washing audit, which was recorded at a self-monitoring compliance rate of 77% at the Enfield site. The Committee welcomed the Hospice's intention to improve upon the statistic. The Committee noted that hand washing compliance was better at the Finchley site.
- The Committee expressed concern at the high cost of an emergency Out of Hours GP home visit which costs approximately £500 and is provided by BarnDoc.
- The Committee suggested that the Quality Account should be consistent in the portrayal of statistics through percentages and raw figures.
- The Committee welcomed the fact that less grade 3 or 4 pressure ulcers were reported in 2014/15 compared to 2013-14, but commented that it would be helpful to have further benchmarking information on pressure sores contained within the Quality Account.

RESOLVED that:-

1) **That the above mentioned comments by the Committee be noted by the North London Hospice and individual Trusts and incorporated into the final versions of their Quality Accounts for 2014/15.**
2) **The requests for information as set out above be provided to the Committee.**

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Appendix 5 – Mid Year Quality Account Reviews – Minute Extract from Committee Meeting in December 2015.

8 **NHS TRUST QUALITY ACCOUNTS 2014/15 - MID YEAR REVIEW (Agenda Item 8):**

The Chairman introduced the report and noted that, following the consideration of various Quality Accounts for 2014-15 in May, the Committee had asked to be provided with an update from each Trust to outline the progress that had been made since then.

North London Hospice:

The Chairman invited Fran Deane, Director of Clinical Services at North London Hospice, to the table.

Ms. Deane commented that the report aimed to provide an overview of how the Hospice had responded to the comments made by the Committee during their formal consideration of the 2014-15 Quality Accounts. Ms. Deane noted that one of the major points raised in the report was that the Hospice had needed to amend the Clinical Effectiveness Priority for Improvement. The Committee noted that the Hospice had originally intended to undertake a scoping exercise in order to map the local services that currently exist within the London Boroughs of Barnet, Enfield and Haringey for those living with and beyond chronic illness. The Committee noted that the postholder who was due to lead on the project had left the organisation and a replacement member of staff could not be identified to undertake the necessary scoping within the timescales required. A Member questioned what the Hospice hoped would come out of the scoping exercise. Ms. Deane advised the Committee that the purpose of the scope was to understand the needs of patients living with a long term condition in the three Boroughs and to understand how the Hospice could support the needs of these patients. The Committee noted that the Hospice had had ideas about how best to provide that support but that they wanted them grounded in factual information.

A Member reiterated a concern they had expressed in May regarding the £500 callout charge for a GP from BarnDoc. Ms. Dean informed the Committee that BarnDoc hold a supply of controlled drugs and therefore they had to use this.

The Chairman questioned if the repeat hand washing audits outlined in the report had taken place at both of the Hospice's sites. Ms. Deane informed the Committee that the Finchley audit had taken place and they were waiting for the results and that the Enfield site was yet to be completed.

The Chairman commented that she had recently attended an event run by the North London Hospice which was attended by day patients, relatives and friends. The Chairman expressed her thanks to the North London Hospice for the work that they do.

Royal Free London NHS Foundation Trust:

The Chairman invited Mr Ian Mitchell, Deputy Medical Director at the Royal Free London NHS Foundation Trust, to the table to introduce the report.

Mr. Mitchell commented that the report that had been provided focussed on the areas that the Committee had expressed concern over, and provided an update containing the following points:

<u>Falls:</u>

- Between April 2014 and March 2015 1,505 falls were recorded within the Trust, 24% of which gave rise to some degree of harm. The Trust has a goal to reduce falls by 25% as recorded on their Datix system by 2018.
- A trust wide falls working group with root cause analysis and risk factors has been convened. There would also be a "Falls Champion" in each service line.
- A Falls screening tool and prevention plan is being drafted
- Staff were educated to prevent falls.
- Learning processes from incidents is ongoing.
- Falls awareness events were being planned and undertaken.
- A National falls audit is being undertaken.
- Expert training is being undertaken.
- Scoping into community setting is being undertaken.
- Pilot wards identified.

<u>Diabetes:</u>

The Committee were informed that the treatment of diabetes across the Trust forms a major area of the patient safety programme. Within the Royal Free Trust 20-25% of patients have diabetes mellitus (DM) against a national average of 10%.

The number of bed days for patients with a diagnosis of diabetes is 76,210 relating to 8,974 admissions of patients with diabetes as a co-morbidity and 498 admissions with diabetic emergency problems.

Mr. Mitchell reported that the common errors noted in relation to Diabetes care across the UK were:

- Insulin prescription errors/delivery errors

- Failure to recognise diabetic ketoacidosis (DKA)

- Lack of recognition of hyper/hypo glycaemia.

The Committee noted that the Royal Free's base line audit showed:

- High numbers of hyperglycaemia
- Variation in treatment
- High blood glucose occurrences out of hours.

Mr. Mitchell informed the Committee that by 2018 the Trust aimed to proceed to a situation where there is no avoidable harm from hyper or hypo glycaemia in a pilot ward. He also mentioned that a diabetes improvement team with members from the diabetic team, other staff members and the pharmacy team had been established.

The Committee noted that there would be priority for Diabetic patients at mealtimes which included special menus and coloured plates to highlight diabetic meals.

A Member questioned why there were 25% more patients with diabetes attending the Royal Free London NHS Foundation Trust. Mr. Mitchell informed the Committee that the Trust had a complex case mix and provided very specialist treatment, particularly at the Hampstead site.

The Chairman referred to performance for patients with diabetes receiving a documented foot risk assessment within 24 hours to assess the risk of developing foot disease. She noted that last year's Quality Account had shown that, whilst Chase Farm had improved, the number of patients undertaking a foot risk assessment from 25.6% to 41.9% (a 63% increase) between the two audit periods, the performance at the Royal Free Hospital site had deteriorated from 24.2% to 6.5% (a 73% decrease). The Chairman questioned if it was the intention of the Trust to perform at an assessment rate of 35% across all sites. Mr. Mitchell confirmed this and expressed the importance of increasing performance.

Discharge Summaries and Incorrect Medication List:

A Member referred to last year's Quality Account which stated that in 2014 a local audit identified that 30% of discharge summaries contained some incorrect information regarding the patient's medication list. The Member asked for information on progress in relation to this point. Mr. Mitchell informed the Committee that the charts are subsequently checked by the pharmacy. Mr. Mitchell noted that prescription errors would be significantly improved by the Trust's electronic prescription programme which was due to go live in Autumn next year.

Infection Control, MRSA and c difficile.

Mr. Mitchell informed the Committee that an independent external expert had reported on the old Barnet and Chase Farm Hospital Trust infection control processes, having already undertaken a similar process at the Hampstead site. The Committee noted that these findings were incorporated into the infection control processes of the new organisation.

The Committee noted that the present situation was that to the end of Quarter 2, there were 39 attributable cases to the Trust against a threshold of 33 which was 'allowable' for that period. The Committee noted that the monitor framework however is that its governance risk rating exempts only those cases where there has been a 'lapse of care' as determined by a local team working under NHS England's guidance framework. Mr. Mitchell noted that when applying this data, the Trust had had seven lapses of care, four at the Hampstead site and three at Barnet. There is ongoing root cause analysis and microbiological audit and a new "Start, Smart and Focus" audit which will be published on the Trust intranet.

Mr. Mitchell informed the Committee that between April and October five cases of MRSA bacteraemia have been documented within the Trust.   Two were assigned outside the organisation and one further case was assigned at appeal to the Trust and two were assigned to Barnet internally, one of which is known to be a contaminant. As a consequence of this there is an ongoing review of policies including:

- Blood culture taking
- Retraining and competencies
- Reviewing of training processes

Acute Stroke Unit

Mr. Mitchell referred to one of the comments submitted by the Committee on the Trust's 2014-15 Quality Account which highlighted an unexpectedly high number of patients not being referred to the relevant Hyper Acute Stroke Unit (HASU). Mr. Mitchell commented that, as a result of some patients not being referred to the HASU, the Barnet unit was being judged against inappropriate measures applicable to the HASU setting. The Committee noted that the Trust was working with the ambulance service, local general practitioners and the HASU to ensure that patients are correctly assigned at the outset of their illness.   As a consequence, Mr. Mitchell reported that the audit of the Barnet Unit's work now grades the Barnet Unit as A rather than D/E.

The Vice Chairman commented that the North Central Sector Joint Health Overview and Scrutiny Committee had recently reviewed Stroke provision and noted that the Acute Stroke Unit at Barnet had been shown in a very positive light.

Friends and Family test:

Mr. Mitchell informed the Committee that NHS England had undertaken a review of the Friends and Family test (FFT) and had concluded that the characteristics of this data meant that it should not be considered as an official statistic. However, the Committee noted that it was an ongoing contractual obligation.

Mr. Mitchell commented that the methodology of data collection significantly alters the outcomes of this process. He commented that particular organisations which collect the data from patients by means of paper or tablet at the time of discharge tend to achieve much better scores than those which use a phone call to the patient within 48 hours of discharge, as is undertaken in the Royal Free Trust. Mr. Mitchell advised the Committee that the Trust was of the opinion that much of the value within the FFT process, at the present time, lies in the "free text" comments of patients which are also fed back directly to staff.

The Chairman questioned if there were any trends in the data that had come back via the FFT. Mr. Mitchell commented that concerns had been raised around night time care, communication and the need for more control around visiting times to control noise on the wards.

The Committee noted that percentage of patients who would recommend remains within a 0.5% variation of the national average and efforts to change this centre on qualitative improvement rather than statistical manipulation. The Committee noted that the Trust was concerned at the “would not recommend” level of 6% which is considerably above the average nationally of 1.5% and makes the Trust one of the poorest nationally performing organisations in this measurement. Mr. Mitchell commented that the methodology by which data was collected, affected the results that were received. Trends arising out of this data are suggestive of patient concerns in the areas of:

- Night time care
- Attitude
- Communication
- Control over visitors

Staff Survey:

Mr. Mitchell informed the Committee that the Trust last completed a National Staff Survey in 2014, the results of which were set out in the 2014-15 Quality Account. The survey had suggested that overall the acquisition and integration of the organisation had begun without major impact on staff motivation and morale. The Committee noted that the Trust was waiting the result of the 2015 survey which closed on 30 November 2015. The organisation awaits the outcome and breakdown of these figures with interest and the Trust Board is focused on ensuring that appropriate measures are taken in relation to this area of concern.

Central London Community Healthcare NHS Trust:

The Chairman introduced the six month update report provided by the Central London Community Healthcare NHS Trust (CLCH) and noted that the officer due to present the report had suddenly been taken ill.

The Chairman noted that CLCH had offered to respond to any questions that the Committee had, following their consideration of the report.

The Committee scrutinised the report and requested that the following questions be put to CLCH on the report:

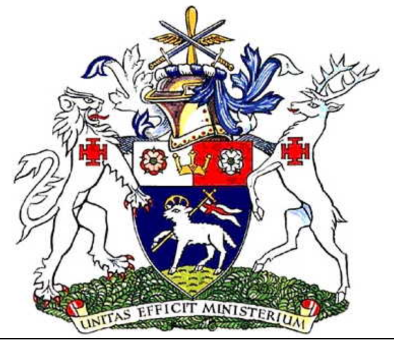
- The Committee referred to the intention to support a single point of access for patients with long term conditions and noted that CLCH would be looking to allocate link specialist team workers to each location that the Trust served. The Committee asked to be informed what was meant by the “locality” and how many link specialist teams there would be.
- The Committee noted that under the “Preventing Harm – User Involvement” section of the report, patients who had been interviewed had felt that communications and administrative systems could be a weakness within CLCH. The Committee requested to be informed as to what the problems were.

- The Committee referred to the “Medication Errors” section of the report and noted that one line within the graph referred to thresholds. The Committee commented that the significance of the threshold was not clear and requested to be provided with detail about the threshold and if it was nationally recognised.
- The Committee noted that the report referred to a “CBU Manager” and requested to be informed as to what “CBU” stood for.
- A Member questioned what mechanisms were in place to ensure that patients who were on long term medication were not receiving medicines that they did not need, particularly if they were elderly and did not go to the surgery frequently.
- The Committee noted that the Trust had planned a range of listening events during November 2015 across all four Boroughs and requested to be provided with feedback from the events.
- The Committee noted with interest that CLCH had commissioned a care home project which provides clinical medication reviews and requested to be provided with further information on the project.

The Chairman thanked CLCH for addressing the comments that the Committee had made so effectively and noted the Trust’s excellent performance in relation to pressure ulcers.

RESOLVED that:-

1. **The Committee noted the report**
2. **The Committee request that their comments be provided to CLCH to respond to.**

	**Health Overview and Scrutiny Committee** **16 May 2016**
Title	**Health Overview and Scrutiny Committee Work Programme**
Report of	Governance Service
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Committee Forward Work Programme
Officer Contact Details	Anita O'Malley, Governance Team Leader 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 2015/16 work programme

Recommendations

1. **That the Committee consider and comment on the items included in the 2015/16 work programme**

1. WHY THIS REPORT IS NEEDED

1.1 The Health Overview and Scrutiny Committee Work Programme 2015/16 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 This approach allows the Committee to respond to Health related matters of interest in the Borough.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 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.

4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be published on the Council's website.

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 Social Value

5.3.1 N/A

5.4 Legal and Constitutional References

5.4.1 The Terms of Reference of the Health Overview and Scrutiny Committee is included in the Constitution, Responsibility for Functions, Annex A.

5.5 Risk Management

5.5.1 None in the context of this report.

5.6 Equalities and Diversity

5.6.1 None in the context of this report.

5.7 Consultation and Engagement

5.8 Insight

5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

London Borough of Barnet Health Overview and Scrutiny Committee Forward Work Programme May 2016 - May 2016

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Title of Report	Overview of decision	Report Of *(officer)*	Issue Type (Non key/Key/Urgent)
16 May 2016			
North West London, Barnet & Brent Wheelchairs Service Redesign	At their meeting in October 2015, the Committee received a report on the North West London, Barnet & Brent Wheelchairs Service Redesign. The Committee have requested to receive a further report on the progress of the project at their meeting in May 2016.	**Barnet CCG**	**Non-key**
Children's Mental Health and Eating Disorders	Following the consideration of a Member's Item in the name of Councillor Trevethan, the Committee have requested to receive a report on children's mental health and eating disorders.	**Barnet CCG**	**Non-key**
NHS Trust Quality Accounts	Committee to consider and comment upon the Quailty Accounts of NHS Trusts for the year 2015/16.	**NHS Trusts**	**Non-key**

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
Items to be Allocated			
Finchley Memorial Hospital - Update Report	At their meeting in October 2015, the Committee receive a joint report from Barnet Clinical Commissioning Group (CCG) and NHS England which provided the Committee with an update on plans to improve utilisation of the Finchley Memorial Hospital site. The committee have requested to receive another update at their May meeting.	**Barnet CCG**	**Non-key**

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