MEETING
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
MONDAY 15TH MAY, 2017
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

Councillor Val Duschinsky
Councillor Caroline Stock
Councillor Laurie Williams
Councillor Gabriel Rozenberg
Councillor Philip Cohen
Councillor Amnar Naqvi
Councillor Alison Moore

Substitute Members

Councillor Shimon Ryde
Councillor Daniel Thomas
Councillor Anne Hutton
Councillor Maureen Braun
Councillor Kath McGuirk
Councillor 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 10th May 2017. Requests must be submitted to Abigail Lewis.

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

Andrew Charlwood – Head of Governance

Governance Services contact: Abigail Lewis, abigail.lewis@barnet.gov.uk, 020 8359 4369

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	5 - 14
2.	Absence of Members	
3.	Declaration of Members' Interests	
4.	Report of the Monitoring Officer	
5.	Public Question Time (If Any)	
6.	Members' Items (If Any)	
7.	NHS Trust Quality Accounts 2016-2017	15 - 250
8.	Health Overview and Scrutiny Forward Work Programme	251 - 252
9.	Any Other Items that the Chairman Decides are Urgent	

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Decisions of the Health Overview and Scrutiny Committee

6 February 2017

Members Present:-

AGENDA ITEM 1

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

Councillor Val Duschinsky	Councillor Philip Cohen
Councillor Gabriel Rozenberg	Councillor Laurie Williams
Councillor Caroline Stock	Councillor Alison Moore
	Councillor Barry Rawlings (Substitute)

Also in attendance
Councilllor Helena Hart

Apologies for Absence
Councillor Ammar Naqvi

1. MINUTES

The Chairman noted the following corrections to the minutes of the meeting on 5th December 2016:

Page 1 Midwifery is misspelt.
Page 4 the phrase should read 'She thought a higher emphasis should be placed on educating people'.
Page 5 should read 'on a first come first served basis.'
Page 6 the word Trust should be removed after North London Hospice.
Page 8 JHOSC has been misspelt.

Subject to the changes being taken into account, the Committee agreed that the minutes of the last Committee held on 5th December 2016 be approved as a correct record.

The Chairman provided the Committee with the following updates:

The Governance Officer is contacting Ms O'Dwyer again to provide copies of the legal high presentation as requested by the Committee.

The Governance Officer is contacting Mr Berelowitz again to provide the Body Dysmorphia literature as requested by the Committee.

At the last Committee meeting, it was requested that the Royal Free NHS London Foundation Trust include the potential for rehabilitation spaces to be included within the winter pressures report (page 6 of the minutes). The Governance Officer will chase for an update to be provided to the next meeting if this is not covered under Agenda Item 11 this evening.

Councillor Rozenberg requested that information from the Royal Free on the new technology 'Streams' be brought to a future Committee meeting. The Governance Officer will add this to the work programme.

The Chairman informed the Committee that Councillor Old had received an update on the incidents that result in harm from Ms Wilkins and that he was happy to send this round to Committee Members.

The Chairman informed the Committee that the Handwashing Audit had now been completed and the results were currently being collated. The Chairman asked the Governance Officer to circulate the results to Members of the Committee once received.

The Chairman updated the Committee on the Winter Pressures and Delayed Transfer of Care data received from the Assistant Director of Adults and Communities.

2. ABSENCE OF MEMBERS

Councillor Amnar Naqvi was absent and was substituted by Councillor Barry Rawlings.

3. DECLARATION OF MEMBERS' INTERESTS

Councillor Caroline Stock declared a non-pecuniary interest in relation to Agenda Item 11 by virtue of her husband being an Elected Public Governor of the Council of Governors at the Royal Free London NHS Foundation Trust.

The Chairman declared a non-pecuniary interest in relation to Agenda Item 11 by virtue of being a Trustee/Director appointed by the Council to Eleanor Palmer Trust which owns Cantelowes Care Home.

4. REPORT OF THE MONITORING OFFICER

None.

5. MOTION REFERRED FROM FULL COUNCIL

The Chairman proposed that the Motion on 'Support our GP's and NHS – Don't attack them', which was referred from the Full Council meeting on 31st January 2017, would now be referred to the next meeting of the Policy and Resources Committee on 23rd February 2017. The Committee unanimously agreed.

6. PUBLIC QUESTION TIME (IF ANY)

None.

7. MEMBERS' ITEMS (IF ANY)

None.

8. DENTAL CARE IN BARNET REPORT (AGENDA ITEM 8)

The Chairman invited the following officers and representatives to the table:

- Kirpal Dhadda, Chief Executive Officer, Homestart Barnet

- Selina Rodrigues, Head of Strategic Development, CommUNITY Barnet
- Lisa Robbins, Manager, Healthwatch Barnet
- Dr Jeff Lake, Public Health Consultant, Barnet and Harrow Public Health Team
- Councillor Helena Hart, Chairman of the Health and Wellbeing Board, Barnet

Ms Rodrigues explained that Homestart Barnet had been commissioned to collate information from families on their experiences of dental services in the borough. She said questionnaires were sent to families and a focus group in Grahame Park as well as advertised on social media. In total there were 56 respondents.

Ms Rodrigues said the results of the survey showed a strong correlation between the experiences of parents with those of their children towards dental health. She said most dental practises had been described as child friendly and welcoming but some parents had expressed this was not the case. Ms Rodrigues stated some parents had experienced difficulties in booking appointments and in finding an NHS surgery within walking distance from their home.

Ms Rodrigues said that further work needed to be done in order to capture more detailed responses. However, results suggested parents' perceptions of access to some services, e.g. braces, is complicated and not consistent across practices. She said that some parents had complained that there was inadequate space in some practices for buggies. Ms Rodrigues informed the Committee that the research also suggested new immigrants and transient families did not view dental care as a priority. She said the report highlighted the need to raise awareness of good diet, increase the availability of local services for families and make services more accessible and affordable.

Councillor Hart reminded the Committee that previously they had been informed that price lists were not being displayed in waiting rooms, which is a CQC requirement. Councillor Hart said letters should have been sent out to surgeries about this issue. She also commented that she felt the survey should have made it clearer which questions and answers referred to adults and which to children, as children receive free NHS dental treatment. She noted that half of the respondents were from Black and Ethnic Minority groups and there may be a perception among these individuals that children also have to pay for dental care. Councillor Hart said more communication confirming that children receive free treatment is needed.

Ms Kirpal stated that difficulties in accessing treatment locally were identified as one of the biggest issues. Councillor Moore said that there was an opportunity to raise awareness during health care visits and via other health checks in order to improve the engagement of parents with dental services. Ms Kirpal agreed that the earlier the information is received by parents the better and that encouragement very early on even at the peri-natal stage was a good idea. Councillor Duchinsky said information should be distributed into GP surgeries.

Councillor Hart stressed prevention is better than cure and this is why getting information out to parents as early as possible is vital. She said that NHS practitioners do not have to accept children and often choose not to, as treatment times are longer.

Dr Lake said that attention is given to oral health at early years' reviews and that through the Making Every Contact Count programme staff should recognise and identify any dental issues. Councillor Rawlings agreed that the role of health professionals in promoting dental health was important as new mothers might be more inclined to take

notice of health visitors rather than posters. Ms Robbins said that NHS England had done some promotional events and had set up stalls in shopping centres to reach out to the public across all age groups.

The Chairman noted that the results of the survey were a small snap shot of the 400,000 families living in Barnet. She questioned whether this could potentially skew the results as 56 families could hardly be an accurate representation of the views of the majority of Barnet families. Ms Rodrigues said that although the results might not be statistically valid, the points that were raised were beneficial. Dr Lake agreed that the issues had been thoroughly explored and that data from Public Health research supported the findings with 68% of 5 year old children not accessing dental care.

Councillor Moore suggested that responses from the dental communities and providers should be collated. Councillor Hart asked Dr Lake for a future update from Public Health on dental health.

RESOLVED – The Committee noted the report.

9. DIABETES IN THE LONDON BOROUGH OF BARNET (AGENDA ITEM 7)

The Chairman invited the following officers and representatives to the table:

- Mr Neil Snee, Director of Commissioning, Barnet CCG
- Dr Jeff Lake, Public Health Consultant, Barnet and Harrow Public Health Team
- Ms Nima Patel, Barnet Diabetes UK
- Ms Lesley Izenberg, Chair of Barnet Diabetes UK
- Councillor Hugh Rayner

The Chairman introduced the report.

Mr Snee addressed the Committee and gave an overview of the report. He noted that significant attention had been given to the awareness of diabetes in society. He informed the Committee that, two years ago, the update of the GP National Diabetes Audit in Barnet had been poor with only six GP Practices participating. The 2015/2016 Audit saw 90%, i.e. 56 Barnet practices participating and he hoped this would reach 100% for the 2016/2017 Audit.

Mr Snee said a number of pieces of work were currently in progress which aim to address the challenges of improving diabetic management for patients. Mr Snee explained that investments had been made to establish multi-disciplinary teams to treat diabetes which he felt was a significant step forward.

Mr Snee informed the Committee that the National Diabetes Prevention Programme was being implemented locally in collaboration with Enfield Council, Public Health England and Diabetes UK and this is due to commence in May 2017. The programme will involve nine months of intensive dietary and physical intervention strategies for individuals who are currently pre-diabetic with a high risk of developing the disease. Mr Snee told the Committee a campaign is currently being planned to raise awareness of the disease and a report on the new prevention programme will be included in a paper submitted to the next meeting of the Health and Wellbeing Board on 9th March 2017.

Ms Isenberg explained the role of Barnet Diabetes UK as one of 150 volunteer groups forming Diabetes UK Central. She said the group hold five talks a year at the local hub from health professionals and support groups on diabetes prevention and care. Ms Isenberg also said that when the group first started in the 1990's, there was not much education available on diabetes and so the aim of the organisation had been to improve education and awareness of the lifelong disease.

Ms Isenberg informed the Committee that an internet programme called 'Help Diabetes' is available from GP practices where patients are provided with a user name to log onto the site and can access learning modules on diabetes. However Ms Isenberg said the programme is only currently available in English and tailored for Type 2 Diabetes and 10% of individuals diagnosed with diabetes in the UK have Type 1. Ms Isenberg said Type 2 diabetes patients do tend to have a more structured care plan.

Councillor Rayner told the Committee about his experience of being diagnosed with Diabetes. He said he had learnt of the dangers of the disease and the future complications on health it can have and the expensive implications for the NHS. Councillor Rayner explained he was currently able to manage his diabetes by a controlled diet and living a healthier lifestyle. Before his diagnosis, he had limited knowledge and understanding about the seriousness of the disease and so he thought it was essential that people should be made aware of diabetes and how to take care of their diet to avoid developing the disease.

Ms Patel explained that their work aimed to emphasis to individuals the importance of physical activity and that talks on the topic were due to be held in the near future. She explained that Diabetes UK hold events such as 'Walk in the Park' to help promote physical activity in communities and that all the money raised from these events is sent to Diabetes UK to fund their research.

The Chairman informed the Committee that she had watched a Panorama programme on diabetes which claimed that around 10% of the health care budget is currently spent on diabetes treatment. Due to the increasing numbers of people being diagnosed with the disease, the Chairman emphasised the huge financial implications for the NHS. The Chairman stressed that emphasis on prevention of the disease is crucial.

Councillor Caroline Stock updated the Committee on the Mayor of Barnet's Golden Kilometre which targets children of primary school age to take part in becoming more active. She explained that the rates of obesity in children were high and that a lack of exercise was a significant contributing factor. She asked the Committee to put forward any other suggestions they may have on ways to encourage children to exercise more.

Ms Isenberg said that Diabetes UK conduct road shows about diabetes to increase awareness of the disease to the public. She said she would be delighted to take part and help out with any initiatives or projects to further increase awareness of the disease within the Borough. Ms Isenberg stressed the need to prevent the development of diabetes in children, as research suggests complications associated with diabetes are accelerated in children compared to those diagnosed later in life.

Councillor Philip Cohen queried whether the CCG expenditure on diabetes care was too heavily weighted on prescriptions for GPs. Mr Snee explained that the CCG monitor all prescribing costs and were reducing the current spend on medication in order to spend more on prevention strategies. However, Mr Snee said that some patients choose higher costing medication. Ms Isenberg said the cost of medication for those suffering with

diabetes was unavoidable as only 5% of patients can control the disease by diet alone. She said a strict diet at the beginning of diagnosis could have beneficial effects but is not effective enough in those who have been diagnosed for longer. Ms Isenberg explained that the disease is a progressive one and that cheaper medication alternatives can often have unwanted side effects such as weight gain which exacerbates the problem. Newer more expensive medications are more effective and have fewer side effects. Ms Isenberg said it is a case of trying to balance the short term costs with the potential longer term costs.

Dr Lake informed the Committee that prevention programmes run by Public Health have focused on obesity for a number of years. He explained that obese children have a lower life expectancy and are at a higher risk of developing diabetes. Dr Lake informed the Committee that obese children and adults are put onto a weight management pathway plan. Dr Lake also noted that targeted work is being conducted on those at risk of developing diabetes. Pre-diabetic risk individuals, with blood sugar indexes of between 42-47, are put on a 12 month review process and this will gradually become standard practice. He emphasised the importance of structured intervention.

Councillor Williams asked whether sweeteners (an alternative to sugar) were just as unhealthy for diabetics as consuming sugar. Dr Lake said that sweeteners offer a lower calorific content and that he would follow up as to whether they are as harmful as the consumption of sugar. Ms Isenberg said the danger with lower calorie options is that people often believe they can then consume more leading, to bad habits.

Councillor Moore asked whether there was a socio-economic aspect to the increase of diabetes, as foods high in sugar and salt are often cheaper to purchase and may seem more affordable than healthier options. Councillor Rozenberg suggested it may be distrust in science as health professionals have moved from the message that fat is bad for the body to sugar being bad. Dr Lake said that research showed awareness of the sugar content within foods was poor and that flagging this on food packaging has led to improvements.

RESOLVED – The Committee noted the report.

10. UPDATE ON WINTER PRESSURES (AGENDA ITEM 11)

The Chairman invited to the table:

- Mr Neil Snee, Director of Commissioning, Barnet CCG

Mr Snee updated the Committee on the winter pressures experienced by Barnet hospitals and highlighted to the Committee that the pressures on emergency departments over the last year had been rising. He noted that Walk-In Centres were now in high demand to help ease the pressure. Mr Snee said that the Royal Free was struggling with the increases in admissions and that the CCG was currently working with social care providers and the Royal Free to manage this. Mr Snee said the measure of weekly volume of delayed transfer of care and the impact this has on emergency departments was being closely monitored.

Mr Snee explained that 30% of the delay in transfer of patients was a result of family choice as families are not always happy with the home that has been allocated to the patient. He said it was a balancing act as patients in acute care need to be moved

through the hospital quickly, although it must always be recognised that people still need to be treated with dignity and respect.

Mr Snee said the CCG had commissioned £1 million of additional investment into the discharge assessment module with 30 beds having been made available with a turnaround of 28 days as a pathway measurement. He said that 90% of patients moved through beds by 18.5 days and 100% by the 28 day target. He said this improvement of flow through the hospital had been achieved by working as a whole system.

Mr Snee told the Committee that the system was facing real pressure due to the increase in demand and was adapting as quickly as possible. He said negotiations were being held around establishing a properly structured workforce with 200 additional evening and Saturday appointments available. Mr Snee explained the pressures faced were not exclusive to Barnet but evident in all urban environments.

Mr Snee said there were problems surrounding ambulances from East Anglia being diverted to Barnet hospitals. He said that due to significant pressure within Hertfordshire trusts, ambulances were being sent to the next nearest emergency department which is in Barnet. He commented that there was a problem with the lack of a dual-system to manage this issue. Mr Snee said conversations with East Anglia had been initiated and there was now a 33% drop in the number of ambulances from these regions being sent to Barnet hospitals. He told the Committee that it was a complex and difficult system but everyone had been very responsive to representations.

Councillor Cohen enquired about the Forest Care Village model. Mr Snee said that this model was being tested to see how well it works before moving to a more appropriate local site. Councillor Cohen asked whether there was a shortage of community places for patients to be discharged to and was this part of the problem. Mr Snee said that the situation is complex and there is a need for a different type of system to improve the flow of patients through hospitals. He also said there was a demand for beds that needs to be addressed and that he would be working with CLCH to monitor the data.

Councillor Old asked whether care homes were sending clients to A&E less frequently. Mr Snee said there was currently not enough data to confirm whether this was a trend. However, anecdotally, he believed that training packages were helping and having a real impact.

Councillor Stock asked whether it was correct that there are significant problems in regard to recruitment within A&E departments. Mr Snee confirmed there was a shortage of doctors in emergency departments and that it is becoming increasingly more difficult to recruit. Mr Snee said that the 'Safer, Faster, Better' programme at the Royal Free was looking into how to improve training for colleagues and how the better allocation of tasks could free up doctor time.

RESOLVED – The Committee noted the report.

11. UPDATE ON DEMENTIA SUPPORT IN BARNET (AGENDA ITEM 9)

The Chairman invited the following officers and representatives to the table:

- Caroline Chant, Joint Commissioning Manager Older Adults, Adults and Communities, Barnet

- Sharon Thompson, Barnet Community Services Manager, Barnet, Enfield and Harringey Mental Health Trust

Ms Chant explained that dementia awareness and provision of care was becoming increasingly important. Demand increases with an ageing population as dementia is an age-related disease. She emphasised the importance of the Dementia Manifesto which involves a significant number of organisations working in collaboration.

Ms Chant explained that the report focused on increasing dementia diagnosis rates and building capacity in the community in-line with the national dementia strategy. She said that early identification of dementia was important as it enables individuals to live in the community for longer. Ms Chant said that funding the enhanced assessment service meant that people were diagnosed quicker and that targets set by the Health and Wellbeing Board were being met. She highlighted that currently there is a higher diagnosis rate of dementia in Barnet compared with the national average.

Ms Chant said that they were already harnessing community services such as the Alzheimer's Society and that a Dementia HUB and Dementia Café would soon be opened. Ms Chant stated that the main current challenge was trying to improve awareness of dementia within the wider public.

Councillor Old commented that a lot of improvements had been achieved within a short space of time. He asked whether there was potentially a better way of measuring accurate diagnosis of dementia rather than purely on the numbers diagnosed by GPs. Ms Chant explained that the dementia diagnosis rate was a government set target. She said that early diagnosis is important as it means patients get access to support and medication earlier and this delays the need for entry into care. She stated the dementia diagnosis rate showed that GPs are correctly screening and referring patients with dementia.

RESOLVED – The Committee noted the report.

12. COLINDALE HEALTH PROJECT UPDATE (AGENDA ITEM 10)

The Chairman invited to the table:

- Neil Taylor, Strategic Lead Development and Regeneration, Barnet

Mr Taylor informed the Committee that three health infrastructure projects were being proposed within the Colindale area:

1) Re-provision of Grahame Park - the design for the Community Hub Grahame Park GP facility has now been decided and the building will accommodate two floors of health based facilities.
2) Temporary accommodation for a new central Colindale APMS (Alternative Provider Medical Services) – the search for a temporary site is currently in progress.
3) Permanent estate solution for the new AMPS – it might be about four years before a permanent site would become established.

Councillor Old commented that the plans seemed to be taking a very long time to be implemented. He said the population was growing and resulting in an increasing need for

more GPs in this area. He noted it was worrying that a site had yet to be found when the facility was meant to be up and running later in the year.

Mr Taylor apologised that he was only able to comment on the premises' issues as currently presented. He notified the Committee that the Grahame Park facility was intended to cater for 16,000 patients and an expansion had been planned to accommodate this. Mr Taylor said that there had been some difficulties in securing a temporary site and that discussions were being held, although nothing had yet been finalised. He said there was no issue with regard to funding, just the location of the site which the team was working hard to resolve. He then told the Committee that a business case was being taken to the next Assets, Regeneration and Growth Committee meeting in April, so that planning could be carried forward.

Councillor Cohen said that Colindale is a growth area and there was a real risk that no temporary site would be secured in time. He asked what measures had been taken to recruit more GP's. Mr Taylor said he could not comment on this but would take the question back to his colleagues. He acknowledged that not having a secured temporary site was a significant risk and it was being worked on as a priority. Councillor Moore said that this had been a long-standing issue raised by residents and that this was causing huge frustrations among residents and Members.

The Chairman requested Mr Snee return to a future Committee to address the issues raised.

Councillor Rawlings enquired as to whether the temporary site needed to be located near to the site of the permanent facility. Mr Taylor confirmed that the sites did not necessarily need to be in close proximity.

RESOLVED – The Committee noted the report.

13. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME

The Chairman asked that the 'Streams' technology report from the Royal Free be allocated to a future meeting.

Councillor Cohen asked that an update report in regard to his Member's Item 'NHS Property Services Ltd - charging market rents' of 5th December 2016 meeting be provided either as a written update circulated to all members of the committee or as a report brought to a future meeting.

The Committee noted the update.

14. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

None.

The meeting finished at 9.59pm.

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AGENDA ITEM 7

Barnet Health Overview and Scrutiny Committee

15th May 2017

Title	**NHS Trust Quality Accounts 2016/17**
Report of	Head of Governance
Wards	All
Status	Public
Key	No
Urgent	No
Enclosures	Appendix 1 –North London Hospice Quality Account 2016/17 Appendix 2 – Community London Healthcare NHS Trust Quality Account 2016/17 Appendix 3 – Royal Free Hospital NHS Foundation Trust Quality Accounts 2016/17
Officer Contact Details	Abigail Lewis Governance Officer 020 8359 4369 Abigail.lewis@barnet.gov.uk

Summary

This report presents the Quality Accounts from NHS health service providers 2016-2017. Health providers are required by legislation to submit their Quality Accounts to Health Scrutiny Committees for comment. 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

1. **That noting the requirement of the NHS health service provider to produce Quality Accounts 2016-2017, the Committee provides a statement for inclusion in the Quality Accounts of the Health provider.**

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 Central London Community Healthcare accounts before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the on-going operation of and planning of services.

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

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

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

4. POST DECISION IMPLEMENTATION

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

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Overview and Scrutiny 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 There are no financial implications for the Council.

5.3 **Social Value**

5.3.1 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.

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

5.41 There are no risks.

5.5 Equalities and Diversity

5.5.1 Equality and Diversity issues are a mandatory consideration in decision making in the Council pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must fulfil its equality duty 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.

5.5.2 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.

5.5.3 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

6.1.1 Health Overview and Scrutiny Committee, 16 May 2016 - the Committee received and made formal comments on the Quality Accounts of health partners:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=8377&Ver=4

6.1.2 Health Overview and Scrutiny Committee 5th Dec - Minutes on NHS Quality Accounts Mid-Year review: https://barnet.moderngov.co.uk/documents/g8784/Printed%20minutes%2005th-Dec-2016%2019.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=1

NORTH LONDON HOSPICE

QUALITY ACCOUNT
16-17
DRAFT FINAL

CONTENTS

Page Number

Executive Summary

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

It is with great pleasure that I welcome you to North London Hospice's (NLH) 2016-17 Quality Account which has been developed in consultation with NLH users, clinical service staff and managers, the Executive Team and the Board of Trustees.

This year, NLH celebrates 25 years of providing inpatient care to the residents of the boroughs of Barnet, Enfield and Haringey. From our initial beginnings as a community team in 1984, we now have 196 staff supporting the delivery of specialist palliative care to 2274 people and their families. Care is provided within peoples own homes, care homes and through outpatient and therapies at our two sites in Winchmore Hill and Finchley and within our 18 bedded inpatient unit.

I am pleased to report that this year we achieved the Care Quality Commission rating of "Good" following three separate inspections of our Finchley, Winchmore Hill and Haringey services. 95% of our users would recommend our service to family and friends.

At all levels of the organisation, we constantly review our care and make plans for improvements that include listening to users when designing new or revising services.
I am delighted to see how our quality projects this year have seen real improvements affecting both the user and staff experience: the successful setting up of a user group in Outpatient and Therapies service; the commencement of Schwartz Rounds to bring together our staff from all backgrounds (clinical and non-clinical)to talk together about the emotional and social challenges of caring for our group of patients; the evidencing in our clinical records of the Five Priorities of Care for the Dying, a national initiative that facilitates the needs and wishes of the dying person and those closest to them being central in both the planning and delivery of care wherever that may be; the introduction of the "Hello my name is…" national initiative that ensures staff name badges are clear to read and staff introduce themselves at every encounter with our patients and their families.

Next year's projects have also been discussed at our user Feedback Group and include: scoping our service provision to 'Hard to Reach Groups' of society to promote equal access to our services; the extension of a doctors' Journal Club to all professionals; the co-production of new Outpatient & Therapies services discussing with potential and actual users and referrers where there are gaps in services and what services need establishing; the development of patient falls management on the In Patient Unit so there is increased understanding by the whole multidisciplinary team and new national guidance is implemented.

Further developments this year have included our open gym, exercise group and introduction of Occupational Therapy within our Outpatient and Therapies service, the extension of our audit and educational programmes, the development of our community clinical nurse specialists to enable more detailed physical assessment and the prescribing of certain medication to facilitate more responsive symptom management and preventing hospital admissions. Increased collaboration has seen our clinicians providing training with older people services, renal, respiratory and care home teams.

I ensure the quality of the care we provide is regularly reviewed and improvements made as needed and can confirm the accuracy of this Quality Account.

Pam McClinton
Chief Executive of North London Hospice April 2017

INTRODUCTION

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

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

OUR CLINICAL SERVICES

The Hospice's services are provided by specially trained multi-professional teams, which include doctors, nurses, physiotherapists, occupational therapists, social workers, counsellors, clinical psychologists, 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 One

PART 2: PRIORITIES FOR IMPROVEMENT 2016-17

The following priorities for improvement for 2016-2017 were identified by the clinical teams and were endorsed by our internal governance structures.

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

Priority One: Patient Experience: Listening to users through the creation of a user forum

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 existed.

Project aim: To establish a User Group for the Outpatients and Therapies service

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

Project Delivery:

- Project Group was formed from September 2106, including 2 service users and monthly meetings were held to formulate effective Feedback Groups (name decided by users for user forum/group).
- 4 open Feedback Groups were held from November 2016, each with a different topic of discussion (what NLH has as a result of user feedback, name of OP&T site, review of new promotional patient information, 2016-17 Priority for Improvement Projects).
- Attendee numbers varied between 1-7. This is in line with the experience of such groups in other hospices.
- In one of the groups we asked patients and relatives to suggest a name for our centre at Barrowell Green. We discussed the issues and the results were presented to the Hospice's Executive Team who have in turn made some suggestions based on the Feedback Group's ideas which is back out to consultation with users prior to presentation to the Trustees.

Outcome: Agreed Terms of Reference put in place; users recruited; schedule of planned meetings for the year put in place; minutes of meetings held produced; identified with users forum members what success of forum would look like to them and monitor performance against these outcomes, patient experience areas for improvement (OP&T centre name and promotion of OP&T services) have an action plan established or being developed.

Challenges to date:

- Maintaining a level of service users attendance at Feedback Group
- Considerable work involved to maintain momentum
- Limited access to patient's email addresses to promote groups differently

Conclusion/Ongoing Plan:
Feedback Groups will continue and plans are in place to widen attendees to all NLH service users and hold on both sites.

Priority Two: Patient Experience: Introduction of elements of 'Hello my name is...' national initiative on IPU

Baseline: IPU Staff had 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. The plan was to purchase dementia friendly 'Hello My Name Is…' name badges to support the ongoing work of creating a dementia friendly environment that was started last year.

Timescale: Project implemented by March 2017

Project Delivery: Meetings with IPU and Front of House staff and volunteers (including housekeeping and maintenance) were held to involve staff in the purpose and process of the project. Name badges were purchased to ensure primarily the clarity of staff's name, the largest black font of person's first name on the largest sturdy badge was selected. The colours selected were mindful of dementia patient's colour sensitivity and to keep with NLH's corporate colours. The badges have been distributed to staff from June 2016 and the experience of using them and feedback received have been discussed regularly in staff meetings and posters displayed.

Outcomes:

- 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. – cannot be measured until March 2018
- 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.- Monthly audits of whether staff are wearing the badges and are they introducing themselves has started. To date of 13 staff members checked, 23% were not wearing their badges. The cause identified was that these staff were new and had not yet been issued one. Of 6 volunteers asked 50% of volunteers were not wearing theirs, 2 had not been issued badge as new starter and 1 volunteer did not have it with them. In response a process has now been established to identify early ordering of badges for new starters and the availability of temporary badges.
- No further complaints or concerns raised by users from 2017 regarding staff not introducing themselves.
- IPU Manager "Feedback from patients has been positive. They can see the name clearly and find comfort in being able to respond to the nurse by name."

Challenges to date:
Staff feedback has raised the question whether the badge should include the staff member's surname or role on the badge. This was reviewed and the decision was made to keep the current format so that clarity and visibility of the name was maintained.

Conclusion/Ongoing Plan
The use of "Hello My Name Is" will continue on IPU and Front Of House at the Finchley site. It is hoped that external funding can be sourced to spread this initiative out to all staff and patient facing volunteers in 2017.

Priority Three: Clinical Effectiveness: Introduction of Schwartz rounds

Baseline: Group supervision had been established for all front-line clinical staff for the previous two years.

Timescale: By end March 2017.

Project Delivery
Two Schwartz Rounds have taken place. The first round there were 58 attendees and 38 at the second. Of the 58 evaluation forms analysed from the first round, 55 described the session as excellent and 3 as good. The second round showed similar feedback. The panelists have included Chief Executive Officer, Medical Consultant, Health Care Assistant, Ward Doctor, Social Worker, Community Clinical Nurse Specialist and Triage Service Lead. The facilitators have attended all training programmes and completed online modules overseen by The Care Foundation. Attendees have commented on the impact of deeper reflective practice and shared learning and greater understanding of the personal impact of the work.

Outcomes:
Register of attendance available and evaluation feedback form is shared with The Care Foundation to measure performance and identify areas of development.

Challenges to date:
Working the programme across three sites; this is now being addressed by delivery at the two largest sites. Availability of staff due to part time working and shift patterns and service needs.

Conclusion/Ongoing Plan:
The rounds will continue 6 weekly and is now an established programme

Priority Four: Clinical Effectiveness: NLH improving its evidence of the implementation of the national initiative "Five Priorities of Care"

Baseline: The Five Priorities of Care (One Chance to Get It Right: Improving Peoples experience of care in the last few days and hours of life. Leadership Alliance for the Care of the Dying People 2014) have been identified as:

1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.
2. Sensitive communication takes place between staff and the person who is dying and those important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care.
4. The people important to the dying person are listened to and their needs are respected.
5. Care is tailored to the individual and delivered with compassion – with an individual care plan in place

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

Timescale: Project implemented in NLH services by October 2016.

Project Delivery:
Both community and IPU projects have worked with the evidence based documents developed by the UCLPartners Five Priorities of Care project.
In the community, the project has delivered the creation of a New Five Priorities of Care documentation which is used by the community CNSs to have a central NLH record.
This has helped with communication within and across teams in and out of hours. Training has been delivered by UCLPartners to the community CNSs as part of a Train the Trainer programme on End of Life (EOL) Care. With the leadership of the Haringey EOL Partnership Group, the CNSs in Haringey have been enabled to deliver the training to the district nurses. UCLH are piloting Pan London Five Priorities documentation. It is planned that this will be rolled out into Haringey and Enfield. Barnet District Nurses are using Central London Community Healthcare NHS Trust (CLCH) EOL document.

On the IPU, a new Five Priorities of Care documentation was created from UCLPartners in patient care plan document. This records key conversations, religious/spiritual and psychological needs, key contacts of those important to the dying person, key elements of the medical plan. In the autumn this was introduced alongside UCLPartners Five Priorities evidence based nursing care plan (Last days of life care plan) via MDT training sessions. The document is completed during the daily MDT meeting when a patient is identified by the team as entering the dying phase (using the Phase of Illness outcome tool). It also triggers the change to the last days of life care plan. Audits were commenced to monitor the new documents use. The document has created a central record of key communication of EOL discussions and plans and staff have commented that it has enhanced more seamless, effective and coordinated end of life care.

Outcome:

- The first audit of IPU deaths demonstrated 100% compliance of completed documentation. A second in depth audit is planned for May 2017.
- Following the appointment of a new IPU senior nurse, it was agreed they would lead on the implementation of a new training plan which included face to face teaching and use of reflection using a poor practice patient story video with all nursing staff. Following learning identified in May's audit, nursing competencies will be introduced in the autumn to ensure ongoing training and demonstrate effective utilisation of the documentation for current and new staff. The senior ward doctor trained the doctors and this will be repeated at induction for new ward doctors.

Challenges to date

Staff continuing to value and understand the purpose of increased documentation.

Conclusions/Ongoing Plan:

- The IPU documentation will continue to be used.
- Regular audits to monitor its use will be conducted and actions taken as required.

PRIORITIES FOR IMPROVEMENT 2017-18

The following Priority for Improvement Projects for 2017-18 have been identified by the clinical teams and endorsed by the Quality, Safety and Risk Committee, Board of Trustees and local commissioners and Health and Overview Scrutiny Committees. The hospice's Feedback Group, which consists of OP&T patients and their families, heard about the projects selected for the coming year and provided comment particularly on Project 2 (see below).

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

Patient Experience - Project 1: Scoping Hard To Reach Groups to address potential inequalities in service provision

Current situation:
Over the years NLH has worked in a variety of ways to understand and promote its service to encourage equal access for potential users of its local community and referring services.

This has included:

- outreach promotional work by its clinical, volunteering and fundraising services;
- collaborative working and projects with local schools, faith groups and services e.g. learning disability service
- user feedback focus groups with hard to reach groups of society.

Our local boroughs, health commissioners and providers are responding to the Equality Act 2010 and the Public Sector Equality Duties and will have plans in place to reduce inequalities in access to health services. NLH wants to review the reach of its current services in order to better understand any new focus required to reach groups in its local boroughs that are not accessing equally the services provided. A Steering Group for this work has developed a plan for the coming year to deliver the results it aspires to meet.

Result to be Achieved:

- Scoping the priorities of CCG's, boroughs and Hospice UK gaps in specialist palliative care provision in relation to improving access to services by Hard to Reach Groups (HTR)
- Identify the current reach of referrals received and taken up by the these HTR groups
- Highlight the gaps in referrals received and service taken up by these HRT groups
- Prioritise a specific HTR group and begin to identify recommendations for NLH to consider for widening access

Timescale of project: This will be at least a two year project. Year One is broadly to scope and identify focus for Year Two.

Patient Experience - Project 2: Coproduction of services in Outpatient &Therapies (OP&T)

Current situation:
In 2015-16, Priority for Improvement Project scoped the need of people living with long term conditions. It identified a model of care for OP&T for people with long term conditions which included outpatient clinics, therapies provision, social support, carer services and the development of wellbeing/social support for patients and their carers in our communities. It recommended the development of these services using a co-production model of engaging with patients, carers, staff and volunteers. New investment in extending the OP&T team including the appointment of an Associate Director, Physiotherapist, Occupational Therapist, Social Worker and Centre Administrator has led to the development of our outpatient and therapy services over the last few months using a co-production model:

- We have completed a Managing Breathlessness programme in March 2017 which has been developed by working with relevant stakeholders; experts in the field, patients and carers, the community respiratory team and our staff. Feedback is currently being evaluated with plans to run another course in a few months time.
- We are now looking at a service development that is required by those affected by neurological conditions. A survey for those with the condition and their carers is about to be sent out as part of the co-production model to start understanding what may be of benefit to this group of patients. Further involvement from experts and specific neurological services will be sought.

Results to be achieved:

- Evaluation of all new service developments will describe whether the users received the right intervention by the right people at the right time by the new co-produced intervention (including use of Outcome Assessment and Complexity Collaborative (OACC) measures)
- The pilot of:
  - three co-produced new interventions for those with long term conditions
  - two co-produced new interventions for those with cancer
  - two co-produced new interventions for carers
  -

Timescale of project:

- One year with the new co-production model to be embedded in all OP&T service development

Patient Safety - Project 3: Falls Management and Prevention Project on the In Patient Unit

Current situation:
The reduction of falls on the inpatient unit has been an ongoing focus for the organisation. The aim has always been to reduce the risk of falls so as to minimize distress and injury to patients. NLH monitors the number of falls per occupied bed days in order to benchmark itself against other hospices which it has done for the past three years.
Hospice UK have revised their falls prevention care plan guidance and the Physiotherapy team believe there is a need to increase the multidisciplinary team's understanding and confidence of falls management and prevention to ensure a consistent approach to the

management of patients.

The project will deliver a new training programme to small clusters of staff in short sessions by the physiotherapy team. Performance tools (modified Karnofsky Performance Scale and Phase of Illness) used on IPU will act as a trigger at the daily Multi-Disciplinary Team (MDT) review for a seamless review of falls and manual handling practice using revised documentation.

Result to be Achieved:

- Revised falls risk and manual handling risk assessment documentation. Policies modified accordingly.
- Daily review of Karnofsky and Phase of Illness tools will be used as a prompt to review patient risk of fall through a new assessment. This will be monitored through spot checks.
- Improvement on the completion of falls risk assessment and manual handling risk assessment documentation. To be monitored by pre and post documentation audit.
- Falls prevention training programme for the IPU MDT in place and 75% IPU staff having completed
- Improved knowledge and confidence of falls prevention strategies. This will be measured by before and after staff questionnaire

User Feedback

OP&T users recommended that the needs of patients in the community and the ability of the hospice to influence external organisations with this work are considered. The project lead will update user feedback group with regards to looking at our falls pathway throughout the organisation.

Timescale of project:

One year

Clinical Effectiveness - Project 4: Establishing a Multi Professional Journal Club for hospice clinicians

Current situation:

The Hospice currently has an established journal club for the doctors, it is felt that it would be beneficial to expand this to a multi professional journal club to:

- Support continuing professional development for clinical staff
- Promote multi-professional working
- Stimulate debate and improved understanding of current topics
- Staff are kept abreast of new literature, clinical evidence and research
- Staff are able to learn / improve their ability to critically analyse and appraise research
- Promote awareness of research skills and encourage research projects
- Improve clinical care & patient outcomes by promoting professional practice that is evidence based
- Fostering of organization-wide practice changes

Result to be Achieved:

- Attendance list of all sessions held
- Journal club schedule will demonstrate different professions as presenters
- Session evaluation to capture any immediate learning and changes required for future sessions

- Summaries of each session will be available to all clinical staff for those unable to attend
- End of year review from attendees of value of Multi Professional Journal Club.

Timescale of project:

Spring 2018

STATEMENTS OF ASSURANCE FROM THE BOARD

The following are a series of statements (italicized) 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 2016-17, 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 2016-17 represents 32 per cent of the total operational income generated by NLH for the reporting period.

Participation in clinical audits

During 2016-17, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that NLH provides. During that period NLH did not participate in any national clinical audits or national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that NLH was eligible to participate in during 2016-17 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2016-17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (nil). The reports of 0 national clinical audits are reviewed by the provider in 2016-17 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 8 local clinical audits in 2016-17 and NLH undertook the following actions to improve the quality of healthcare provided.

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

1&2. CONTROLLED DRUGS AND CONTROLLED DRUGS ACCOUNTABLE OFFICER AUDIT

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 and is undertaken annually. As a result of 2015-16 audit the Medicines Management Policy has been reviewed, updated and re-issued with a resultant increase in compliance in the 2016-17 audit. Recruitment to additional Pharmacy hours have been agreed with Barnet Pharmacy who provide Pharmacy services to NLH.

3. SAFE PRACTICE IN THE MANAGEMENT OF MEDICINES

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) and is undertaken annually. As a result of 2015-16 audit the Medicines Management Policy has been reviewed, updated and re-issued with a resultant increase in compliance in the 2016-17 audit.

4. ANNUAL EXTERNAL INFECTION CONTROL AUDIT ACROSS THREE SITES

At Winchmore Hill site, the overall level of compliance has risen from 90% to 94%. At the Haringey site a small drop in compliance from 100% to 98% was noted. This reflected a requirement for regular reviews of the Infection Prevention & Control policy manual rather than any deterioration in operational working practices.
In Finchley the compliance fell since last year's audit from 95% to 89%. This reflects a range of minor non-compliances in areas including linen management, management of re-usable and single use equipment, sharps and waste management and training updates.
Action plans were developed to cover all the issues raised and have been fully implemented.

5. HAND WASHING AUDITS

On the IPU levels of compliance were 86% in May 2016 and 88% in November 2016 which represents a reduction from November 2015 when it was 97%. In Winchmore Hill levels of compliance were 91% in June 2016 and 86% in November 2016 which both represent a significant improvement from January 2016 when it was 61%. A rolling programme of training, reinforcement and challenge will be led by the Infection Prevention and Control Nurse Lead.

6. SPIRITUAL CARE DOCUMENTATION RE-AUDIT

This audit reviewed the nature of the records made in terms of spiritual needs and care for a random selection of patients known to either a Community Team or the IPU. This was a re-audit, following an initial audit in 2012, thus closing the audit cycle. The results of this re-audit indicate that documentation of spiritual issues still

does not fully meet the level to which we aspire and that the introduction of a records template has not been effective in improving documentation in this area. The Spiritual Care Reference Group continues to evolve and develop, including work to develop new Patient & Family Support service Guidelines.

7. CROSS-ORGANISATIONAL DOCUMENTATION AUDIT

Based on the standards defined in the NLH Record Keeping Policy an audit was undertaken to review the standard of clinical record keeping.
Overall the results were encouraging, but a key finding was the widespread use of abbreviations not on the approved list included in the NLH Record Keeping Policy.
In paper notes on the IPU, the format of the notes was generally good.
In electronic patient notes 92% of the records reviewed included ethnicity. In terms of the format requirements levels of compliance were close to 100% in all categories except the use of abbreviations. There were, however, 9 occasions when an entry in an electronic record was deemed to be non-contemporaneous.
An action plan is being developed, including a review of the agreed list of approved abbreviations.

8. COMMUNITY NURSE SPECIALIST TIME TO FIRST VISIT AUDIT

Referrals to NLH three Community Team (based in Barnet, Enfield & Haringey) are handled by the Triage Team. At the point that a patient is passed from Triage to the relevant Community Team they are assessed as being either a 'standard' or a 'rapid response' referral. The Community Operational Policy sets a standard for how quickly patients in each category should be first contacted and then assessed by a CNS. This audit was against these standards. The overall level of compliance was 95% in terms of the timing of first contact and 85% in terms of first assessment. It has been agreed that further work is required to ensure there is clarity about which patients are standard and which are rapid referrals. This clarification will be one of the outcomes of the full review of the Triage Service, due to be completed by Summer 2017.

We have also been involved in one external audit:

1. **NLH COLLABORATIVE BLOOD TRANSFUSION AUDIT**

NLH has taken part in an external audit organised by the National Blood Transfusion Service, in collaboration with the Royal College of Nursing, the Association of Palliative Medicine and Hospice UK, to compare blood transfusion practice across hospices. Data collection has taken place during Oct to Dec 2016 and the results will be analysed by NHS Blood & Transplant. We expect to receive the audit report by June 2017 and will then consider any action required at a local level.

Research

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2016-17, that were recruited during that period to participate in research approved by a research ethics committee was nil.

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

NLH has contributed to a national research study, which was supported by Hospice UK and undertaken by researchers from the University of Leeds. The aim of the study was to explore which factors influence the duration of time patients receive hospice care prior to their death. The study used routinely collected data to determine the length of time that UK patients receive palliative care before their death and had received NHS ethics approval. NLH has submitted anonymised data concerning patients known to the Hospice who died during 2015. Once the results of the study are published we will be able to benchmark our activity against a range of other hospices.

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2016-17 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

What others say about us

The Care Quality Commission (CQC) monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. They consider five domains of service provision:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well led?

They publish their inspection performance ratings and reports to help the public.

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). The Care Quality Commission has not taken any enforcement action against North London Hospice during 2016-17 as of the 31st March 2017.

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

NLH's three sites were separately inspected in 2016. They observed how people were being cared for, reviewed documentation of care and staff records, examined orgnisational processes and talked to staff and the people who used our services. NLH was found to be compliant in all of the areas assessed;

- Woodside Park, North Finchley site (IPU, PCSS and Barnet Community Palliative Care Team) received an unannounced inspection in October 2016 and was rated "Good" in all domains.

- Barrowell Green, Winchmore Hill site (OP&T and Enfield Community Palliative Care Team) received an unannounced inspection in August 2016 and was rated "Good" in all domains.

- George Marsh Centre, St Anne's Hospital, Haringey (Haringey Community Palliative Care Team) received an unannounced inspection in November 2016 and was rated "Good" in all domains.

DATA QUALITY

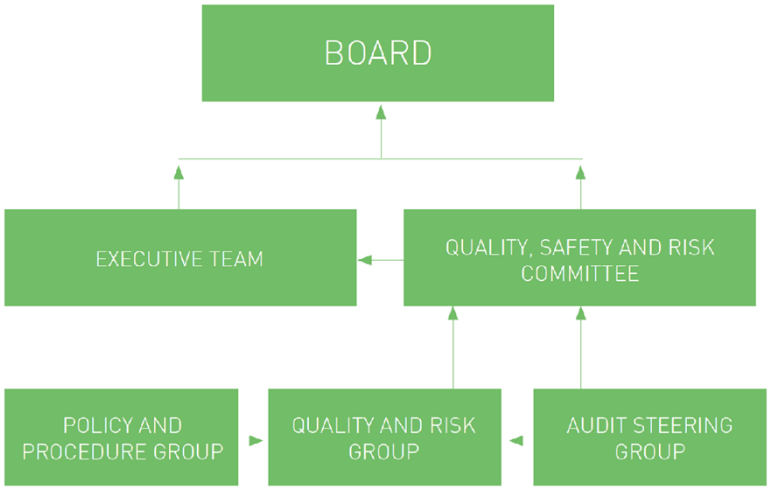
NLH did not submit records during 2016-17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as it is not applicable to independent hospices.

Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner. As part of the monitoring of the IG Standards within the Hospice NLH completed the annual IG Toolkit in 2016-17 and received a score of 98%. In 2016-17, NLH received confirmation that our assessment has been reviewed by the Health and Social Care Information Centre (HSCIC) and has been confirmed as .
NLH was not subject to the payments by results clinical coding audit during 2016-17 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 2016-17:

Broadening the Offer by Outpatients and Therapies (OP&T)
The main focus throughout 2016 – 17 for the OP&T service has been the development of the service with a view to broadening what we can offer, concentrating particularly on the needs of those with long term conditions that are under represented in accessing the hospice.
New roles have been established: Associate Director, Physiotherapy, Occupational Therapy and Social Work posts to work with the already established medical and nursing outpatient team.
The team has introduced a Co-design service development model to ensure all stakeholders (professionals and service users) are involved in the planning and development of new interventions. It is aimed that this model will become the norm for future service developments.
Alongside individual appointments the number of group sessions are increasing.

- four days of Come and Connect (our social programme), two on each site,
- piloting Managing Fatigue and Breathlessness courses
- exercise group and open gym session established.
- complementary therapy service has continued to grow and a weekly symptom control acupuncture group has been established
- piloting craniosacral therapy sessions for carers.

We are reviewing our volunteer roles and developing some new roles with specific skills to support the developments in the service.

Community Nurse Specialists' (CNS) Development
An Enfield CNS has commenced the Non Medical Prescribing course to enable prompt access to appropriate medications and treatment for patients in their own homes.

Enfield and Barnet team CNSs have started the Advanced Physical Assessment course to enable prompt and effective assessment to support effective treatment for people in their own homes.

Haringey GP teaching session
Delivered by Medical Consultant and the CNS team.

Training to Haringey District Nurses
A teaching programme was delivered to District nurses at the request of the District Nursing leads and CCG. 15 sessions were delivered between October – December 2016 by the CNS's in three different sites. The programme provided sessions on communication skills, the Five Priorities of Care and symptom management. We are currently evaluating the programme, however it was generally well received and attendance ranged from 3-11 nurses per session.

End Stage Renal failure project in Haringey
Community Medical Consultant has commenced a project working with patients attending the renal dialysis unit in Tottenham Hale. Support is being provided to the renal team to develop Advanced Care Planning (ACP) for their patients with end stage renal failure.

Whittington Respiratory Team
The Haringey team are working together with the Respiratory Team to identify appropriate referrals to palliative care services and promote ACP discussions.

Advanced Care Planning in Care Homes in Haringey
The North Middlesex University Hospital have employed a Nurse to develop ACP in the two nursing homes in Haringey. The nurse will be based within the community palliative care team in Haringey and managed by NLH Community Team Leader.

Rapid response by Community Teams
All the community teams now have a nurse identified each day who can respond to urgent issues.

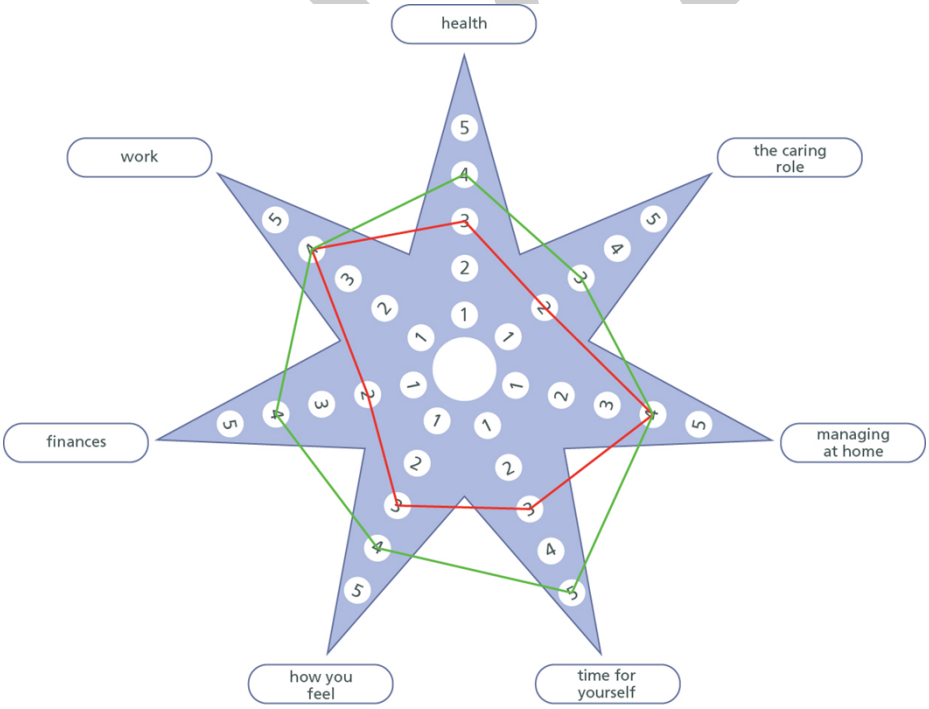
Finchley Laundry Refurbishment
IPU Laundry Facility has undergone a full refurbishment with the installation of new washing machines, dryers and an ironing machine. The equipment is more energy efficient as they have quicker wash and drying cycles. This provides assurance that laundry is washed at an appropriate temperature.
We are very pleased to continue to be able to launder patients washing at the Hospice as this removes the need for relatives to do this and helps the patient to remain independent.

Finchley Easy to Read Plans
We have introduced easy to read plans of our In Patient Unit which helps with orientation of both patients and visitors.

Visitor Facilities at Finchley
We now have a Visitor Shower Room which is fully stocked with toiletries and towels. This is particularly useful for family members who do not live locally and are staying overnight at the Hospice with their family member.

Increasing the Quality Team
In September 2016 we recruited to a full time post of Quality and Audit Manager.
This is a new role, identified in our Audit Strategy. It has made a substantial difference to the way we undertake clinical audit and other quality projects throughout the hospice.
We have successfully completed all our audits planned for 2016 /2017 and have been able to put a more detailed audit plan in place for 2017 /2018. This includes not only the compulsory audits for example for Infection Prevention and Control, but also audits relevant to Hospice care such as Advance Care Planning and Pain Management.

Outcome Star (or in partnership working)
The Outcomes Stars™ are evidence-based tools for both measuring outcomes and supporting change. Each version is an assessment, support planning, review and outcomes tool in one, measuring change however that is defined for the particular group. They are also tools to engage people, open discussion and encourage professionals and other workers to listen, empowering people to express what is important to them and make changes.
The Outcomes Star was originally developed for the homelessness sector by Triangle[1] . There are now over 25 published versions, including the Independent Living Star, Well-being Star and Carers Star (pictured), and a growing body of evaluation and research into the validity and reliability of the Stars.



Carers Star™ © Triangle Consulting Social Enterprise Ltd
Authors: Sara Burns, Joy MacKeith and Amaragita Pearse
www.outcomesstar.org.uk

NLH initiated the development of an 'End of Life Star' to be used in palliative/EOL care (final name to be decided) and invited in other collaborators to help fund the development. These include: St Josephs Hospice, Macmillan Cancer Support, Jewish Care and the London Association of Directors of Adult [Social] Services. Two one day workshops have taken place. A first draft Star will be designed for piloting in the Spring of 2017 with a view to having a completed version by 2018. This tool will then be available nationally.

Clinical Supervision
A new approach to delivering Clinical Supervision has been put in place. Clinical Supervision is intended to provide patient facing staff with a confidential space in which to reflect on the impact of the work on them as well as their impact in relation to others. This helps to sustain staff who are facing difficult emotional situations on a day to day basis, as well as keeping them open and available emotionally. We have now appointed two Clinical Supervisors to provide four half days a week so that the opportunity to take up Clinical Supervision is available to clinical staff on a regular basis. Some staff are finding support through individual sessions and some in small groups.

PARTNERSHIP WORKING

NLH are working together with:

Enfield Integrated Team. The Enfield CNS's continue to offer specialist palliative advice at the meetings for patients predominantly with long term conditions.
Enfield Social Services Occupational Therapy. The Occupational Therapist from Enfield social services plans to meet with the CNS's monthly to work with our patients ensuring a timely response for OT assessments.
Care Home Enhanced Support Service (CHESS) team In Barnet. The CNSs are working together to avoid unnecessary hospital admissions and improve standards of end of life care for patients in Care Homes.
NLH CNSs are supporting **Two Barnet Nursing Homes** with an embargo preventing further continuing care admissions, to improve their standards of end of life care.
Locality District Nursing managers and the community teams hold regular professional meetings.
Haringey Link District Nurse. The nurse meets regularly with the community team to develop their skills in end of life (EOL) care.
Barnet Clinical Commissioning Group pharmaceutical advisor to improve access to medication required to support people dying in their own homes.
Barnet Independent Living Team (BILT) Multi-Disciplinary Team. Community Team regularly attend multidisciplinary meetings discussing older adults with complex care needs to prevent avoidable hospital admissions and identify patients requiring hospice care.

EDUCATION AND TRAINING

The Education Department is situated at the heart of North London Hospice, promoting end of life care of the highest standards. We provide a range of multi-professional courses, supporting both internal and external colleagues to develop their knowledge and skills, thereby improving the care they give to patients and their families. Details of all our courses and a booking form can be found in our Education Prospectus, which is published on the Hospice Website (see http://www.northlondonhospice.org/for-clinicians/education/).

North London Hospice is a regional Gold Standards Framework (GSF) Centre offering the 'GSF in Care Homes' training programme. The Gold Standards Framework Care Homes programme (GSFCH) is the UKs largest and most comprehensive training programme for providing end-of-life care.

Education Department Developments

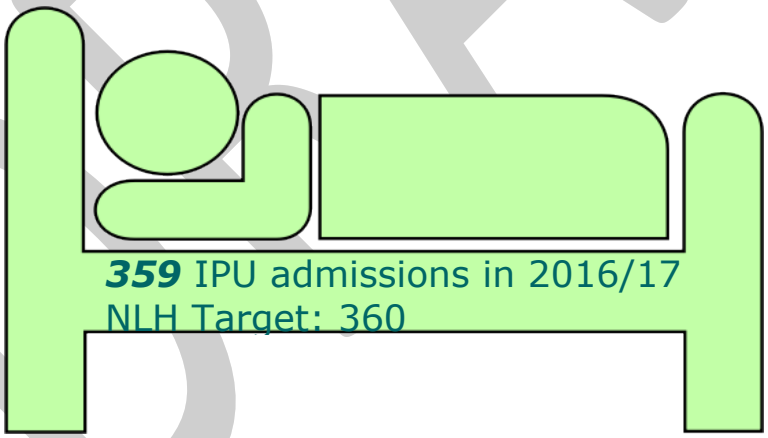
- The educators ran NLHs first two **Qualifications and Credit Framework (QCF) Level 2 Awards in End of Life Care** for internal and external staff. The QCF is a nationally recognised credit transfer system. All 6 NLH staff who completed the course were successful in achieving the qualification.
- A **4 week course for new PCSS health care assistants new to healthcare** was piloted. It consisted of classroom based training and work experience. The programme will run again in 2017-18.
- NLHs first **Summer School for 16 and 17 year olds** was run as a 3-day workshop to allow them to gain experience of the Hospice and healthcare. It was positively received and 2 further workshops are now planned.
- **Dementia Friends:** (An Alzheimer's Society initiative to create 'dementia friends' and dementia friendly communities) NLH so far this year has created '122 dementia friends'. This is now mandatory for NLH staff and there has also been a great demand for places on sessions advertised externally to the local community.
- **Enfield Care Homes Project**: Recognising Dying and Communication Skills training has been completed in 32 care homes in Enfield.
- **Palliative care study days for both registered nurses and Health Care Assistants**
- **GP end of life care education** afternoon held. Extremely positive feedback on project.
- **The Gold Standards Framework Care homes training programme** is currently being delivered to a cohort of 4 nursing homes. NLH will be working in partnership with GSF and other Regional Centres to update the course material.
- 5 new courses have been developed to feature the 2017-18 **Education Prospectus**. Presentation Skills and Clinical Audit were added to the prospectus in response to needs identified in the NLH Training Analysis.
- A new course, **'Supporting young people facing bereavement' course**, in partnership with Noah's Ark Hospice was delivered in March.
- **Reflection for learning**: A process for reflection on medicine errors was introduced at NLH.

- Kings University Medical students: 45 medical students attended half day attachments of end of life care training.
- **Tours:** 80 people have had a tour of the Finchley site including people from as far afield as Taiwan and the USA.
- NLH supported 8 **student nurses from Hertfordshire University**. Placement feedback was extremely positive. A student e-welcome site was created. Attendance at University meetings, DBS and Fitness to Practice panels maintained.
- **Apprentices:** NLH have been working in partnership with Barnet and Southgate College to introduce health care and administration Apprenticeships into NLH in 2017.

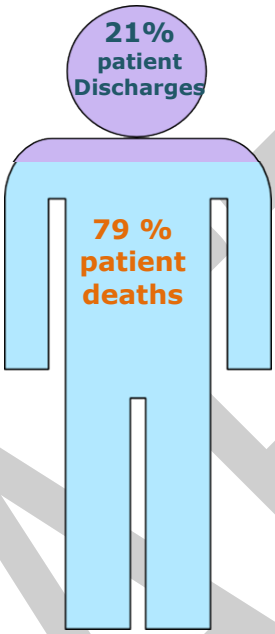
SERVICE ACTIVITY DATA

NLH monitors the performance of different aspects of its services quarterly against some annual targets. Highlights of this year are included here.

IN Patient Unit (IPU)



The number of IPU admissions has remained fairly consistent over the last 3 years with a similar proportion of patients with a cancer diagnosis (86% in 2016-17)versus non cancer diagnosis (14%) despite NLH referral criteria being inclusive of all life limiting conditions. 21% of IPU patients were discharged home, with the remaining 79% dying whilst with the care of the IPU team. The average length of stay remains consistent year on year and was 13.5 days in 2016-17.



Bed Usage

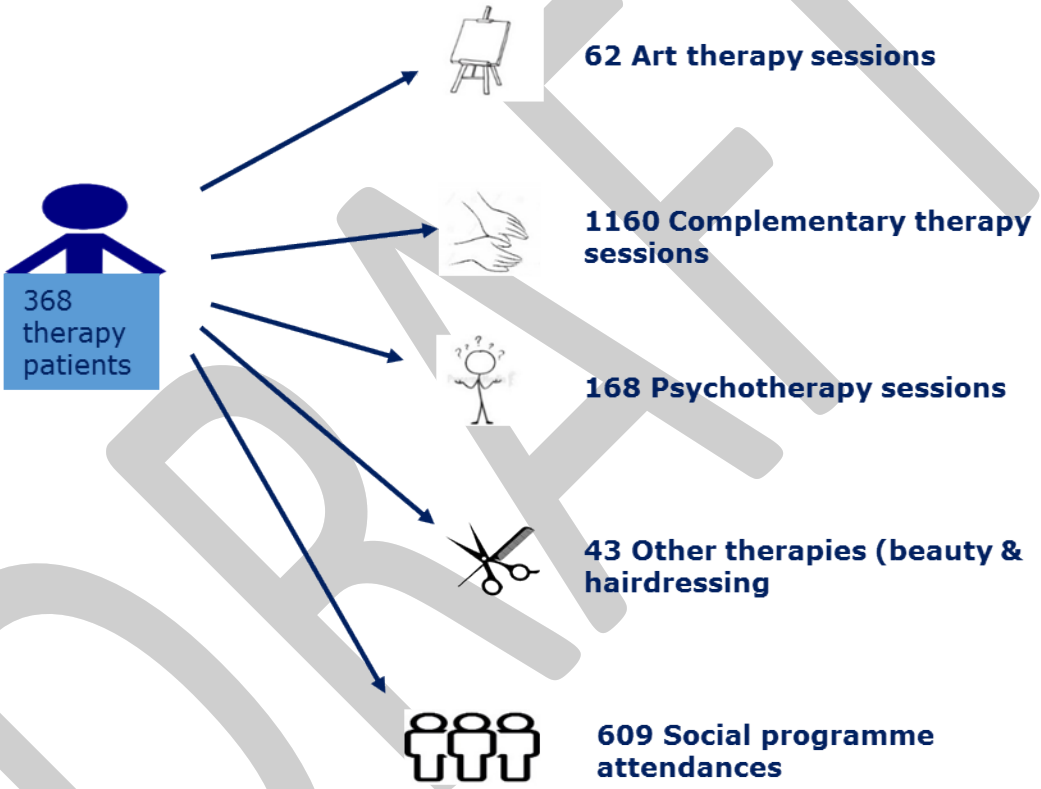
Bed occupancy is the percentage use of all 18 IPU beds calculated for the whole year and is used to monitor maximum use and availability of IPU beds for referrals. This year there has been a slight increase to 74.8% IPU bed occupancy from 70% last year. NLH compares bed occupancy quarterly to other similar sized hospices. In the first two quarters, NLH achieved higher bed occupancy scores (Q1: 79.8%, Q2: 80.7%) when compared with other similar sized hospices (Hospice UK Benchmarking)but lower in third quarter (Q3 69.6% vs 78% national).Full year comparative figures awaited. Factors that impact include ebb in referrals, daily admission capacity, staff sickness and staff vacancies. As part of daily admission meetings, NLH consider actions being taken to address any closed beds.

Closed bed days has increased to 39 days this year compared to 30 days last year. The causes were solely plumbing issues which rendered some rooms unavailable.

Outpatient and Therapies Service

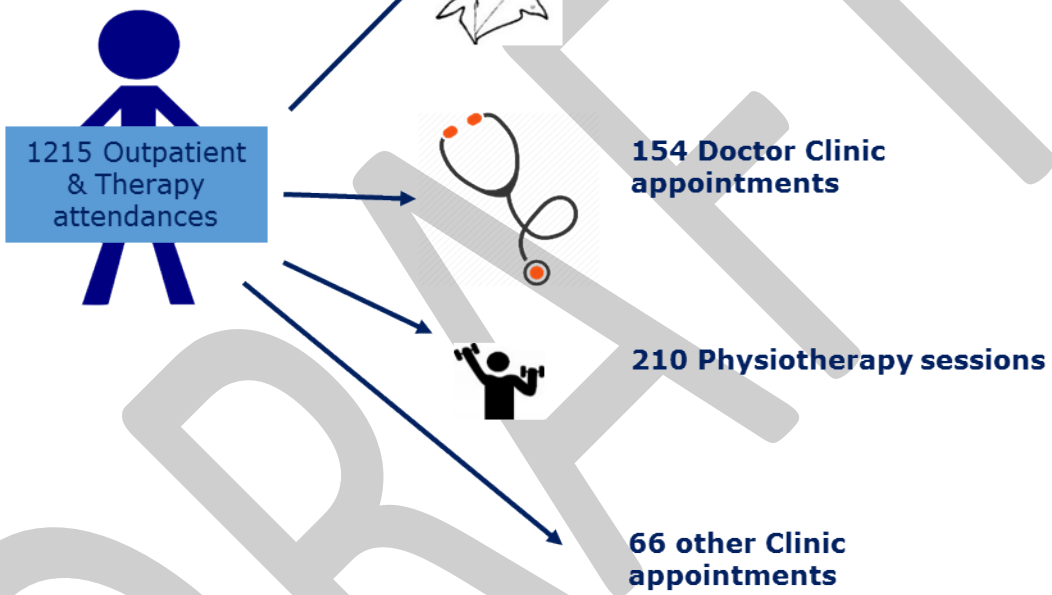
Therapies:

This year there were 368 patients who used Therapies Service. The type of therapies received is displayed below in the diagram.



Outpatients:

278 patients were seen in Outpatients with a total of 1215 attendances. "Other appointments" included those with the Occupational Therapist and Social Worker.

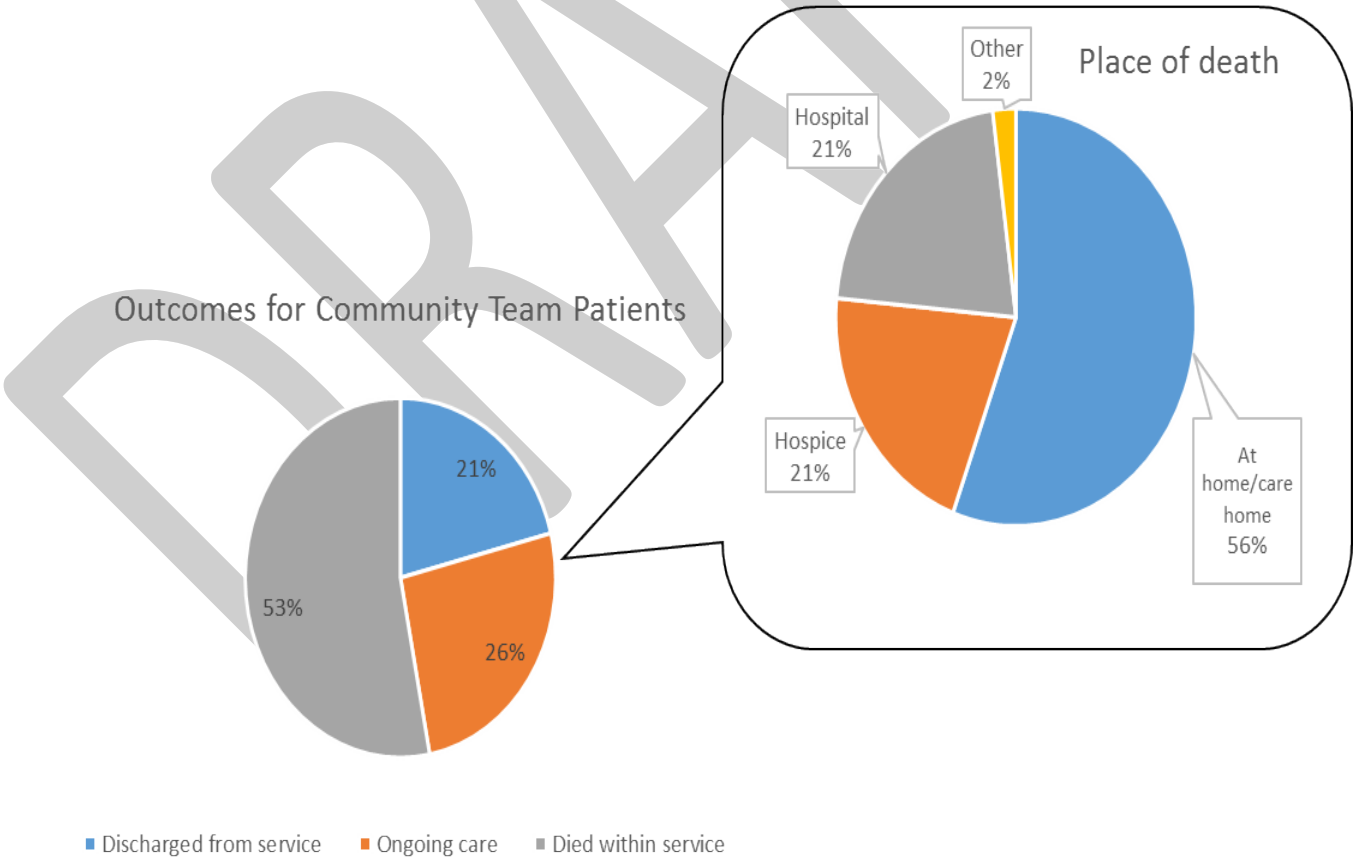


Community Teams

The community teams have supported 2155 patients in their homes this year which is an increase from last year (1973 patients). NLH are thus supporting more and more very ill people to remain in their own homes.

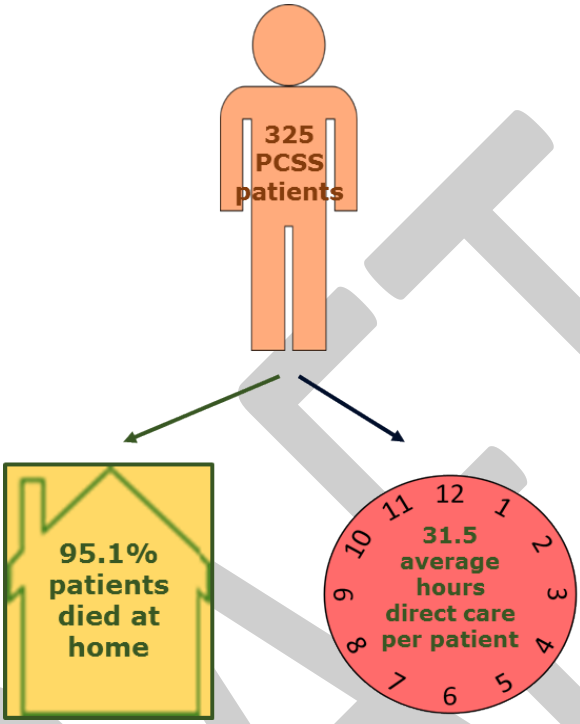
Of these community patients, 21% were discharged when they no longer required specialist support, 53% were supported by the service until their death, with 26% remain on the caseload

Of the 1145 patients who died whilst under the care of the community teams, 641 patients were supported to die in their own homes (56% home deaths) this year.



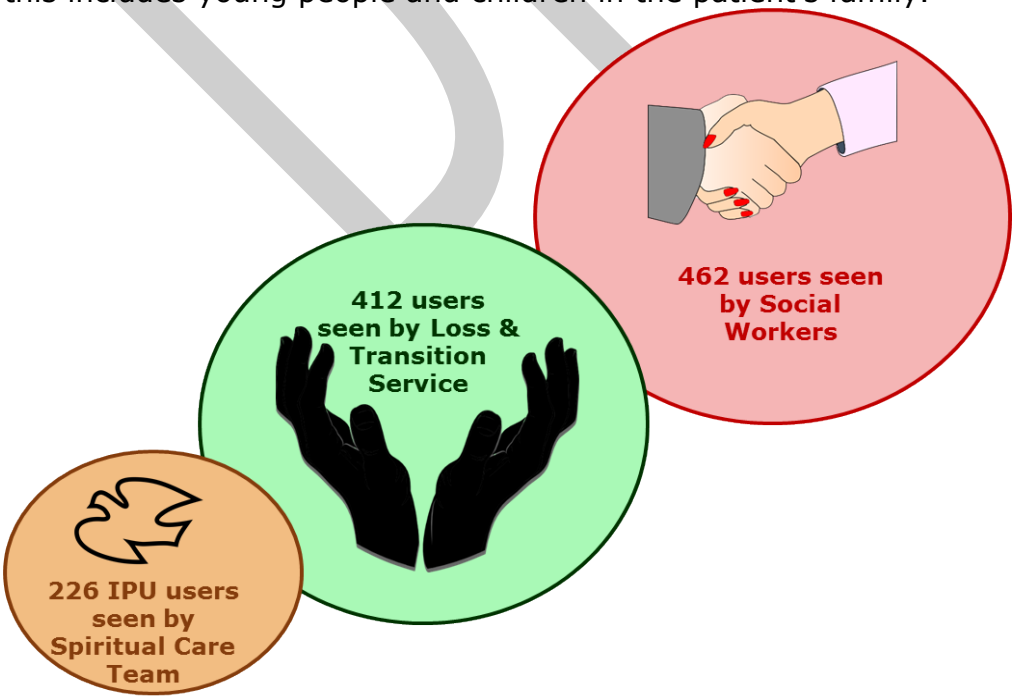
Palliative Care Support Service (PCSS)

325 patients were supported in their own homes by the PCSS. 95.1% patients died whilst under the care of the service with an average of 31.5 hours of direct care provided per patient.



Supportive Care Team

The infogram below shows the significant contribution the Supportive Care Team make to the multidisciplinary care provided by NLH to its users. This ranges from specialist professional support provided by the Spiritual Care Coordinator, Specialist Social Work staff as well as Loss and Transition Staff who offer bereavement support for more complex situations. The team has the expertise to provide more complex psychosocial interventions to patients and families; this includes young people and children in the patient's family.



SERVICE USER EXPERIENCE

This year, we have been surveying patients attending Therapies service and those on the Inpatient Unit using hand-held tablets, rather than paper surveys. This has enabled us to hear current or real time feedback and gives the opportunity to take immediate action where necessary. Comments cards, the logging of compliments, gathering patient stories to add richer narrative to our user feedback remain the NLH standard for obtaining user feedback. Feedback is reviewed at service level with team members and also through NLH governance groups. All feedback is collated and analysed for themes and to identify improvements or changes required to endeavor to best meet our users needs.

User Surveys 2016

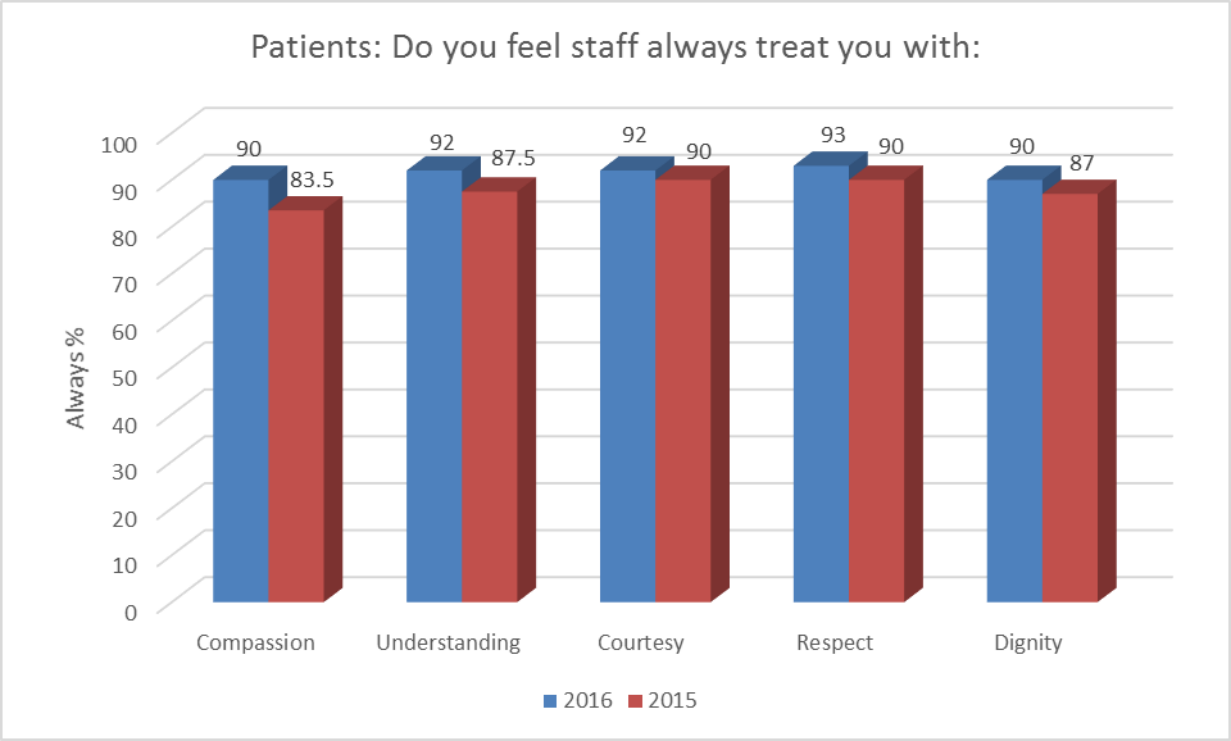
- Paper surveys were sent out from May-October 2016 to the following services:
  - Community patients and relatives
  - Outpatients
  - Inpatient relatives
- Tablet surveys were undertaken throughout the year with
  - Inpatient patients
  - Therapies patients.

There was a 31% overall response rate with 306 patients/relatives providing feedback which is comparable to last year. The full results are collated in a report that has been presented to service leads, the Executive Team, governance meetings and the Board of Trustees. All services each year identify key areas for improvement.

Below NLHs key performance indicators' results are displayed.

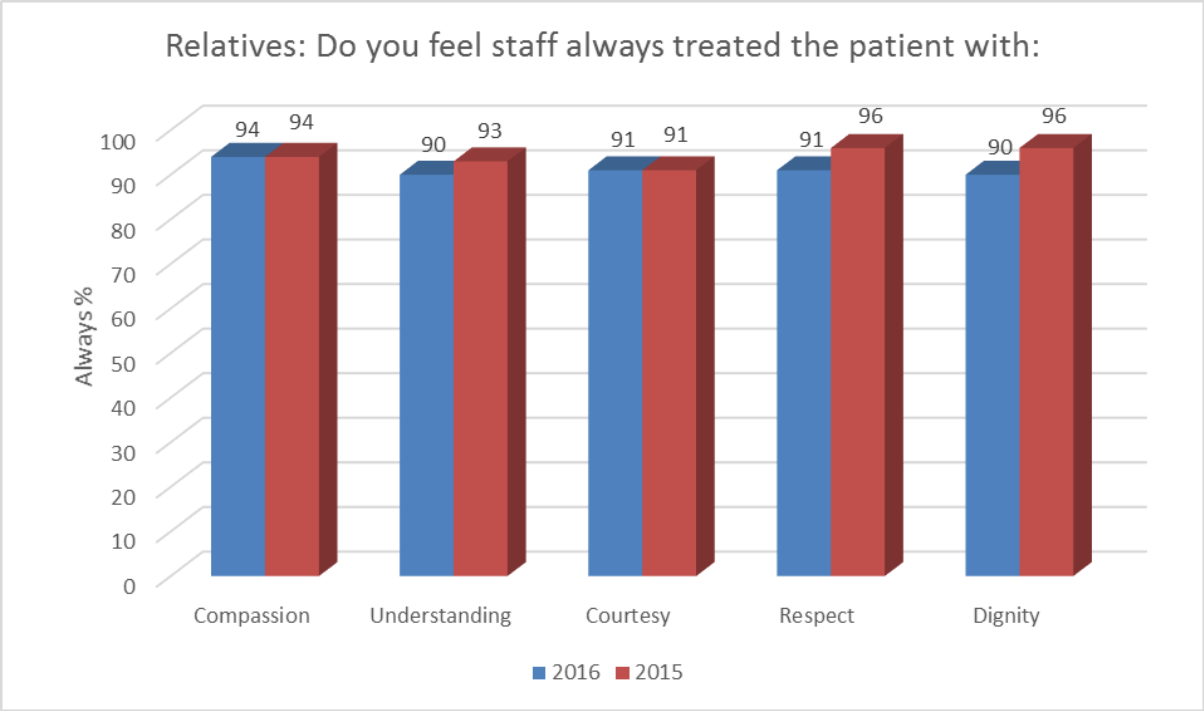
Key Performance Indicators

Key Performance Indicator 1



These results are the averages of the patients' experience for Inpatient Unit, Community Teams and Outpatients and Therapies services.

Outpatients and IPU had increases in all areas, Therapies and Community patients each had 3 areas which performed slightly less well in 2016.The Community Team saw a 4% decrease to 87% this year in "understanding" . Therapies had a 5% decrease in "courtesy" and "respect" however this was still 95% in 2016.

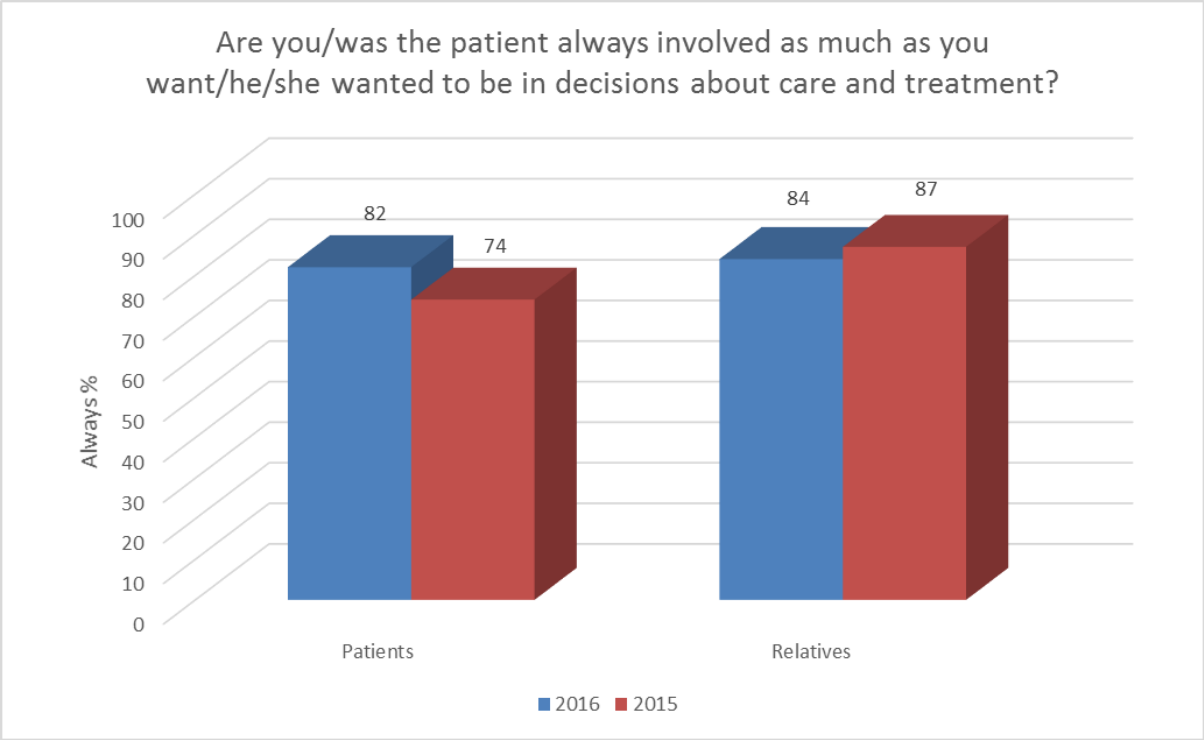


These results are the averages of the "always" results from Inpatient, Community Teams and Palliative Care Support Service relatives.

IPU, Haringey, Barnet and Enfield relatives results have improved from 2015.
In all areas Palliative Care Support Service have seen a move from "always" to "sometimes".

The Palliative Care Support Service has now developed a new training programme on identifying needs of patients and individualising care. This is currently being used with new and existing staff.

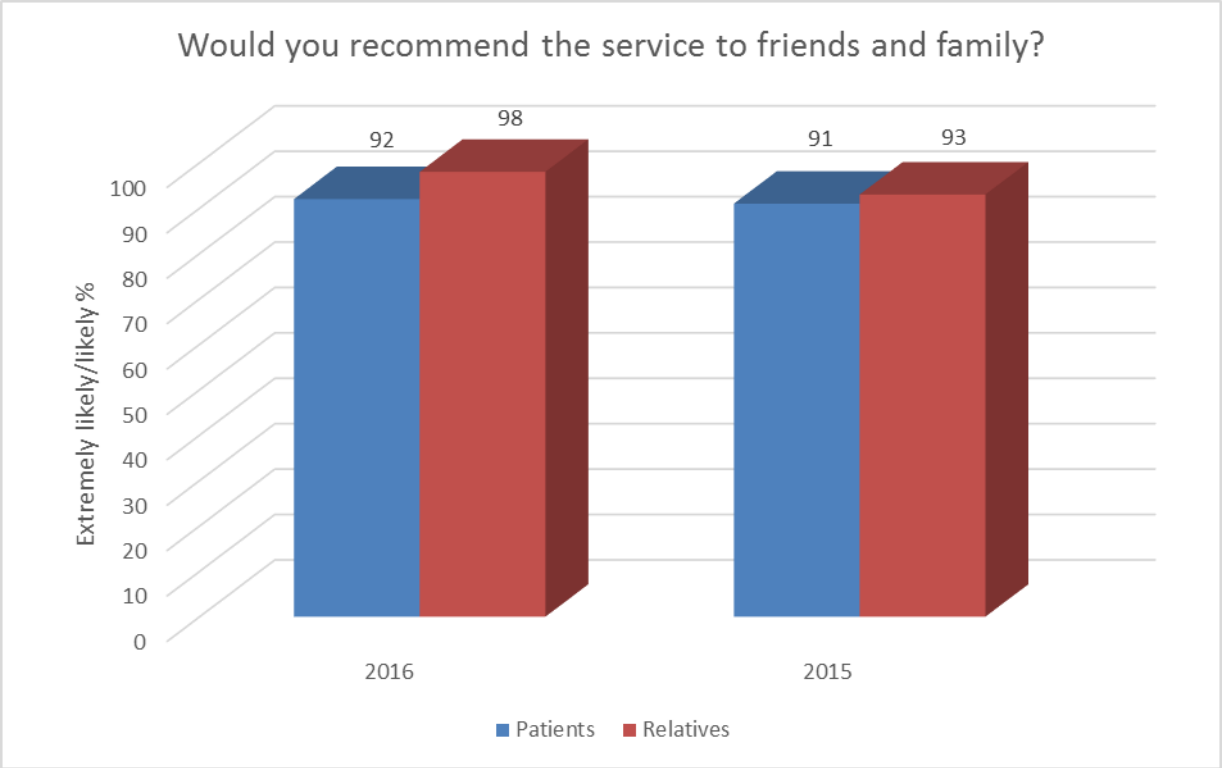
Key Performance Indicator 2



For patients, this question features on the Community and Inpatient's surveys only.

For relatives, those who were visited in the community by our Clinical Nurse Specialists had an increase in the number who said they were always involved. The responses of relatives of patients in the Inpatient Unit or who had the Palliative Care Support Service at home are the reason for the decline in the overall results.

Key Performance Indicator 3



This year, the average of the responses, 'Extremely likely' and 'Likely' across the services is 95%.

There is an increase in the number of Haringey relatives who would be extremely likely to recommend the service. (93% in 2016 - 56% in 2015).

No-one has indicated that they would be unlikely or extremely unlikely to recommend the service.

Across all services 4% answered 'Don't know/not applicable' or left blank.

COMPLAINTS

Quality Performance Indicator	2013-14	2014-2015	2015-2016	2016-2017
Number of Complaints (NLH target less than 30)	34	19	21	10

Quality Performance Indicator	2013-14	2014-15	2015-16	2016-17
Investigations completed, complaint upheld/partially	25	19	11	8
Investigations completed, complaint not upheld	6	0	5	1
Investigations unable to proceed as complainant not able to give full information	3	0	4	

Analysis:

NLH receives complaints about its clinical and non clinical (charity shops) aspects of its business. This year of a total of 10 complaints received. 8 were clinical (patient services) complaints. 5 of these clinical complaints involved our community teams and 3 our IPU. This correlates with 0.35% of patients and families supported by NLH this year made a complaint.

Of the completed investigations 8 of the 9 complaints were upheld/part upheld. 1 complaint is in progress. The predominant theme of these complaints was communication issues and two related to inadequate standard of care. The following are some examples of actions taken following completed investigations this year:

- Arranging a meeting with the GP practice to explore ways of improving relationships
- Communication training given to staff member

As well as complaints, we record concerns and compliments. Concerns are an issue raised by a user that requires consideration.

Concerns:
This year we received 37 concerns from our users. 30 related to clinical care.

Example 1: Difficulty getting through on the telephone to our Barrowell Green site
Conclusion: Increase in staff required so an extra member of staff is available to answer calls.

Example 2: Wife felt upset that her husband was transferred from IPU to a care home and

died shortly afterwards.
Conclusion: Unfortunately, NLH IPU is only able to offer short stay admissions due to the demand for its 18 beds from three Boroughs. When the patient was transferred it was not expected that he would die shortly after transfer.

Compliments:
This year a total of 277 written compliments were received and recorded on NLHs Compliments Log

Community Team Barnet:
".Mums overriding wish was to be able to remain at home and your support and organisation of care and equipment made this possible. We are so incredibly grateful to you for enabling mum to pass peacefully at home."

Community Team Enfield:
"Patient had such confidence in your expert care of him, you always listened to his concerns and respected his wishes."

Community Team Haringey:
"You gave us a shoulder to lean on and for that we are very grateful."

Inpatient Unit:
"The nurse with us at the time of the death went out of his way to help put not just the patient but the whole family. He really put us all at ease with the situation. Because of this nurse the patient died peacefully and with dignity - the whole family felt reassured"

PCSS:
"I was hugely impressed by their knowledge of palliative medicine and their kindness and compassions not just towards him but towards me too. They went well beyond the call of duty."

Outpatients:
".We can't speak highly enough of the kindness, compassion and help we are receiving.
A big "Thank you" in gratitude to the Outpatient Department."

Therapies:
"The atmosphere is always friendly and relaxed. The ambiance and the environment is very pleasant & welcoming. The staff are lovely and immediately offer a cup of tea or coffee"

Supportive Care:
"I cannot thank everyone at the North London Hospice enough for getting me through the first five months after my mother died. The combination of the walk and talk and counselling with Ruth, on the same morning really helped me cope."

User Narratives
Four patients/relatives agreed to record their experience.

"Out of hours number worked well and the instructions are extremely clear. When you're stressed sometimes it's difficult to process information but it was explained to her by the CNS. The card was clear, the message on the phone was also very clear. She always heard back within 15 mins. On one occasion someone phoned her back even when she hadn't been able to leave a message because the nurse spotted a missed call. Other services she dealt with were nowhere near as good. Our telephone service was invaluable."

"The love and care they treated my granddad with was wonderful. He was afraid that he would just be seen as an old man in the corner and not the person he was but the staff asked me to bring some pictures of him when he was younger to show them."

PATIENT SAFETY

Incidents

	2013-14	2014 -15	2015-16	2016-17
Total number of Incidents	279	250	216	371
Total Number of Clinical Incidents	168	173	152	312

Analysis:
The total number of reported incidents this year has increased by 58%.

This is attributed to our improved reporting system using Sentinel (electronic reporting system), which is now embedded in the organization. The continued emphasis on the importance of reporting of all incidents and our "no blame" culture has also helped ensure all incidents are reported. We have systems in place to ensure incidents are analysed for trends and themes and any learning needs identified.

Additional training has been carried out for staff on health and safety issues such as being a fire warden or first aider. This has further increased awareness amongst hospice staff on importance of incident reporting.

NLH aims to be open and honest when any incident happens. There is also a legal duty for NLH to follow "Duty of Candour" regulations where incidents have caused or could lead to significant harm to patients. There has been one Duty of Candour incident where a patient was admitted with a grade 2 pressure ulcer and during their admission "acquired" a Grade 3 pressure ulcer. The patient was informed of the change in the grade of her pressure ulcer. The investigation concluded that this was an avoidable pressure ulcer and therefore Duty of Candour applied (as Grade 3 avoidable pressure ulcer equates to significant harm). NLH were unable to proceed in accordance with Duty of Candour Policy and discuss this with the patient or next of kin as the patient had died and their next of kin did not have mental capacity.

Inpatient incidents:
NLH continues to benchmark itself by submitting quarterly data to Hospice UK and comparing its IPU incident numbers with other hospices of this size.
*Full year comparative data will be entered when available.

Falls

	2015 - 2016	2016 - 2017
Number of Patient related slips, trips and falls	36	27
Falls per 1,000 occupied bed days	7.83	5.74
Hospice UK Benchmarking Falls per 1000 occupied bed days	10.6	*

Medicine Incidents

	2015 - 2016	2016 - 2017
Number of medicine incidents	22	28
Medicine incidents per 1000 occupied bed days	4.8	5.74
Hospice UK Benchmarking Medicine incidents per 1000 occupied bed days	6.4	*

The first three quarters comparative data with other similar sized hospices shows that NLH has well below the national hospice average for falls (40% of national average) and medication errors3(5%).

Pressure Ulcers

Please see Appendix 4 for definition of acquired, inherited, avoidable and non avoidable

	2015 - 2016	**2015 - 2016**	**2016 - 2017**	**2016 - 2017**
	NLH	**Hospice UK Benchmarking (average)**	**NLH**	**Hospice UK Benchmarking (average)**
Pressure ulcers inherited	**	**	139	
Pressure ulcers acquired (avoidable)	36	3.1	6	*
Pressure ulcers acquired (unavoidable)	12	17.8	51	*

* *Data for inherited pressure ulcers not collected previously

This data shows us that North London Hospice inherits and acquires patients with a greater number of pressure ulcers than other hospices of its size.

The reason for this is yet to be understood and could be due to differences between units' patient profiles. It is possible NLH admits more patients for end of life care than other similar sized hospices as this would make patients more susceptible to the development of pressure ulcers.

What we have done / are doing:
For 2016 – 2017 the increase in numbers of Quality Team staff has enabled more scrutiny of all incidents reported, and for pressure ulcers in particular. All pressure ulcers (inherited and acquired) are logged and reviewed in a timely and detailed manner. This includes assessing to ensure appropriate care is in place as well as accurate reporting and analysis.

Further analysis of inherited pressure ulcers examined where patients admitted with pressure ulcers came from, and did not find any particular trends or patterns

- 40 % from home
- 40 % from local hospitals
- 20% miscellaneous (from individual care homes, private hospitals, other hospitals)

NLH continues to report all patients who are admitted with Grade 3 (or above) Pressure Ulcers to the CQC, relevant CCG and Safeguarding Team as per policy.
NLH will continue to monitor inherited pressure ulcers and are working with Tissue Viability nurses in the Community to ensure best practice is maintained.

NLH aims to have no avoidable pressure ulcers acquired in the IPU. To ensure that all our pressure ulcers are unavoidable, NLH are taking the following actions:
After a 5 month vacancy, in January 2017 a senior registered nurse already working in the inpatient unit was employed, to work 2 days a week as a Tissue Viability nurse.
His current priorities are

- To work with the team to prevent and manage pressure ulcers by ensuring best practice is followed
- To implement recommendations and changes to practice identified from Route Cause Analysis's from Grade 3 pressure ulcers that have developed in the unit.
- To continue to monitor pressure ulcer prevalence and identify trends / patterns that can be learnt from

He will receive training and mentoring to ensure he has the knowledge and skills to undertake this role.

Infection Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2013-14	NUMBER 2014 –15	NUMBER 2015-16	NUMBER 2016-17
Patients who contracted Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia whilst on the IPU (NLH target 0)	0	0	0	0

NLH are pleased to note that no patients have contracted any of the above infections whilst under the care of IPU.

NLH STAFFING

NLH employs a total of 196 (154.4 WTE) permanent staff and 58 bank staff. It benefits from the efforts of approximately 980 volunteers who are used as required in clinical and non-clinical roles. The Hospice has many staff working part time or flexible hours.

	2013-14	2014-15	2015-16	2016-17
Staff joined	52	54	50	74
Staff left	30	50	52	59

Recruitment, particularly of Band 5 and Band 7 nurses, has continued to be difficult. NLH has embraced the concept of apprenticeships, enrolling two current employees on appropriate advancement courses. A number of recruitment and retention incentives have been considered, including introduction of a health cash plan launched during the year and agreement in principle to an annual leave sale/purchase scheme for possible future implementation. Research is underway into possible negotiation of staff price discounts with local and national retailers and service providers. Long service will now be recognised by presentation of appropriate certificates during suitable staff functions. As one of a range of measures to improve internal communication, weekly Staff News Exchange events, to which all are invited, are held. The staff Information & Communication Forum continues to mature and plays an important role as a platform for issues and concerns to be raised, discussed and addressed as necessary.

NHS England (2017) asked for comment on NHS Staff Survey KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion relating to the Workforce Race Equality Standard).

NLH use the Hospice UK-sponsored staff survey where some questions relate to the indicators above. Below are the questions asked and responses:

	In the last year I have not been bullied at work			**Diversity is welcomed at the Hospice**		
	%			%		
	Staff N=112	Volunteers N=200	All hospices	Staff N=112	Volunteers N=200	All hospices
Strongly disagree	4	0	3	5	1	2
Disagree	10	2	5	5	2	4
Neither agree nor disagree	10	8	8	26	23	23
Agree	32	32	30	41	45	46
Strongly agree	44	58	54	24	29	25

The survey was completed by 43% of our staff and 20% of volunteers. Although participation was marginally lower than the average for all hospices using the survey, responses from NLH staff who took part this year in these two areas, were better than those submitted during the previous year. As the survey was anonymous a further survey was circulated asking for narrative comments on areas where scores were lower. The Executive Team continue to seek clarification where possible and to address any issues felt to be relevant, and satisfaction levels will continue to be monitored through staff surveys, open forums, Personal Development Review comments and exit interviews. Any allegations of bullying are rigorously investigated and dealt with.

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

NLH Board of Trustees Quality Account Comment

Reflecting on the many achievements of this last year as we celebrate 25 years of inpatient Hospice care, the Board of Trustees particularly welcomes the independent corroboration by the CQC (Care Quality Commission) of the quality and standards of care provided by the Hospice across all service areas. A rating of GOOD was achieved in all the three service settings visited, Finchley, Winchmore Hill and Haringey. This rating as well as the achievements reflected in this year's Quality Account serve once again to give sound assurance of the ongoing high standards of care as well as the continuous efforts to respond to the views and needs of carers and users of Hospice services across all settings.

The Board has been kept informed of progress made throughout the year against the areas identified as Priorities for Improvement. As in previous years, these build on existing good practice both internally and externally. Establishing the User Forum builds directly on the priorities identified in 2015/16 and is the next step in taking the user feedback pilot to the next level. Likewise, although the work relating to the Five Priorities of Care was well embedded in practice, there was concern that documentation and record keeping did not always reflect the full implementation of good practice. A simple yet very effective communication and engagement tool recognised nationally has been the introduction of the 'Hello my name is….' model. All staff and volunteers have been issued with new names badges and there is positive feedback from relatives and patients about the helpfulness of this initiative. This last year's priorities also recognised the challenging, sometimes distressing and often stressful nature of caring in any health related setting. Although the Hospice has a supportive culture, excellent training and supervision systems, the introduction over the last year of the Schwartz Round model widely implemented in the NHS, has created the opportunity across all disciplines and levels of responsibility to share some of the pressures and anxieties in a safe and containing manner. The Board especially welcomes this development, recognising that the pressures on teams across all services continue to be significant.

The Board welcomes the improvements and achievements illustrated in this year's Quality Account. As in previous years, the Board fully supports the Priorities for Improvement identified for 2017/18, recognising that they build on much of the excellent work already being undertaken. Of particular interest to the Board is the work being proposed around co-production with users of the services, carers, volunteers and staff in shaping the Outpatient and Therapies services and the focus on Hard to Reach groups in the community that the Hospice serves. In terms of patient safety, again, building on good practice and responding to the data around slips, trips and falls, this initiative is particularly welcome as is the ongoing support for the development of staff and maintaining good practice through the work of a multi professional Journal Club.

Once again, this year's Quality Account illustrates that the Hospice is committed to serving the local community and making services more accessible to a greater number of people through the commitment, dedication and loyalty of its skilled staff and volunteers.

John Bryce
Chair - North London Hospice Board of Trustees

STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

APPENDIX ONE: OUR CLINICAL SERVICES

1. Community Specialist Palliative Care Teams (CSPCT)

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

The service emphasis is based on:-

*Care closer to home

*The Facilitation of timely and high quality palliative care

This is achieved by providing:-

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

*Specialist advice and support on the physical, psychological, emotional and financial needs of the patients and their carers.

*An out-of-hours telephone advice service

2. Out-of-hours telephone advice service

Community patients are given the out of hours 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. Outpatients and Therapies - OP&T (formerly Day Services)

The Outpatient and Therapy Service is based at the Winchmore Hill site and aims to improve the quality of life for patients and carers from the time of diagnosis. The services are run at Winchmore Hill and the Finchley site.

The Outpatients and Therapies Service provides a range of interventions on an individual and group basis to help with the management of symptoms, emotional support, wellbeing and planning for the future. The service also offers opportunities for social interaction and peer support.

The multi professional team includes a Palliative Care Consultant, Specialist nurses, physiotherapy, occupational therapy, complementary therapy, psychological therapies and social work.
The services are available from the time of diagnosis and we work closely with the community teams to provide a seamless service.

4. Inpatient unit (IPU)

NLH has 18 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons including symptom control or end-of-life care. As the unit is a specialist palliative care facility, it is unable to provide long-term care.

5. Palliative Care Support Service (PCSS)

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

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

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

6. Loss and Transition Service (including Bereavement Service)

The 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. In Haringey, are a signposting service for patients in the last year of life.

APPENDIX TWO: INFORMATION GOVERNANCE

The NLH Information Governance Framework sets the process and procedures by which the Hospice handles information about patients and employees, in particular personal identifiable information. To support this framework the Hospice annually completes the NHS Information Governance Toolkit. The annual submission process provides assurances to external agencies and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

Delivery of the information work programme is overseen by the Information Governance Steering Group which is chaired by the Commercial and Financial Director.

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

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

1. The Department of Health and NHS commissioners of services

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

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

1. Information Governance Management

2. Confidentiality and Data Protection Assurance

3. Information Security Assurance

4. Clinical Information Assurance

The last assessment was completed in …. In April we received confirmation that our assessment has been reviewed by the HSCIC and has been confirmed as satisfactory.

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

Hospice Board

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

Executive Team (ET)

ET reviews and monitors the minutes of all quality meetings, NLH's Balance Scorecard, and clinical and non-clinical risk.

Quality, Safety and Risk Committee (QS&R)

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

Quality and Risk (Q&R)

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

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

Audit Steering Group (ASG)

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

Policy and Procedure Group (PPG)

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

APPENDIX FOUR: DEFINITION OF *AVOIDABLE AND UNAVOIDABLE PRESSURE ULCERS*

An **Avoidable pressure** ulcer means the person receiving care developed a pressure ulcer and the provider of care did not do the following:

- Evaluate the person's clinical condition and pressure ulcer risk factors.
- Plan and implement interventions that were consistent with the person's needs and goals and recognised standards of practice.
- Monitor and evaluate the effect of the interventions.
- Revise the interventions as appropriate.

An **Unavoidable pressure** ulcer means 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 were consistent with the person's needs and goals and recognised standards of practice.
- Monitored and evaluated the effect of the interventions.
- Revised the approaches as appropriate.

Alternatively, the individual refused to adhere to prevention strategies in spite of education about the consequences of non-adherence.
(Department of Health 2010)

Acquired pressure ulcer refers to a pressure ulcer that developed after 72 hours of care by a service and the service is accountable for its development.

Inherited pressure ulcer refers to a pressure ulcer that developed before 72 hours of care by a service and the previous service is accountable for its development.

ACCESSING FURTHER COPIES

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

HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

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

If you have comments contact:

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CLCH QUALITY ACCOUNT 2016-17

SECTION 1 – INTRODUCTION	
About our Quality Account	
About CLCH	
Chief Executive	
Chair of QC	
SECTION 2 – LOOKING BACK AT QUALITY 2016-17	
Progress against our agreed quality priorities 2016-17	
Progress against our three year quality strategy 2013-2016.	
Trust quality projects and objectives	
SECTION 3 – LOOKING FORWARD	
Our six priorities for quality improvement 2016-17	
Who did we involve	
SECTION 4 - REQUIRED INFORMATION	
CQC	
CQUINS	
Data quality, NHS number, general medical practice code validity, clinical coding error, information governance toolkit, Review of services	
NHS England – Prescribed information	
Statements from Healthwatch and OSCs	
SECTION 5 – FEEDBACK AND FURTHER INFORMATION	
How to feedback, useful information and glossary	KW
SECTION 6 – APPENDIX	
Complaints annual report	KW

SECTION 1
ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2016/17. The Quality Account is a summary of our performance in the last year in relation to our quality priorities and national requirements

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 fifth year that we have done so.

What does the CLCH Quality Account include?

Over the last year we have collected much information on the quality of all of our services within the three areas of quality defined by the Department of Health: safety, clinical effectiveness and patient experience. We have used the information to look at how well we have performed over the past year and to identify where we could improve over the next year.

Our updated Quality Strategy

As in previous years we have reported our progress against our quality strategy objectives. This year we are also taking the opportunity to introduce our updated quality strategy, *Simply the Best, Every Time,* and we explain how the quality priorities will be aligned with the strategy. The updated strategy, launched in January 2017, describes how we will be keeping our original three quality strategy campaigns; positive patient experience, preventing harm and smart effective care as well as adding three new campaigns namely; modelling the way (providing world class models of care, education and professional practice); Here, happy, healthy and heard (recruiting and retaining an outstanding clinical workforce) and Value Added Care (using enhanced tools, technology and lean methodologies to manage resources well).

The strategy describes how we will introduce and apply our model of shared governance to ensure that front line staff, as well as patients and members of the public, will be involved in the delivery of care. We also explain the purpose of quality councils (which will be chaired by staff lower than a band 7) showing how they will have two main functions; to achieve objectives as set by their division and to act as a resource for front line staff to provide informed, evidence based advice on issues to assist in the delivery of safe and effective care.

Patient stories

Patient stories have again been interspersed throughout the account to demonstrate how quality makes a difference to our service users. These stories inform us about what we do well and where we might improve. Within the quality account we also provide examples of quality put into practice within our services.

Developing the 2017-2018 Quality Priorities.

Our updated quality strategy describes how the quality account priorities will be aligned to the six quality strategy campaigns. In the light of this, we consulted widely with all our stakeholders asking them for their comments on both the proposed measures for success and what success would look like for them in respect of these campaigns. Where appropriate we have incorporated their suggestions into our 2017-18 priorities.

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

CLCH provides healthcare in people's own homes and in a wide range of community settings including GP practices, walk in centres (WiCs) schools and early year centres. We provide services for two million patients with 10 million separate interactions.

We provide a wide range of services in the community including:

- Adult community nursing, including 24 hour district nursing, community matrons and case management.
- Children and family services including health visiting, school nursing, community nursing, speech and language therapy, blood disorders and occupational therapy.
- Rehabilitation and therapies including physiotherapy, occupational therapy, foot care, speech and language therapy.
- End of life care, supporting people to make decisions and to receive care at the end of their life.
- Long-term condition management supporting people with complex and substantial ongoing health needs caused by disability or chronic illness.
- Specialist services including delivering parts of long term condition management for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies.
- Walk-in and urgent care centres providing care for people with minor illnesses, minor injuries and providing a range of health advice and information. Our Central London walk-in and urgent care centres help support healthcare for the influx of workers and tourists which more than trebles the resident population during the working week.

During 2016-17, the Trust acquired and commenced some significant new service contracts. These included Merton Community Services (from April) and Harrow Adult Community Services (from May).The Trust mobilisation processes worked well and at the end of the first year of delivery these services are delivering effectively and have transitioned towards new models of care. This work has been achieved in close cooperation with commissioners and local stakeholders.

Further and more detailed information about our services can be found in our annual report. Information is also provided on our website at the following link
http://www.clch.nhs.uk/about-us/who-are-we.aspx

CLCH provides services in the following areas.
(CLCH map to be inserted here)

CHIEF EXECUTIVE'S STATEMENT

add picture

It gives me great pleasure to introduce my first Central London Community Healthcare NHS Trust Quality Account as Chief Executive.

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. As a learning organisation we have invested in continuous quality improvement processes to ensure that we deliver safe, effective and responsive services to our patients.

The Quality Account contains many examples of our approach to quality, and importantly references our new Strategy*; Simply the Best, Every Time: A strategy for the delivery of outstanding care 2016-2020.*

This year we welcomed a number of new services to the Trust, including community services in the Boroughs of Harrow, and Merton, and I would like to take this opportunity to thank our staff, old and new, who work to improve the quality of care they deliver.

I would like to express my gratitude to our patients and users for taking the time to give us feedback; and our colleagues across health and social care for working with us to provide a comprehensive health service.

I would also like to congratulate the following staff and teams who won or were nominated awards during the year:

- The medicines management team who won the top prize at the Pharmacy Management National Forum for 'Best Medicines Optimization in Primary Care'
- School nurse Ruth Butler, who in addition to winning the prestigious Child Health Award at the Royal College of Nursing awards also achieved runner up in the Innovation in School Nursing category at the Cavell Nurses Trust awards.
- Dimitra Verra , one of our dieticians won the Health Service Laboratories' award for rising stars in the Advancing HealthCare awards
- The speech and language team who were shortlisted in the workforce category for their Newly Qualified Speech and Language Therapists Professional Development Programme

I can confirm that the information contained in this document is, to the best of my knowledge, an accurate reflection of our performance for the period covered by the report.

Signed

Andrew Ridley

Chief Executive Officer

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

add picture

As the newly appointed Chair of the Trust's Quality Committee I am pleased to introduce the Trust's Quality Account for 2016/17. Whilst we recognise there is always more to do the committee is pleased to report the progress the trust has made in relation to quality this year.

As Committee Chair I am looking forward to seeing progress against our new quality strategy and in particular to involving staff more as we move forward using a model of shared governance. Staff and patients are clear that they want to be more involved in important decision making related to quality and we know that having engaged, motivated staff leads to better patient outcomes. The model of shared governance, which is fully outlined in our quality strategy, will help us to achieve this.

I would also like, on behalf of the Trust and the Quality Committee, to express our thanks to Julia Bond, the outgoing Chair of the Quality Committee, for her support and commitment to the Quality team and the wider organization.

Signed…….

Carol Cole

Non-Executive Director and Chair of Quality Committee

PATIENT STORY – BARNET PHYSIOTHERAPY

I was referred to physiotherapy for knee pain, because I was worried about them and stressed about the swelling I had.

The waiting time wasn't that bad really. The department wasn't hard to find, and the reception staff were wonderful. I was seen on time and the team were very helpful.

When I first came to the department I was worried about what was going on with my knees and what would happen in the session. I wondered if the exercises and the equipment would be right for my knees as when I went to a normal gym I found it was too much for me, but I found I was given information about my condition and information about whether exercise would be good for me or whether or not it would harm me.

I was excited to go to the classes and when it came to the end after 6 sessions I wished I could have stayed for longer, but I wasn't really worried when I had to be discharged as I had felt an improvement. I felt different after physio and think that exercises are the reason why. The exercises in the class were fantastic. I liked being in the class with other people as we could have a chat. Also some of them had started before me so I could ask them how they felt at the end of the class, and because they said they felt good it gave me confidence that the class would work. All the staff were wonderful and very helpful and professional. There was also a student helping in the class who was very good.

When I was finished I asked for the exercises that were done in the class and I bought a mat so I could do the floor based exercises at home. I don't have the other equipment though but I really enjoyed the exercises on the floor.

I work in a nursing home with three floors and I feel bit lighter and quicker now when I'm doing the stairs. The swelling around my knee has also gone.

I would definitely recommend the exercises for anyone else with the same problem. For me there was nothing that I feel that could be done differently or better. If the pain ever came back again I would want to come back to the physio department here.

Learning from this story

A number of good practices were taken from this including sharing relevant information; enabling patients to access and attend appropriate classes and providing exercises that could be replicated at home. In future, in response to the patient's concerns whether classes will be 'right' for them, patients will have their personal exercise programme discussed with them from week one.

SECTION 2 - LOOKING BACK QUALITY IN 2016-2017

PROGRESS AGAINST THE 2016-17 QUALITY ACCOUNT PRIORITIES

AT A GLANCE SUMMARY OF PROGRESS AGAINST 2016/2017 QUALITY PRIORITIES			
Quality domain	**Priority**	**Achieved**	**Further Action**
Positive patient experience/preventing harm	Developing a quality alert process for stakeholders	In progress	Patient experience team to co-ordinate receipt of quality alerts centrally. The system is currently used n Barnet and Merton.
Positive patient experience/preventing harm	Implementing a quality early warning system	Achieved	The red flag system is in place and we will continue to review and improve this system.
Smart effective care	We will ensure the balance between assuring safe effective care and enabling systematic improvement of service quality	In progress	We will continue to work within the framework of the Trust's continuous improvement strategy to achieve this

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 1
Developing a quality alert process for stakeholders

A quality alert process exists in both Merton and Barnet and the alerts are discussed as part of the CCG quality review meetings. This is being reviewed with the aim of rolling out the process across the Trust. From 2017/18 the Patient Experience Team will co-ordinate the receipt of quality alerts and distribute them to divisions using a similar process to the dissemination of PAL's concerns / issues. This will assist in the development of more quality improvement systems and processes and enable learning to be shared across the organization, whilst ensuring that rapid responses are put in place to mitigate and respond to any quality or safety issues.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 2
Implementing a quality early warning system

We developed a set of red flags as our early warning system and the system is now embedded. We will continue to review and improve the system as part of our Quality Strategy.

A monthly list is produced which list highlights services that either do not meet two of the following seven key criteria or which have not met one criteria for two consecutive months. These services are then red flagged. The seven criteria are:

- No leader for 2 months or more
- Vacancies > 12%
- Sickness > 5%
- A reported serious incident
- A 10% increase in incidents causing harm
- Increase in complaints
- New internal (clinical) serious incident

When a team is red flagged, the relevant Associate Director of Quality determines if a quick intervention can be undertaken (for example where the team is already working on the problem) or if they need the support of a Quality Action Team (QAT).

Red flag reports are reviewed monthly at divisional level as well as at the Quality Committee. They also form part of the quarterly quality reports. Each QAT is added to the sustainability log.

PROGRESS AGAINST QUALITY ACCOUNT PRIORITY 3
We will ensure the balance between assuring safe effective care and enabling systematic improvement of service quality

To ensure clinical effectiveness, we agreed to develop and build on existing approaches to embedding continuous improvement into our daily working practices. The following demonstrate our achievements in this area:

- We developed a continuous improvement strategy which enabled us to embed systematic continuous improvement at all levels of the organisation.

- We established a strategic improvement group to oversee the development of a culture of continuous improvement and learning. (This is referred to in more detail elsewhere).

CLCH has also established a closer alignment between the clinical audit and quality improvement processes. This has helped us ensure the balance between quality assurance and quality improvement. We have also established robust systems to strengthen the quality of our clinical effectiveness data.

PATIENT STORY- CHILDREN'S SPECIALIST HEALTH VISITING

The Health Visiting (HV) left me a card and I was able to call you to arrange to meet, whilst I was pregnant. I was with my sister in hospital when you rang me. I was a bit embarrassed I'd forgotten our appointment. You didn't give up just because I wasn't here. I was able to talk to you, so you got to know me and didn't judge me by only what was written down. I didn't feel you judged me. When I've met people before, they have obviously made a judgement based on their written notes and the way they have looked at me, tells me it was not a good one. I like the fact you have seen him (her son) since he was born, seen him grow and seen him change. You know him that little bit so will look out for him.

I'm not nice when I do drugs and when they have just read a piece of paper and made their own opinion, getting those looks and making snide comments can mean I don't want to meet again and can't really trust them. I've got older children so I have 'done it before', but meeting you made the difference. I felt you weren't judgemental, but you really listened.

I know we have to have meetings, but despite having been to them before they still feel threatening. Home visits make a difference. I like being seen at home and sometimes you just drop by, but I know I can say no. I know I haven't been to a clinic yet, but I prefer just seeing you. I feel I can trust you and don't want to keep re-telling my story. It's not like it's something I can be proud of, 12 years of using and my girls being with my mum.

I like that professionals work together and know me. You (the HV) and the social worker told me the worries, which I knew, but it's helped us see I'm moving forward. 'I want to get my daughter back and I know I need help to do that'. I would be angry, which would lead to an argument if I didn't think people were being honest, then I'd end up not meeting up. When any thing has happened I know professionals are going to check.

I've had lots of health visitors with my two girls; some are more supportive than others. You never know who you're seeing next though, they leave or change. No-one tells you, just a different voice or face. They didn't really bother after she was about 2yrs. I was signed off (by health visitor and social worker) and then trouble started. Being a new mum is scary and I need support, their (babies) bodies changed and babies can be demanding, so you're tired. I was also in recovery and needed someone.

I find it difficult to walk in to new groups. People don't realise, that you can feel really isolated in places like this and you give up trying, after a few moves. People don't realise you 'make friends and then they are gone'.

Learning from this story

The health visiting team took the following learning from this story: that it was important to find appropriate buildings for social groups and meetings; that home visits are as important as service users attending clinics and that even calling a duty line can feel like a big step for some. The team also learned that given the chaotic nature of some people's lives, appointment times may not be adhered to. Finally it was agreed that the provision of effective managerial support for our health visitors was important as their work really makes a difference to isolated families.

PROGRESS AGAINST OUR QUALITY STRATEGY 2013-16

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.

THE Q4/ANNUAL QUALITY REPORT WILL BE INSERTED HERE.

PATIENT STORY - DEMENTIA SERVICE

I started coming to the service to see if I have a brain (!) and to see if my memory is working and that. Having input from the dementia team has been helpful. It makes me feel that I'm not so dumb, or daft what people think I am, because I am, at an age of 90, a lot of people say "no you can't do that, you can't do this. " OK, so I do things what I shouldn't do and that's why I have falls but that's not the reason why I have falls, I'm losing me balance.

You service has been A1. I have been happy with you, you are very polite and you enjoy a joke. You are not one of those yes sir, no sir, three bags full sir sort of girls. We filled in that book [The document from the Alzheimer's society] and that was nice I thought, nice to talk about my life so as people like you understand people like me better.

The only problems I have had are that I like to have a phone call first, you do always do that, but sometimes other people don't and I have a lot of hospital appointments, I mean last week, or the week before I went up to hospital 3 times in one week. It's only cos I don't want to miss anyone.

I was treated as a client, and I hope all your other clients feel the same way. I take life to be happy, no point in being miserable, just you coming round here today has taken something off of me, I feel like I'm not just sitting here on my own, you have come and been with me and I feel good that I've seen you. I say things as I see them if people come in here telling me what to do I tell them where to go.

I go to the lunch club weekly. I can sit and have my lunch and it turns out I know some of the other people that go there. The van comes and it takes me, I could walk it but they want to pick me up. I used to go down to Wetherspoons regularly but they moved the bus stop so now I can't go anymore.

Me stepsister Brenda comes out with me and walks by the side of me, she says what if I fall down, I say "call an ambulance" if I'm dead just leave me there. I like the lunch club, I find there a lot of couples that go, but it's getting out isn't it and that can't be bad.

You tried to help me remember things. When you asked me to remember words, coffee, butter and eggs, and I had to draw those pictures. I don't remember doing that before, but I felt good cos I did it and my boy thought I couldn't do it, but I did it with you when he was here. This memory is not that bad is it?

Learning from this story.

This particular patient story was collected by one of the staff members participating in the Dementia Care Champion Programme. The aim of the programme is to help identify service improvements required for people with dementia and for the champion to act as an advocate for people with dementia and a source of information and support for co-workers. Dementia Care Champions are supported to review their service and to make improvements in consultation with their manager, team and those with dementia.

In this story the patient requested a phone call before his appointment. In response to this request, CLCH will follow up our patients with dementia so that they can be absolutely clear when the dementia service is calling (as opposed to other hospital appointments the patients may have).

LOOKING BACK – TRUST QUALITY PROJECTS AND INITIATIVES

As well as the implementation of the quality strategy described above, the Trust was also involved in a number of other quality projects and initiatives. Several of these are described below:

TRUST PROJECTS - POSITIVE PATIENT EXPERIENCE

Recruitment and retention

Along with other London trusts, CLCH has been affected by the shortage of available nursing and other key staff. In order to address this and the associated spend on agency staff, CLCH established a trust wide clinical recruitment and retention forum. A key focus of the forum has been the reduction of vacancies across all divisions. This has involved initiatives such as focused and local recruitment campaigns, fast track programmes, apprenticeships, rotational programmes and oversees recruitment (described further below).

There has also been an increased focus on retention and a working group was established to support improved retention rates and staff experience. The group supported initiatives such as the creation of career clinics which enabled staff to discuss their careers and identify opportunities available to them at CLCH. Additionally a recruitment campaign was developed to attract young people to the Trust with 21 apprenticeships starting in 2016.

Overseas recruitment

CLCH was pleased to welcome several cohorts of staff that had been successfully recruited from the Philippines; the first of these started in January 2017 with the fourth and final cohort arriving in March 2017. The feedback on this initiative from staff and patients, as well as from the new recruits themselves, has been positive.

Although in future the government plans to charge employers for each overseas nurse certificate of sponsorship (currently proposed to be £1000 per employee) the overall cost of recruiting from overseas, particularly where there are known 'hotspots' and difficulties in recruiting, is likely to remain a more effective strategy than the use of interim or agency staff. Given this, an international recruitment sub group meets monthly to ensure that a structured programme is in place to support the continued retention and recruitment of overseas staff. A business case has been developed that proposes a further overseas recruitment campaign to support recruitment for Trust `hotspots' including the recruitment of community nurses, school nurses and health visitors.

Co design project: Improvement of waiting time satisfaction in our Walk in and Urgent Care Centres

To improve waiting time dissatisfaction and improve overall experience of our patients attending a Walk-in Centres (WiCs)/Urgent Care Centre (UCCs), an experience based co-design (EBCD) project was undertaken. The EBCD approach brought together staff and patients to jointly identify and address areas for improvement with regards to waiting times across each of our 5 centres. The project started with observational visits taking place at each centre. This involved staff and patients being interviewed about waiting times along with their overall experience of working in and using the services. We then proceeded with a co-design event, where selected interview footage, along with other patient and staff feedback, was presented and discussed. This led us to us to identifying 3 improvement areas as described below. For or each of these areas a working group was set-up and the following progress has been achieved.

- **Information and communication:** With the help of our patients we have reviewed and amended the information displayed on our webpages to more accurately reflect the service provided by the centres.

- **Environment:** With support of the trust charity, we have been able to identify and purchase child-friendly equipment to develop dedicated paediatric areas in 3 of the centres to keep our younger visitors entertained whilst they wait to be seen. Work is also ongoing with our IT department to explore enabling Wi-Fi for use by patients in the waiting areas in all centres.

- **Personal and Professional Development of Front of House Staff:** An administrators' development programme was established for front of house staff working across each of the WiCs/UCCs. This included the provision of local induction, ongoing learning and a skills assessment portfolio. In collaboration with Imperial College Health Centre for Engagement and Simulation Science through the use of Sequential Simulation (SqS) we are also developing bespoke customer service training to support our front of house staff to transact their roles effectively.

End of Life Care (EOLC)

EOLC Strategy: The Trust has an EOLC strategy (2015-2018) which sets out plans to improve the care given to as well as well as the experience of people and carers using CLCH services at the end of their lives. To achieve the aims of the strategy, the programme for adults focusses on six objectives, based on the EOLC model and outcomes for the Trust. The objectives are as follows and examples of each area of work are provided below.

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

High quality, relationship centred, compassionate care: Working alongside Chelsea and Westminster NHS Foundation Trust, we have developed a facilitator's programme on self-compassion. The contents of this programme include; compassion in care model and competencies; mindfulness in practice; coaching skills and helping conversations; facilitation skills; providing positive feedback and affirmation and action planning.

The Patient Experience Team is also introducing the concept of patient stories and dynamic patient stories within palliative care services.

Advance care planning/risk stratification: Two national Advance Care Plan documents were implemented within the Trust, supported by Advance Care Planning teaching sessions which have taken place in each borough.

Assessment and care planning: Work continues to develop an Individual Plan of Care to support end of life care. This will be implemented in 2017/18 following consultation with patients and other stakeholders.

Symptom management, comfort and well-being: A review of incidents and complaints highlighted a number of issues including aspects of equipment, the provision and use of equipment and delays in home visits. Following discussion by the EOLC group, it was agreed to develop a standard operating procedure for staff to support the obtaining and setting up of equipment. In addition, local communication processes were established in Barnet to enable District Nursing staff to make direct contact with palliative patients at the beginning and end of each shift in order to discuss any concerns that they might have.

Support for families including bereavement care: Schwartz rounds continue to be undertaken within the Trust with very positive feedback from staff. A further two facilitators have been identified who will undertake training in the next few months.

Education and training: Training for Healthcare Support workers has been taking place, supported by very positive feedback. In addition, Merton services and St Raphael's Hospice have been undertaking joint training of staff.

Children's Work Programme: The current model for EOLC for Children in CLCH is delivered in accordance with the principles embedded with the core care pathway for children with life limiting and life threatening conditions. This is divided into three stages, comprising six standards which specify the level and quality of care that every family should expect. This work is overseen by an EOLC Working Group for Children's Services, the purpose of which is to take forward and embed the six standards contained within the EOLC for Children framework.

PATIENT STORY - MERTON END OF LIFE CARE

I think that some people would struggle, but my Mum was a different type of person and thank goodness she never got down or miserable or angry or upset because there's masses of emotions during that process and for some reason she didn't really go through those emotions as such. I felt really comfortable, it was well explained. I think what the service did was it became the main backbone.

Even a bit of a something that you can go 'right I need this, right this is where I go, I need that – this is who I contact, this is, you know'. A directory, but a simple one. And also day time night time there's a big issue – you know, you contact one number for day, one number for night.

I think the end went really well if I'm going to be honest, I think the end was absolutely… it was magical really. I couldn't fault it at all. I think the whole process was brilliant and I often say to people, you know, it's actually a nice experience, because we, we were in a situation where it was rushed in a way. So we'd seen the hospice people prior and everybody was very much along the lines of "don't worry it'll be months, it won't be years, it won't be weeks, it'll be months and so we're having all these conversations and it is very much with Mum's disease there was no pathway.

Originally Mum had said that she wanted to go into the hospice when she's ready and I said, well we've got so much care in place and at this point we had the DNs clocked in, you've got your caring system which is slightly different to the other caring system, so you had the carers coming in 4 times a day. You've got you night nurse situation and then you also had, the hospice giving us help at night, so we were fairly covered and I said to Mum – you don't really need to go in. II think originally she thought the medical side of it would be an issue. So we all agreed that she didn't need to go in medically and that she was going to get enough cover and basically it worked in that way. I think she went to sleep, as I put it, on the Sunday and then she died on the Tuesday. She kept going though, oh my gosh- she wasn't going to give up.

I think it made a big difference being at home. I don't think she would cope being in a hospital; getting better was actually to be comfortable and that was home. I think the best thing, an attribute, was that she had wanted to go to the hospice, but in the end she didn't because she got enough care at home. There wasn't anything we asked for that we didn't get. It was a hard ask though to get all the services to speak to each other. It's practical stuff as well – all these practical issues – where do we put the meds (medication drugs) do we chuck the meds, do we give them away, where do they go? Who takes that machine – who does that belong to, because don't forget we've got all this equipment in our house and then suddenly they're gone.

There were not any bereavement services I think, I didn't get any.

Learning from this story

Overall the daughter of the lady who was referred to the EOLC team was very complimentary about the service that she and her mother received. Becoming the main point of contact and focal point for coordination and integration of the services helping to meet the lady's needs was apparent. The service delivered what was needed to achieve the ultimate aim of the service: a 'good death' in her preferred place of death, with well managed palliative symptoms.

The main issue for further improvement was in making it even clearer who was involved in the patient's care, in what capacity, how to contact them and their hours of service.

The idea of a resource pack for patients and families at end of life was suggested, which could include a simple directory of services in Merton, with blank spaces so that different people/agencies can be added. Providing leaflets was also advised, covering what to expect when somebody is dying, and practical information about what to do after a death. The need for the service to develop bereavement support was made very apparent during the discussion.

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. Listening events were held which led to the identification of five themes - 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.

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'* and within CLCH it was agreed that this should continue to be facilitated through the CLIPS (Complaints, Litigation, Incidents and PALS) processes within the organisation. The Trust wide CLIPS group has continued to meet to discuss shared learning and communicate this back across the organisation via the group / committee structure and the Spotlight on Quality newsletter.

The next stage of our campaign will be to integrate Sign up to Safety into our patient safety groups using the shared governance approach set out in our Quality Strategy 2017 – 2020. Sign up to Safety is an enabling strategy; further information about our commitments can be found in our 2017-2020 quality strategy.

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 in reports which are submitted and presented to the CCG clinical quality review groups. Within 2016/17 we reviewed our Being Open policy (which incorporates the duty of candour) and the DATIX system to ensure this is capturing the compliance data appropriately.

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 are widely shared.

Discussion of incidents and the associated lessons learnt is important and helps us to reduce the risk of reoccurrence. Incidents are regularly discussed within team meetings to ensure lessons are learnt. Furthermore discussions also take place at specific meetings such as the pressure ulcer working group, the falls steering group, information governance group and complaints litigation, incidents and PALS (CLIPS) group meetings. Summaries and highlights are also presented to the Quality Committee, a sub committee of the board, every month.

In 2016 a trust wide action plan for pressure ulcers was developed which is monitored by the pressure ulcer working group and reported into the patient safety and risk group. Key points from the CLIPS meetings are included in the monthly trust wide *Spotlight on Quality* newsletter.

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

- Ensured a continued control on the quality of the data entry on incident reports. This entailed accurate recording of the degree of harm through quality checking by the patient safety managers and updating of the DATIX to improve the integrity of the data.

    - Regularly included articles in the 'Spotlight on Quality' monthly publication from the Complaints, Litigation, Incidents, PALS and Serious Incidents (CLIPS) group, for example on cold chain incidents, handling personal information and written communication , Duty of Candour/Being Open, transport incidents, information governance breach and falls. Additionally regular DATIX updates are provided.
    - Held incident workshops in July and October 2016 to help raise awareness of the increasing number of data breaches within the Trust, facilitated by the Trust's Information Governance (IG) team and supported by the Deputy Senior Information Risk Owner (SIRO). A total of 33 members of staff attended the workshops and a discussion board was created on the IG Hub page where staff were encouraged to post their questions ahead of the workshops so they can be discussed. The workshops were a good opportunity to engage with staff and raise awareness of IG incidents within the Trust.

During 2016/17 the total number of incidents reported on the Datix system was 7,855. This is a 24% increase from 2015/16 when a total of 6,328 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.

It should be noted that within the arena of patient safety it is considered that organisations that report more incidents usually have a better and more effective safety culture. This is because organisations that report more incidents usually have a better and more effective safety culture, the theory being that if you do not know what your problems are, you cannot learn and improve.

In addition, as part of the Trust statutory and mandatory training programme, a new booklet was launched in November 2016 and this included level 1 training on patient safety.

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) published a report in March 2017 which indicated that we reported 1,370 incidents occurring between the 1st April and 30th September 2016. This is an increase from 1,154 for the same reporting period in 2015.

This time, the NRLS publication did not provide a reporting rate or compare us to other community trusts as it was realised that the variation in services provided by organisations within the NHS Community trust cluster (i.e. comparing CLCH with other NHS community organizations) would render such comparisons inappropriate as it would be misleading.

During this period, we reported 45 incidents (3.3%) resulting in severe harm. Although this was higher than the cluster rate of 0.5%, it is a decrease from the same time last year when 58 incidents (5.0%) resulting in severe harm were reported. The severe harm cases we reported all related to pressure ulcers.

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 – HOUNSLOW DIABETES COMMUNITY SERVICE

I was diagnosed with Type 2 Diabetes 30 years ago and have been taking insulin treatment for the last 18 years. I was never referred to any diabetes specialist service when I started insulin or when diagnosed. My blood sugar was not controlled and the practice nurse advised me to keep increasing the insulin doses. I was taking 4 injections – 30 units of Novorapid three times a day and 35 units of Lantus. This however made no difference to the rising blood glucose level. I was getting very concerned and thinking what am I doing wrong? Is the insulin not working?

I expressed my concerns to the practice nurse who then referred to the Hounslow diabetes community service. I saw the diabetes specialist doctor and the diabetes nurse in The Grove clinic. This was the turning point for me. The doctor prescribed metformin in addition to my insulin. The nurse explained why the insulin was not working in certain injection sites. She advised me to change my injection sites. She also asked about my diet and advised me to cut down on my frequent snacks of dried fruit and explained the effect of the sugar in the fruit. My blood glucose levels dropped and I was advised to reduce my insulin doses. The diabetes nurse was fantastic; I would describe it as a miracle.

I was also referred to the 6 once a week *XPERT* diabetes course. As soon as the course started the professional manner, confidence, knowledge friendly and adult teaching approach convinced me I was in the right place. Everybody was treated with respect. The explanations, literature, visual resources/food models were very good. We all got an excellent handbook .The course was an eye opener and the best experience. My diet was sugar free but I was eating lots of carbohydrate and snacking often. I never realized the effect of eating these foods and snacking. My cultural needs were taken into account e.g. the diabetes nurse explained how I could fast safely for Ramadan.

I was involved in decisions made about my care. Communication was two-way, very effective. Confidentiality was maintained at all times and the staff asked for consent before treatment. The staff delivered care without rushing.

The results have been positive and motivated me to continue. I feel my health and life has changed in a big way without any negative effects. I think such courses are so important for all patients with diabetes to raise awareness. We often eat without awareness e.g. order pizza and watch TV when eating, not realizing how much we are eating and only thinking about not eating sugar. I share the messages I have learnt and the XPERT book with my friends and family so they can also benefit from the learning.

I would highly recommend your service to friends and family. My only regret is that I was not referred several years ago.

Learning from this story

In response to the patient's comment that they should have been referred to the GP earlier, the service has agreed that patients diagnosed with diabetes should be referred to education sessions at the point of diagnosis. The story will also be discussed as a case study and shared with GP practices as a model of good care.

TRUST PROJECTS - SMART EFFECTIVE CARE

CONTINUOUS IMPROVEMENT

Since 2014 CLCH has developed and run an internal improvement skills development programme known as the 'Continuous Improvement Programme.' The aim of the programme is to develop quality improvement skills in front line staff with the intention being for the programme's graduates to take the lead on continuous improvements within their own services.

The programme received excellent feedback and was successful in developing motivated and confident graduates. Although there was success in training individuals, there was limited evidence of organisational impact resulting from the programme. This led to the training programme being paused to allow for the development of the Continuous Improvement (CI) Strategy which was launched in July 2016. In August 2016, CLCH initiated the Continuous Improvement Transformation programme. The aim of this was to ensure that Trust leaders enable and support improvement, build capacity and capability for improvement and develop approaches to embedding continuous improvement into current working practices. This led to the development of a knowledge and skills framework for improvement skills which will be used in future years to ensure more effective targeting of improvement training.

Whilst the training programme was paused, the CI team ran classroom based sessions covering topics including; the introduction to continuous quality improvement; process mapping and improvement analytics and change management. The sessions were well attended and participant evaluations were extremely positive.

The CI team also provided support and assistance for teams to collect and analyse data in order to identify improvement opportunities. These included Barnet Musculoskeletal (MSK) service (analysing referral patterns, patient experience data, demand and capacity data); Merton 0-19 services (caseload analysis, stakeholder experience on referral process for integrated therapies, staff experience in specialised school nursing service) and Pembridge palliative care service (utilisation of administration team): the medicines management team (using statistical, process control to analyse trends in medication incidents) and the Health Improvement team (clinical outcomes analysis).

The team also provided direct improvement facilitation for several projects including three projects which were directly managed by the team, including the Barnet MSK service (project management and rapid improvement facilitation support to improve waiting times) and the Walk in Centres (project management and process mapping support to improve waiting times and efficiency).

Other projects supported by the continuous improvement team included: improving new starter experience project; improving end of life care for patients in Harrow; improving utilisation of administration team in Pembridge; transition to an integrated 0-19 therapies service in Merton and the vulnerable antenatal pathway in Merton.

CLINICAL AUDIT

Following peer review by the Clinical Effectiveness Steering Group and ratification by the Quality Committee, CLCH launched a comprehensive clinical audit and service evaluation programme based on national and mandatory requirements as well as locally driven priorities in the year under review. The programme additionally took into account areas of high risk concerning patient care.

Participation in clinical audits

During 2016-17 there were no clinical outcome reviews (formerly known as national confidential enquiries) which covered NHS services that CLCH provided. Therefore CLCH did not participate in any clinical outcome reviews.

We also registered in all (100%) of the national clinical audits where we were eligible. These are as listed in the table below.

The national clinical audits that CLCH participated in and for which data collection was completed during 2016-17 are listed in the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Participation	Submitted cases or reason for non-participation
SSNAP (Sentinel Stroke National Audit Programme) (Previously known as the National Stroke Audit)	Yes	69 (tbc) Services/team taking part: Stroke ESD team, Merton ESD team, Merton Community Neuro Rehab Team. Data collection is currently in progress.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	126 (tbc). Services taking part: West Herts, Respiratory Service Barnet Respiratory Service, Merton Respiratory Service, Harrow Respiratory Service. Data collection is currently in progress.
National Diabetes Foot Care Audit (NDFA)	No	*Reason for non-participation to be confirmed.*

LOCAL AND TRUST-WIDE CLINICAL AUDITS

The reports of 12 local clinical audits were reviewed by the provider in 2016/17. The actions CLCH intends to take are incorporated into the table.

Title	Division	Service	Outcomes and actions
1. An audit evaluating the quality of initial assessments by community physiotherapists in Barnet Intermediate Care Services	North	Barnet Intermediate Care Services	The aim of the audit was to evaluate the current practice of assessing patients in the community by Barnet Intermediate Care Services. Findings: Out of 45% of the audited sets of clinical notes that required a multifactorial falls risk assessment, 15% had one completed, 35% of the audited notes had a documented rehabilitation goal. 60% of the audited notes had an initial assessment however only 50% of the total audited notes had a fully completed initial assessment. 60% of the patients audited had a physical assessment completed by the physiotherapist. However only 30% had the physical assessment fully completed. Actions identified: All physiotherapists to complete initial assessments for all patients referred to the service, use the multifactorial falls risk assessment form with patients who score positively on the falls risk assessment tool within three months of the date of this audit, and complete a full physical assessment with all patients seen within the service.
2. PACE/Rapid Response Assessment Pack Documentation	North	Intermediate Care Services	This audit aimed to establish whether the Rapid Response and PACE team are completing the documentation correctly and to identify any areas of improvement to ensure that the paperwork is fit for purpose. Findings: PACE- 100%. Rapid Response - 82%. The target for both was 100%. Actions identified included: staff should complete all required documentation for all the patients, whether PACE or Rapid Response, a shorter version of the pack to be used for the Rapid Response one off visits and shorter visits to help support compliance with the documentation standards, and encourage nursing staff to utilise mobile working devices to complete documentation
3. Venous Leg Ulcer Assessment and Management	North	Tissue Viability	The aim of this re-audit audit was to establish compliance with NICE Clinical Knowledge & Skills guidance: Leg Ulcers; Venous; Uncomplicated venous leg ulcer (2012) and CLCH Leg Ulcer Policy (2015). Findings: Overall compliance was 98.2%; an improvement from 60% in 2015. Actions identified included: Review of all patients attending clinic to determine when Dopplers are due and plan dates. Contact IT to identify how to flag these up on SystmOne, review well leg caseload

Title	Division	Service	Outcomes and actions
			to ensure all on follow up list. Establish and communicate procedure with team and implement, re-audit.
4. Medicines Management audit (documentation)	North	PACE/Rapid Response	This audit aimed to establish whether the Rapid Response and PACE team were completing the documentation correctly and to identify any areas of improvement to ensure that the paperwork is fit for purpose. Findings: PACE- 100%. Rapid Response - 90%. The target for both was 100%. Actions identified included: Ensure all referred patients have correct medication list available, highlight audit results at team meetings, ensure correct procedures are followed when a medication error has occurred, and re-audit.
5. Use of Antimicrobial prescribing at bedded services	Medical Directorate / Trust-wide	Medicines Management	The aim of the audit was to ascertain whether antimicrobial prescribing in CLCH bedded areas is in line with CLCH antimicrobial prescribing guidelines 5 and whether documentation around their use is in line with CLCH guidelines which are incorporated the standards and recommendations made by DoH and World Health Organization Findings: 9 standards were addressed: 3 standards achieved 100% compliance, which is the same as the 2015 audit results. 6 standards achieved a compliance range of 13 % to 99%. This is an improvement from previous audits. Actions identified included: Doctors and pharmacists to review prophylactic antimicrobials that may have been discontinued unintentionally or temporarily when patient is transferred between services e.g. from acute to CLCH, provide induction relating to antimicrobial prescribing for Locum doctors and out of hours doctors (Barn-doc in North beds.)
6. Safe Management and Use of Controlled Drugs - Bedded Areas	Medical Directorate / Trust-wide	Medicines Management	The aim of the audit was to assess compliance with the audit standards for the safe and secure management of CDs as laid out in CD legislation and the CLCH CD policy MM002. Findings: 2 services were fully compliant 2 improved their compliance since the last audit, while 2 services saw a slight worsening of compliance. Actions identified included: Annual and six monthly IP audit reports must be carried out locally by the dental practice and results available at all sites, manual cleaning equipment (if required) must be complete and all products within expiry date.

Title	Division	Service	Outcomes and actions
7. Dental audits	Medical Directorate / Trust-wide	Infection Prevention	This audit aimed to evaluate whether all patients are cared for in a safe and clean environment protected from infection and that all re-usable dental equipment is safely decontaminated. Findings: Two out of fifteen areas did not meet essential quality requirements and one out of fifteen did not meet best practice. Five out of fifteen services scored gold (98 – 100%). The remaining ten services scored green (90 – 97.9%). Actions identified included: Annual and six monthly IPC audit reports must be carried out locally by the dental practice and results available at all sites, spillage kits must be complete and products within expiry date.
8. Clinical Records Keeping Re-audit Audit 2016	Medical Directorate / Trust-wide	Clinical Effectiveness Team	The aim of this re- audit was to obtain assurance that the services that had not met the 90% compliance in the Annual audit had achieved compliance in line with the Trust's clinical record keeping standards. Findings: the re-audit show indicated overall ≥90% compliance. Actions identified included: the Clinical Records Steering Group to discuss the report and put forward recommendations.
9. Clinical Records Keeping Audit 2017	Medical Directorate / Trust-wide	Clinical Effectiveness Team	The aim of the audit was to monitor Trust record keeping standards and support improvement in patient safety and quality of care. Findings: The compliance level achieved by the Trust was 83% demonstrating a 'Significant Assurance' Rag Rating (RAG). Actions identified included: wider publication and dissemination of crib sheets for recording patients' allergies and sensitivities in advance of the next re-audit, the Clinical Effectiveness Team to deliver training (initially to non-compliant teams) in advance the HRK re-audit in Aug/Sept 2017.
10. Community Nursing NICE Guidance CG179 Pressure Ulcer	Quality/ trust-wide		This audit aimed to measure the extent to which the record of patient care reflects the NICE guideline CG179 for prevention and management of pressure ulcers. Findings: (192) 91% of records demonstrated that patient held records or electronic progress notes were updated appropriately. (172) 81% reported that information and advice on pressure ulcer prevention was given to patients (& carers if applicable), whilst (16) 8%, stated this was not applicable. This shows good compliance with regard to these standards, although not the required 100%.

Title	Division	Service	Outcomes and actions
11. Re-audit of Radiographs taken on Adult patients (Inner CLCH Community Dental Service)	South	Community Dental Services	This audit aimed to ensure that adult patients with the dental service had appropriate radiographs taken, with justification and reporting of films Findings: Compliance in either taking radiographs or recording a valid reason why not has increased from 55% to 82% since the original audit. Actions identified: All dentists to record this in case notes and will be informed by email, with immediate effect, followed up at next Peer Review.
12. Effectiveness of Employee Health Consultations	Quality and Learning	Employee Health Service	The aim of audit was to rate the usefulness of advice to managers provided by Employee Health Medical and Nursing Staff, with a target of a minimum of 60% of all managers referring to the service. Findings: Achievement was 100% indicating the advice was fit for purpose. Actions identified included: Review of the consent process to release reports to managers once a date for revised GMC guidance on confidentiality is released by the Faculty of Occupational Medicine (FOM).
13. Stress Reduction of CLCH Employees	Quality and Learning	Employee Health Service	The aim of audit was to assess the clinical effectiveness of the psychology/counselling service within Employee Health in relation to reducing the stress symptoms reported by CLCH Employees who access its service. The Hospital and Depression Score (HADS) was used as the assessment tool. Findings: Employees reporting improvement 82.63% (target 80%); improved reported 26.97% (target 18%). The results met and exceeded the 2014/15 audit. Actions identified: HADS form to be issued after the 4th counselling session. Additionally, the HADS form to be emailed to telephone consultation clients.
14. Rating effectiveness of physiotherapy interventions within Employee Health	Quality and Learning	Employee Health Service	The audit aimed to ensure that 80% of all employees accessing the service reporting improvement in their symptoms by the end of therapy, and with a minimum improvement of 40% in their EQ-5D-5L scoring. Findings: Employees reporting improvement 82.04% (target 80%), improvement reported: 28.29% (target 40%). Actions identified: Increase training on chronic pain management and provide advice on managing ergonomic risk factors in work settings.

Audit acronyms used.

APC	CLCH Allied Primary Care
ACPIN	Association of Chartered Physiotherapists in Neurology
BCSS	CLCH Barnet Community and Specialist Services
CD	Controlled Drugs
CHD	CLCH Children's Division
CG	Clinical Guideline
COT	College of Occupational Therapists
CSP	Chartered Society of Physiotherapy
DATscan	Ioflupane iodine-123 radiopharmaceutical injection
FURST	Fluid chart, Urine Specific Gravity, Risk factors, Signs and symptom, Treatment dehydration assessment tool
GULP	Gauge, Urine Colour, Look for signs, Plan Dehydration risk assessment tool
IPC	Infection Prevention and Control
INR	International Normalised Ratio
IPU	In-patient Unit
MDT	Multi-disciplinary Teams
MFRA	Multifactorial Falls Risk Assessment
MUST	Malnutrition Universal Screening Tool
NPSA	National Patient Safety Agency
OT	Occupational Therapy
NCNR	CLCH Network Community and Rehabilitation
NICE	The National Institute for Health and Care Excellence
PANG	Palliative Adult Network Guidelines
PH	Public Health guideline
PROMs	Patient Reported Outcome Measures
STarT	Tool for assessing low back pain
TCu380	Intrauterine copper device

PARTICIPATION IN RESEARCH 2016/17

Participation in clinical research (i.e. research that has received a favourable opinion from a research ethics committee within the UK and given Health Research Authority approval) demonstrates CLCH's commitment to improving the quality of care we offer and to making our contribution to the wider health improvement.

At CLCH, research activity is regularly monitored through the Clinical Effectiveness steering group and is overseen by the Quality Committee. This year's opportunities for research growth were mainly focussed in the following service areas: Parkinson's disease, stroke, diabetes, and sexual health. In particular there was, in November 2016, a very successful patients' Parkinson's research event; this attracted so much interest that it will be repeated later in the year.

The Trust continued to make steady progress promoting research activity and developing a research culture in the Trust. The aim of this was to develop a supporting environment by encouraging and facilitating researchers and to make effective partnerships with clinical research networks, other NHS Trusts, academic and industry sector.

During 2016-17, there were over 20 clinical staff participating in research covering 3 specialities that had been 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 for MSc or PhD qualifications.

Examples of current studies that CLCH is involved in include:

- Sexual health services: A study called SAFETXT. SAFETXT is a randomised controlled trial of an intervention delivered by mobile phone messaging to reduce sexually transmitted infections by increasing sexual health precaution behaviours in young people (16-24).
- Familial Parkinson's study; a study using Genetics to understand Parkinson's disease. This may lead CLCH future involvement into research for new treatments
- Lots to Care- a stroke study – involving participants at 4 month post stroke. The emphasis will be on improving quality of life by addressing unmet needs and enhancing participation.

This year CLCH was involved in 17 clinical research studies in a number of specialities during 2016/17 either as a (PIC) or a host site. The number of patients receiving relevant health services provided by Central London Community Healthcare NHS Trust during 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 125.

Going forward, the Trust's updated Research Strategy (2017-2020) will be launched in May 2017. Its foundation is the pledge made that `every NHS patient a research patient' along with the commitment to inform people of research studies they may be able to take part in. The new strategy will expand this to include that every member of staff will have an opportunity to participate in high quality research thereby improving the quality of services and care to patients.

PATIENT STORY – HEALTH IMPROVEMENT TEAM

I was referred by my GP to the healthy lifestyle check programme (run by the health improvement team) but I was really encouraged by my social worker to attend. He did a lot of work with me over the months helping me to think the positives and negatives of changing my lifestyle. Then the instructor rung me and we met. On my way to the meeting I was not sure if I really wanted to do that. My confidence was low and I had been feeling depressed. The Instructor took my blood pressure, weight and had a long chat with me. We talked about things…

We started off gently, training once a week as I had been inactive and overweight for a long time. After 6 weeks, we did another assessment and things were going well. For the rest of the programme, I was training twice a week. I had set my mind to it.

The Instructor listened to me, encouraged me and treated me well. He did not push me too much, just enough when I was ready which helped me a lot. He takes his job seriously and he is always available for help. Sometimes there are other people in the programme who need more help than I do and demand a lot of his attention, so he spends time with them and sometimes I had to wait if I needed to ask a question.

At the end of the programme we did another assessment. I lost a stone in weight, I was 13 ½ and it dropped to 12 ½ stones. My confidence and my mood also improved.

I would *highly recommend* the programme to friends and family if they needed similar care. That is because it helps people with their confidence, to be happier, to eat better, to socialise more and may be take less medication.

I think you (CLCH) should be talking to social workers and carers more. There are many isolated people out there who they don't know about the programme. Also, look for volunteers who want to gain experience as they can help the Instructor with running the sessions. It would be good to do activities outdoors or even go swimming not just stay in the gym. It will make the programme more fun. Also to have a morning session as some people prefer to exercise in the morning.

Learning from this story

Service users informed us that `it might be hard to know that the healthy lifestyle check existed unless you are involved in the community'. In response to this the service created a new flyer providing information on all the community clinics and shared this with Westminster Health Trainers who are in contact with local people in the borough. The clinics are now advertised in the local library.

The service is also in discussion with other partners, such as the Recruit Team Active Westminster, to see if they can provide additional activities (such as a walking group) to add activities to the programme within the community.

SECTION 3
LOOKING FORWARD - OUR QUALITY PRIORITIES FOR 2017-18 (CS)

Our quality priorities for 2017- 18 are the same as laid out in our Quality Strategy, *Simply the Best Every Time: A strategy for the delivery of outstanding care 2017 – 2020*. The strategy can be found here http://www.clch.nhs.uk/media/232999/quality_strategy_2017-20.pdf

Our Quality Committee has agreed a revised quality dashboard to monitor progress against each of these priorities. Progress against our priorities will be reported to the committee on a quarterly basis as part of our comprehensive quality report.

The priorities, their key outcomes and associated measures of success are as follows:

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE –

Changing behaviours and care to enhance the experience of our patients and service users

Key Outcomes	Measures of success 2017-18
Service developments and plans of care co-designed with patients and service users.	• Maintenance of 90% and above of proportion of patients whose care was explained in an understandable way • Achievement of 85% of proportion of patients who were involved in planning their care • The use of co-design will be embedded throughout the organization • Patients will be members of the Quality Councils in each division
Patient stories and diaries used across pathways to identify touch points and `Always events'	• Always Events will be implemented across the Trust • Continued use of patient stories by all services and shared at divisional and trust forums. • Develop a plan to implement patient diaries in services and how these can be used to inform service improvement. • Implement patient diaries into identified services.
Patient feedback used to inform staff training	• Implement patient feedback into the Trust Education forum through the use of complaints/ PALs and patient stories • Identify opportunities for patients and carers to participate in training • Develop and implement patient stories as part of the learning from serious incident reviews, for example impact of a pressure ulcer/ fall. • Patients to be members of the Quality councils for education and training
Divisional quality council Objectives	• One objective with outcome measures

CAMPAIGN TWO: PREVENTING HARM

Reducing unwarranted variations in care and increasing diligence in practice.

Key Outcomes	Measures of success 2017-18
Systems in place to provide early warning to illness, service failure or a reduction in the quality of care	• Maintenance of 98% or > harm free care • Severity of PU and falls will continue to fall (5%) • Red flag reporting will be embedded throughout organization • Revised early warning system developed for patients in community setting including revised early warning assessments for falls and pressure ulcers • 0% PU in bedded areas • 100% RCA completed on time
Safety culture and activities signed up to in ALL services	• Trust maintains good or outstanding in NHSI learning from mistakes league table • No outstanding actions from SI • All risk register actions are met by identified completion date.
Variations in practice identified and acted upon	• All staff are aware of learning from incidents
Divisional quality council objectives	• One objective with outcome measures

CAMPAIGN THREE: SMART EFFECTIVE CARE

Ensuring patients and service users receive the best evidence based care, every time.

Key Outcomes	Measures of success 2017-18
Clinical staff use the most up to date clinical practices	• CAS alerts (inc. PSAs) –Monthly Board KPI target for timely alert closure ≥90% • NICE – 75% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe.
There will be demonstrable culture of clinical enquiry and continuous improvement across the Trust	• 76% staff able to contribute to improvements at work (staff survey) • Staff to have access to analytics training, tools and support via the intranet
CLCH will be a leader in innovative community practice	• Develop a learning repository for lessons learnt regarding change projects • PID documents to include section for on-going learning
Divisional quality council objectives	• One objective with outcome measures

CAMPAIGN FOUR: MODELLING THE WAY

Providing world class models of care, education and professional practice

Key Outcomes	Measures of success 2017-18
New roles and career pathways are in place which supports the needs of patients/service users.	• The development of clear career pathway frameworks for Bands 1-9 for all services and staff groups with associated competencies and skills required • The continued implementation of Apprenticeship roles • The continued pilot of the Nurse Associate role in Adults and Children services • The continued pilot of the Capital Nurse foundation rotation programme • The implementation of the staffing models into all clinical services following the safer staffing review • The evaluation of existing fast track programmes and the development and implementation of further fast track programmes
Each clinical profession has a clear and successful model of professional practice which includes their role in improving population health as health champions.	• Research and develop a model of professional practice for clinical staff
Clinical staff are well led, educated, trained and involved in research to evidence the impact of what they do.	• Increase the number of research projects involving/ led by clinical staff within the Trust • Raise the profile of research in the Trust in conjunction with the training and education available to staff and the career pathway mapping • Review the Trust's research strategy
Divisional Quality Council Objectives	• One objective with outcome measures

CAMPAIGN FIVE: HERE, HAPPY, HEARD AND HEALTHY

Recruiting and retaining an outstanding workforce

Key Outcomes	Measures of success 2017-18
Staff are fully engaged and involved in the model of shared governance	• Three Quality councils per division are established and well attended. • Evaluation of the model used and any changes made to support the effective management of the councils.
Voluntary staff turnover below 10% by 2020 Staff vacancies below 10% by 2020	• Voluntary staff turnover below 15% (12% by 3/18) • Staff vacancy rate below 15% by3/17 and 12% by 3/18
Staff surveys are undertaken which demonstrates improving levels of staff engagement	• Staff engagement index score of 3.88 or above
Wellbeing strategy to support staff health and well-being and reduce staff absence	• A 2% reduction in the number of staff who report feeling unwell as a result of work related stress in the 2017 Staff Survey. • Sickness absence remains below target of 4%
The Trust is committed to and makes demonstrable reductions to agency spend	• The Trust meets its targets relating to agency spend • The number of staff recruited to staff bank increases by 10%
Divisional quality council objectives	• One objective with outcome measures

CAMPAIGN SIX: VALUE ADDED CARE

Using enhanced tools, technology and learn methodologies to manage resources well including time, equipment and referrals

Key Outcomes	Measures of success 2017-18
The user experience across CLCH, primary care, specialist services and social care is as seamless as possible	Divisions to assess experience through patient and user involvement
Clinical staff use the latest technology to improve care delivery	• Each division has explored how technical innovation can be used to improve quality. • Each division has used improvement tools to improve one service
Front line staff lead new lean ways of working	• 5% staff to have been trained to basic level in improvement skills including lean
Divisional Quality Council Objectives	• One objective with outcome measures

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

As described elsewhere in the account, in January 2017 CLCH launched its updated quality strategy Simply *the Best, Every Time.*

As part of the launch of the quality strategy, we consulted widely with all our stakeholders, including commissioners, local Healthwatch, Health Scrutiny Committees and our shadow membership, and explained to them how the quality account priorities would be aligned with our quality strategy. We asked our stakeholders for comments on the proposed measures for success for each of the quality campaigns; as well as asking what success might look like for them. We created a web survey that would allow our patients, staff and carers to comment on our quality priorities to respond to us via the survey as well as giving them the opportunity to respond in e mail or in writing.

In accordance with our statutory obligations, we circulated our draft quality account for consultation. The responses to this consultation have been included within this account.

(themes and response demographics will be added)

PATIENT STORY - MERTON FAMILY NURSE PARTNERSHIP

Before I had a family nurse, I don't know how to explain that but I was really living a miserable life. To me that's what I was thinking that I was miserable all the time. I wasn't myself really. I thought I'm worthless but ever since I got you – you are such a blessing in my life to be honest. I feel I'm loved, I matter to everyone. I just feel I'm blessed really. I'm happy. I'm extremely happy with my life now – seriously, so happy I just can't describe it in words.

I was living with my family – my mum, my siblings but life wasn't really easy. I shared a bedroom with my sister then my other sibling came and we shared a bedroom, the three of us and the baby. A little bedroom, lots of clutter – it was just too much for me, too much and I had issues with my mum – it was just too much.

The family nurses came into my life when I was pregnant. I felt so happy- I felt like I've got someone to lean on and talk to, someone to advise me on what to do. Like really you were like my mum – I don't know how to explain it. I am thankful to both you and for the Family Nurse Partnership. I'm so happy – really.

Family Nurses are different – they get to give you time, they come to your home, they listen to you, they give you advice, which you can't really find in other health professionals like midwives and so on – in hospital they can give you the right advise but they can't really give you their full attention all the time cos they need to catch up with other patients and everything. But for the Family Nurse she gives you a time and comes to visit you and listens to your problems, it's such a wonderful job… really.

Without a family nurse, I don't think I'd be here where I am right now. I wouldn't be anywhere, that's what I think. I wouldn't be here, I wouldn't be happy, I wouldn't … I don't know if I would have made it.
I feel happy now as a parent. I feel I matter, I feel like I'm important. I feel happy, I'm so happy really.

I'll feel ready now I have completed the family nurse programme because we've come a long way. You've really raised me up. Like you've raised me on my feet to able to do things on my own- I gained my confidence in everything. I think really I can cope.

Learning from this story.

The good practice of the Merton family nurse partnership will be shared across all CLCH family nurses.

SECTION 4
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

CLCH is required to register with the Care Quality Commission (CQC) and the Trust is registered with the CQC (under the provider code RYX) without any conditions. The CQC has not taken enforcement action against Central London Community Healthcare NHS Trust during 16/17. CLCH has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2017.

The Trust's last comprehensive CQC inspection took place in April 2015, with the report being published in August 2015. The grids below reflect the inspection report ratings.

In their report, the CQC highlighted eight actions that the Trust must take to improve. In response to this, CLCH created plans to address these actions. These actions were completed in March 2016 and shared with the CQC.

The Trust's compliance team is now actively working to move the Trust from good to outstanding. This includes all teams assessing themselves against CQC standards as well as benchmarking our services against trusts that have been rated as outstanding.

As can be seen from the above grid, CLCH was rated as Requires Improvement in the Safe domain. This was mainly due to staff vacancies in some services. In response to this, CLCH put in place a number of initiatives including a successful nurse recruitment drive in the Philippines. Further information on this is provided elsewhere in the account.

CQUIN PAYMENT FRAMEWORK

A proportion of CLCH's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between CLCH and the three CCGs which make up the Central London, West London, Hammersmith & Fulham, Hounslow and Ealing (CWHHE) Barnet, Harrow and Herts Valley CCGs and NHS England. Our achievements against the CQUIN goals for 2016/17 are detailed in the following tables.

(Please note that the figures below are based on the evidence submitted by CLCH to commissioners and the amount that we believe has been demonstrably achieved. However, we have not yet received formal confirmation of achievement for all of these CQUINS and hence final achievement could vary).

CWHHE

CQUIN	Goal	Plan £	Forecast £
NHS staff health and wellbeing - Initiatives	To improve the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	£224,783	£224,783
NHS Staff health and wellbeing - Flu Vaccination	Improving the uptake of flu vaccinations for frontline clinical staff of 75%.	£224,783	£94,409
Digital Roadmaps 2020	To support the design, development and delivery of the NWL Digital Roadmap and the associated Digital Programme, and provide appropriate expertise and input into variance governance arrangements	£899,132	£899,132
Tissue Viability	To standardize and improve the quality and effectiveness of Tissue Viability services across the geographical boundaries of the Central London, West London and Hammersmith and Fulham CCGs.	£150,000	£112,500
CWHHE TOTAL		**1,498,698**	**£1,330,823**

BARNET CCG

CQUIN	Goal	Plan 16/17 TOTAL £	Forecast 16/17 £TOTAL
District Nursing	Develop and implement Emergency Admission Avoidance Care Plans to deal with care of housebound patients within the community to reduce re-attendance back to hospital.	£221,049	£206,366
Diabetes Self-management	Diabetes- self management support programme for new insulin users.	£147,336	£132,602
Depression Screening	Mapping of local pathways to manage onward referral and draft protocols for initial screening of depression in older people. • To ensure screening for depression is carried out in the community for older people.	£81,051	£73,756
Depression Training	Development of virtual depression awareness programme for District Nursing, BILT, Parkinson's and COPD clinical staff.	£66,314	£66,314
Flu Vaccination	Improving the uptake of flu vaccinations for frontline clinical staff of 75%	£110,524	£0
Health and Wellbeing	To improve the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	£110,524	£110,524
BARNET CCG TOTAL		**£736,798**	**£604,246**

HARROW CCG

CQUIN	Goal	Plan 16/17 TOTAL £	Forecast 16-17 £TOTAL
Diabetes Self-management	Diabetes- self management support programme for new insulin users.	£52,998	£52,998
Depression Screening	Mapping of local pathways to manage onward referral and draft protocols for initial screening of depression in older people.	£35,332	£35,332
Depression Training	Development of virtual depression awareness programme for District Nursing, BILT, Parkinson's and COPD clinical staff.	£35,332	£35,332
Flu Vaccination	Improving the uptake of flu vaccinations for frontline clinical staff of 75%	£26,499	£13,250
Health and Wellbeing	To improve the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	£26,499	£26,499
HARROW CCG TOTAL		**£176,660**	**£144,861**

HERTS VALLEY CCG

CQUIN	Goal	Plan 16/17 TOTAL £	Forecast 16-17 £
Ambulatory Care	Identification of Patients with asthma, COPD and bronchiectasis who attend ambulatory care at WHHT to scope and provide review within 2 days.	£36,647	£36,647
Depression and Mental Health Screening	Improvement of screening for common mental health disorders among people with respiratory long-term conditions	£36,647	£36,647
HERTS VALLEY CCG		**£73,294**	**£73,294**

NHS ENGLAND

CQUIN	Goal	Plan 16/17 TOTAL £	Forecast 16-17 £
Child Health Information Systems (CHIS)	CHIS teams to consolidate into four CHIS hubs. This CQUIN facilitates quality improvements in this substantial project plan, as per CHIS Strategy for 2017, including the roll out of eRedbook to London parents from December 2016.	£7,610	£7,610
Flu Vaccination	Improving the uptake of flu vaccinations for frontline clinical staff of 75%	£5,045	£0
Health and Wellbeing	To improve the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	£12,360	£12,360
AAC Patient Activation	To introduce an Activation System for patients with Long Term Communication Disability Conditions through the use of Talking Mats, in order to support adults and children with long term conditions of complex communication disabilities to communicate their views and enhance patients' activation.	£10,300	£10,300
NHSE TOTAL		**£35,315**	**£30,270**
ALL TOTAL		**£2,520,765**	**£2,183,494**

MERTON CCG

Merton CCG did not have a CQUIN with CLCH but instead had an incentive scheme, related to the reduction of emergency hospital admissions, as follows:

> Scheme for Complex Adults, for those aged 50 and over, which is to proactively support patients and prevent avoidable emergency hospital admissions.

This scheme was worth 2% of the contract value, which would represent £327,109 over and above the contract value. However, the target could not be achieved since it depended on reducing emergency admissions in acute hospitals, which is beyond CLCH's control.

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.

Given the importance of good quality data to the effective delivery of patient 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 Trust is fully committed to improving the quality of the data in use across all of its services and the following is a summary of the actions that CLCH has taken to improve its data quality during the 2016/2017 year:

- The data quality strategy has been reviewed and approved in preparation for a revision to the data quality policy.

- Data quality reports are provided on a key number of data items and composite scoring has been introduced and reported through to all performance reports at both divisional and trust level.

- Third-party data quality reports from NHS Digital, relating to submissions to the secondary uses service (SUS), inform areas to address, along with other returns applying data quality checks.

The Performance and Information Data Quality Operations Group (PIDQOG) continues to have oversight of this area of work. It has a very strong operational input supported by the relevant functions responsible for systems and analysis. In the context of data quality this group has the following specific aims:

- To 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, for both a clinical and corporate services, including having ownership and responsibility for reviewing data quality issues and developing action plans to address those issues

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

CLCH submitted records during 2016-17 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 90.9%for accident and emergency care.
CLCH submitted information about the percentage of records for patients admitted to our Walk in Centres which included the patients' NHS number to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics. We reported that 94.6% of records included the patient's NHS number and 90.9% included their General Medical Practice number.

CLINICAL CODING ERROR RATE

CLCH was not subject to the Payment by Results clinical coding audit during 2016/17

REVIEW OF SERVICES

During 2016-17 CLCH provided and or sub contracted 77 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 2016-17 represents 100% of the total income generated from the provision of NHS services by CLCH for 2016-17.

INFORMATION GOVERNANCE TOOLKIT

The Trust has maintained Level 2 compliance against the Information Governance Toolkit and achieved a score of 77%. This represents overall satisfactory compliance which has been confirmed by the Trust auditors.

STAFF SURVEY RESULTS

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%
2016 Score – 23%

This represents a continuing improvement of 5% over the last three years, but it is still above the national average for community trusts which is now 20%, down from 21% in 2015.

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

In 2014 82% said yes.
In 2015 83% said yes
In 2016 82% said yes

This represents a largely static score over the last three years, but it is still below the national average for community trusts which is now 90%, up from 89% in 2015.

Our Plans for improvement:

We have recently launched careers clinics for all clinical staff, irrespective of their grade our experience, whereby staff have the opportunity to discuss their career aspirations with a senior member of staff and to fully review and develop their personal development plans.

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 and more meaningful working relationships.

Additionally we have developed options to prevent bullying and harassment at an early stage. These included developing a local mediation service, raising its profile and recruiting an additional four mediators.

We have also changed our policy framework to provide a greater emphasis on mediation and the greater 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 or disciplinary policy.

We have built 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 have and continue to increase the profile of health and wellbeing for all of our staff with a particular emphasis on how to spot and handle stress and/or mental health issues. A total of 176 managers have now been trained in how to identify and respond to mental health issues in their teams.

STATEMENTS

Healthwatch
OSC etc

PATIENT STORY – MARJORIE WARREN FINCHLEY MEMORIAL HOSPITAL

I was admitted to a rehabilitation unit after I sustained a fractured hip. I also had a stroke.

My stay on the unit - Yeah it's ok, there is good and bad in most things. Sometime the food is really good sometimes not so good. I have ordered something but they have given me pasta and I know I would have ordered pasta as I can't stand it. Sometimes when they give you food they don't help to cut up the meat or take the cling film off. I only can use one hand and it is very difficult to take the cling film off. I also think they should give you a tea spoon with your yoghurt or pudding as the other spoon is too big.

The nurses are very busy sometimes it can be quite a long time when you press the bell. I understand that they are very busy. The nurses themselves - well 99% of the time are kind and caring and have looked after me well and thanks to all the staff.

I have seen the physio. I have found it difficult this time due to my stroke and now broken hip. It has been difficult to put weight on that side to walk. Sometime when they help me they hold on to me and pull or push me and I feel that I might fall over, I don't like it. I didn't make any progress with the physio as I could not put weight on that side. We talked about going home with a rotastand and 2 carers coming to see me at home.

Then when the physio came to see me again I thought what's the point and refused to do it. Then I thought I would try, we went to the bars and I walked up and down. I set myself the goal to walk again. If I go home with a rotastand then I will need two carers 4 times per day. But that is a lot of time when I am at home on my own between carers. We have talked about going into a care home, but it's too expensive

The worst thing is when the convene (a type of catheter) comes off, I previously had a catheter but I can't have it because of the risk of infection. Some of the nursing staff don't know how to put a convene on.

I don't like the blind at the window (in the hospital) It is down for privacy and then blocks out the light or it is up and you can see the flats, I think there should be net curtains. The cleaner– she does a really thorough job, under the bed, everywhere.

Sometimes when staff have finished helping me, they leave the call bell at the end of the bed but I can't get to it there as I can't use my arm. I have to hope someone walks past.

Learning from this story

The team identified a number of actions in response to the issues raised by this patient. This included looking at the option of providing blinds that maintain privacy as well as allowing light in. Feedback was also provided to the catering manager regarding the cling film and the food likes and dislikes. In respect of the convenes, convene sizes were reviewed and different sizes ordered as appropriate. Staff were reminded to place call bells appropriately and to consider if the patient can access it.

SECTION 5
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
2nd Floor, Parsons Green Health Centre
5-7 Parsons Green
London SW6 4UL

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 0207 798 1424 or e mail communications@clch.nhs.uk

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.

Cold Chain: This is the process used to maintain optimal cold temperature conditions during the transport, storage, and handling of certain pharmaceuticals, starting at the manufacturer and ending with the administration of the vaccine to the patient.

DATIX: A web based risk management system, via which the Trust manages its complaints, incidents and risks.

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.

PALS
Patient advice and liaison service (PALS) provide a point of contact for patients, their families and their carers, and offer confidential advice, support and information about the services at CLCH.

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*.

Schwartz rounds
The Schwartz rounds are an opportunity for staff acknowledge and reflect upon the emotional impact of our daily working lives openly and honestly

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.

SECTION 6
APPENDIX - COMPLAINTS ANNUAL REPORT

Quality account 2016-17

world class expertise local care

Quality account 2016/17

Part one: embedding quality

Part two: priorities for improvement and statement of assurance from the board

Part three: review of quality performance

Annexes

Appendices

Part one: Embedding quality

1.1 Statement on quality from the chief executive

Information to follow- (in line with themed statement in our Annual report 2016/17)

Part two: priorities for improvement and statements of assurance from the board

This section of the quality report describes the progress made against our priorities during 2016/17. It includes a look back on how the priorities were chosen and the process for monitoring and reporting improvements throughout the year. Our priorities for the year ahead are also presented, along with a series of mandatory statements on key quality activities, which are outlined within the section, statements of assurance from the board.

2.1 2016/17 quality improvement priorities

In 2015/16, following consultation with our key stakeholders, we agreed that during 2016/17 we would focus on three areas of quality; patient experience, clinical effectiveness and patient safety.

Table 1: Quality domains with designated trust lead and associated committee

Quality domain	Designated trust lead	Associated committee
Patient experience	Associate medical director for patient experience	Patient and Staff Experience Committee (PSEC)
Clinical effectiveness	Associate medical director for clinical effectiveness	Clinical Performance Committee (CPC)
Patient safety	Associate medical director for patient safety	Patient Safety Committee (PSC)

Improving quality: continual development of a strong organisation

In addition to the three key quality improvements, the trust also agreed to have an overarching quality priority - the continual development of a strong and highly capable organisation - that originated from the five principles identified within our quality strategy.

Principles for our 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 multi-professional teams which serve patients (or other 'customers') 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 frontline staff to gain greater control of the systems that they work in. 5. All trust initiatives and strategies will dovetail and pursue the same goal of quality and continuous improvement.

Led by our director of quality, the priority centred on equipping staff with the capabilities to make continuous improvement central to their daily work. Progress was monitored by our trust board and Trust Executive Committee (TEC).

Improving quality priority for 2016/17

What did we aim to do?	What did we achieve?
For the trust board and senior leadership to work on their collective development, enabling them to provide effective leadership for improvement across our hospitals.	Workshops on 'leading for improvement' were led by Institute Healthcare Improvement (IHI). Attendees included: • Trust Executive Committee (TEC) • Trust board • 112 senior leaders across disciplines and professions trust-wide.
To use a diagnostic tool assessing our readiness for Quality Improvement (QI), helping us prioritise and focus our work to implement the quality strategy.	Trust-wide QI diagnostic assessment sessions were held with IHI in June 2016 over three days. In total, over 70 sessions were conducted with patients and over 500 staff participated.
To begin to build our trust-wide improvement team whose job is to support quality improvement work at the frontline across the trust.	The trust has developed a QI team and plans are in place to recruit members in the first half of 2017/18.

Priority one: Improving patient experience - delivering excellent experiences

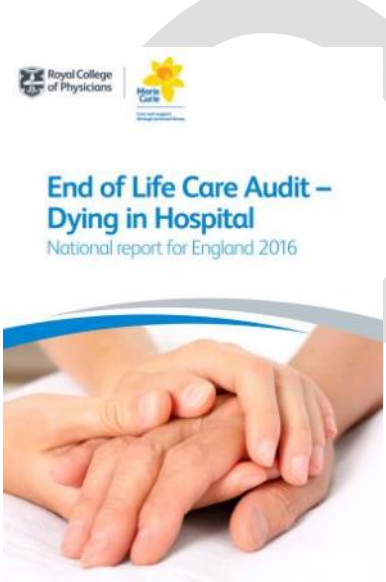
We aim to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences. The trust's definition of patient experience is derived from the Beryl Institute: 'The sum of all interactions, shaped by the culture of the Royal Free, that influence patient and carer perceptions across their pathway'.

We are fully aware that in delivering this definition we need to do more than provide excellent clinical outcomes. At the start of each board meeting, patient stories are presented which articulates their experience of our care through a complaint and a compliment. It allows the board to see the impact of decisions they are making and how embedded our World Class Care values are in the organisation.

Building on our four-year patient experience strategy (which was published in autumn 2015) we continued to focus on making improvements for those who use our services, their carers and families; with an added emphasis on dementia and end of life care. Through the Patient and Staff Experience Committee (PSEC) we have monitored, measured and reported progress to achieving our priorities. The committee reports quarterly to the trust board.

Patient experience priorities for 2016/17

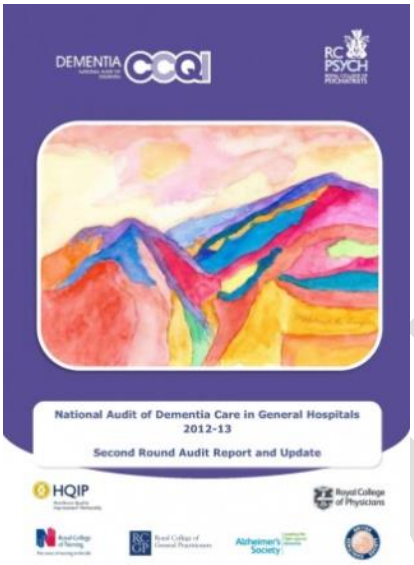
What did we aim to do?	What did we achieve?
To publish an annual report; to include a statement of dementia care on progress against the trust dementia strategy and fixed dementia care (Alzheimer's Society report) metrics	We successfully published our annual report in November 2016 and included a statement on progress against the trust dementia strategy. Our dementia lead has written the trust dementia strategy for 2017-2019 which has been approved and agreed by the Dementia Implementation Group (DIG) and is currently being implemented.
To allow flexible visiting times for carers of people living with dementia on 100% of inpatient wards (in line with the principle of John's Campaign).	For this priority, the trust choose to embed the principle of 'John's Campaign', which focuses on the right of people with dementia to be supported by their carers in hospital. John's Campaign was founded after the death of Dr John Gerrard in November 2014. John Gerrard had been diagnosed with Alzheimer's

	disease. The Dementia Implementation Group (DIG) has taken a non-prescriptive approach to implementing John's Campaign as we strongly feel that participation must be at the discretion of the ward manager and their matron. As a result, implementation of John's Campaign remains voluntary. We now have 71% of all wards signed up and actively practising John's Campaign. We have three champion wards across our sites, which collect feedback and data related to the campaign. DIG members from these wards will share this information and encourage the remaining wards to participate.
To achieve trust certification for The Information Standard by 2018 Health & care information you can trust The Information Standard Certified Member	Supported by NHS England, The Information Standard is a certification programme designed to ensure that public health information services adhere to: • a set of best practice principles, • use only recognised evidence sources • present all information in a clear and balanced way. In January 2016, we produced a patient information policy and are in the process of implementing this across the trust. This forms the foundation for the trust's future application for The Information Standard and to achieve certification by 2018.
To ensure that 95% of patients (identified as end of life) have an end of life care bundle in place. 	Subsequent to the Royal College of Physicians (RCP), National Care of the Dying Audit of Hospitals (2015), the palliative care team is working with renal, Intensive Care Unit (ICU), Health Services for Elderly People (HSEP) and cardiology teams to identify patients who are likely to be approaching the end of their lives to assess their capacity to be involved in decisions about their care. The assessment allows the patients to make known their wishes and preferences and to support them and their families in ethical decision-making about end of life care. The results of this work are in their infancy but will be available for publication in due course. The palliative care team has also contributed to the patient safety work around the deteriorating patient and we have applied for funding for an end of life care programme manager to further drive improvements in this area.

Priority two: improving clinical effectiveness - delivering excellent outcomes

Clinical effectiveness can be measured using various methods, including clinical audit, to ensure high quality patient care and outcomes. During 2016/17, we choose to further drive improvements in dementia care, building on the key messages that were identified from the National Audit of Dementia (NAD) 2013 and the pilot for national dementia 2015/16. Through the Clinical Performance Committee (CPC) we monitor, measure and report progress. The committee reports quarterly to the trust board.

Clinical effectiveness priorities for 2016/17

What did we aim to do?	What did we achieve?
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. 	According to the national audit of dementia (2013), at any one time, a quarter of acute hospital beds are occupied by dementia patients. We recognise that caring for someone with dementia or a terminal illness can be stressful and difficult, so it is important our services provide people with dementia and their carers with the support they need. As a result, we have developed a passport that entitles carers of people with dementia to staff reductions in the canteen, reduced parking costs, free massages and companionship from our dementia volunteers.
Linked with our patient experience priorities on dementia, we will work to improve our discharge co-ordination for patients with dementia.	The trust is currently participating in the National Audit of Dementia, which is due to publish its findings in May 2017. The national audit supplier has recently commended both the Royal Free and Barnet Hospitals on their carer's questionnaire submission, asking for feedback on our process so it can be shared with other trusts.
To develop metrics to measure improvements in dementia care.	The metrics have been developed by our dementia lead and work is in progress to embed these across the trust.

Priority three: Improving patient safety - delivering safe care

Through the Patient Safety Committee (PSC) we have monitored, measured and reported progress made during 2016/17 to achieve the set priorities. The committee reports quarterly to the trust board.

Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the trust (measured by incidents relating to NHS Legislation Authority claims) by 50% by 31 March 2018. Our targets are set out in our three-year Patient Safety Programme (PSP) improvement plan and we will be delivering key milestones along the way.

While the Quality Account's focus is on patient safety (as determined by the legal framework), we also take our staff safety just as seriously. Throughout the progress updates reviewed here, there are references to communication, debriefs and huddles, and all of these help support our staff to provide quality care to our patients. Our chosen priorities for 2016/17 are as follows:

Falls prevention

Aims

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days (OBDs)
- To reduce by 20% the proportion of patients that experience moderate harm or above from falls

Our 2016/17 milestones:

Falls chosen priority	Progress to date
We will continue to harmonise documentation relating to falls risk assessment, so we can introduce a falls package that includes assessments, a care plan, a bedrail assessment and a post-fall checklist. We will develop an amended 'immediate post falls care guideline' that can work across all sites. We will continue with the trust-wide IHI learning sessions and increase our informal meetings to share and review information.	We are actively counting the number of days since the last fall on each pilot ward to encourage engagement and develop healthy competition. During this reporting period we have so far achieved 12% reduction in the number of falls and a 73% reduction in the proportion of patients that experience moderate harm or above from falls. We submitted our falls improvement work to the Patient Safety Awards, where we were shortlisted as a finalist. We also presented our falls improvement work at the Falls Prevention and Management conference on 6 July 2016. We have shared our work at both national and international conferences: the 17th International Conference on Falls and Postural Stability (September 2016), The Science of Improvement Conference (November 2016) and National Patient Falls Improvement Collaborative run by NHS Improvement and NHS England where 21 trusts participated from across the UK. We have implemented small changes in pilot wards and assessed progress and shared learning in formalised learning sessions and webinars.

Acute Kidney Injury (AKI)

Aims

- To increase by 25% the survival for inpatients with AKI
- To increase by 25% the proportion of patients who recover renal function
- To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days
- To measure and improve patient experience and wellness scores by 2018

Our 2016/17 milestones:

AKI chosen priority	Progress to date
We will co-design and deliver an educational package to build knowledge around recognition and treatment of AKI. We will co-design a care bundle package to support the local clinical teams to deliver interventions specific to AKI pathology, such as hypo-perfusion, toxicity, obstruction and primary renal disease. We will develop a reliable creatinine review and response system.	Initial AKI improvement work has started at the Royal Free Hospital before rolling out to the other sites. This improvement work is a collaboration between the renal team, Patient at Risk Resuscitation Team (PARRT), the Patient Safety Programme team, pharmacy services and dietetic services alongside DeepMind Health. Our AKI champions have been collecting and analysing 11 months of baseline data for Royal Free patients, which was presented at the regional UCLPartners Measurement day. We have developed an AKI portal on Freenet with training materials and resources. Changes that are currently been tested include the designing and testing of an Enhanced Care AKI Care pathway: a) A technology platform (AKI App), developed by DeepMind Health. It utilises the national mandated AKI detection algorithm and sends AKI alerts with other relevant data to the clinical responders. b) Response team, which consists of the on-call renal consultant and the renal registrar as primary responders. Secondary responders will include the PARRT team and renal pharmacy. c) An AKI care plan completed by the response team as a written handover to the clinical ward team. We are now also testing our AKI patient experience survey on 10 East ward (renal ward). This survey has been co-designed with AKI patients and our Patient Experience Team. We have analysed last year's data relating to the number of new AKI patients identified per ward. This data identified the six wards on which the highest number of AKI triggers were received. These are all non-renal wards: Emergency Department, 9 North, 8 West, 10 West, 8 North and 9 West. Our next step will be to develop a training pack and deliver AKI education to all multi-disciplinary teams on these wards.

Safer Surgery

Aims

- To improve compliance to 95% for each of the five steps to safer surgery by 2018
- To reduce by at least 50% the number of surgical never events from 10 in (2015/16) to 4

Our 2016/17 milestones:

Safer Surgery chosen priority	Progress to date
By scaling up our plan-do-study-act (PDSA) cycles, we will develop locally driven methods to robustly imbed the quality of the content within steps 1 and 5 (the brief and debrief) in the theatre lists across all sites. (See glossary of terms for details on the 5 steps for safer surgery) We will co-design and test interventions to improve team culture and 'buy in' across general theatres, particularly during sign in, time out and sign out (steps 2, 3, 4). This will include the co-designing and implementation of a local theatre/surgery faculty to build skills and knowledge. We will co-ordinate the development of an organisational framework for implementation and co-design local national standards for invasive surgical-related procedures.	We have continued to test the debrief tool (step1 & 5) in nine theatres. Testing of this tool started in Oct 2015 and we have now captured over 995 team debriefs. Current MDT contribution of the three most senior disciplines and observed 'buy-in' to the running debrief continues to be captured and measured monthly. In quarter 3, the following metrics were achieved: • 92% all attendance and 'buy in' at brief • 52% attendance and 'buy in' at debrief Recent learning includes improving the effectiveness of the debrief by testing the idea of weekly summaries of Monday-Friday debrief data. This is expected to be the most efficient method for collection, analysis and sharing of information from the debrief tool. Through this testing it has been highlighted that staff did not feel confident with how to escalate some issues raised. This has resulted in an escalation ladder to accompany the debrief tool, with clearer instructions and contact details for different categories of issues. We have co-ordinated the development of an organisational framework for implementation and co-design of local national standards for invasive surgical related procedures (NatSSIPs) and will include this within our approach as we develop our Safer Surgery improvement plan over the next two years. The Safer Surgery policy incorporates Local Safety Standards for Invasive Procedures (LocSSIPs). We have identified a more robust observational tool for counting swabs and instruments within Maternity Services (step 4). Our updated Swabs, Instruments & Needles Counting policy has been developed and dissemination of this includes a new peer review of competency of scrub practitioners. The collection of step 4 data started in February 2016 with weekly updates. The observational collection of counting swabs and instruments within Maternity Services (step 4 data) now happens on three sites and has seen an average compliance increase from 65% to 86% in reliability. In quarter 3, these metrics were observed 89% of the time.

Deteriorating unborn baby

Our initial work in this area is funded by the NHS Litigation Authority, based on the extremely high costs of claims. Therefore, our aim is to reduce of these claims, which will ultimately be reflected in a reduction in harm to the unborn baby. We realise that this is not a person-centred aim and are in the process of developing more relevant measures for this workstream.

Aims

- To reduce by 50%, the number of incidents resulting in a claim relating to deterioration of the unborn baby from a mean of two per year to a mean of one per year, during three years: 2015-2018.

Our 2016/17 milestones:

Deteriorating unborn baby chosen priority	Progress to date
We are setting up the unborn baby working group and will map out ideas for change/improvement. This will include the identification of a clear aim, driver diagram and process measures. We will identify pilot area champions within Barnet and Royal Free hospitals' labour wards.	Baseline data has been collected from incidents to provide a themed analysis to understand current barriers. The baseline data has been shared with staff at audit and perinatal meetings and will be absorbed into the online maternity 'lesson of the week' feedback processes. We have identified our initial champions and have hosted two maternity planning meetings with neonatologists, midwives and obstetricians where they have created the driver diagram. External collaboration with Scottish National Maternity Patient Safety team has enabled sharing of ideas and approaches including testing MDT huddles. We have spent time information gathering to triangulate data sources for the tracking of new-born episodes, including accessing the National database Badgernet and local maternity unit systems to capture babies transferred externally. A confidence survey for all maternity staff has now been completed. The data is currently being analysed and will help to influence the design phase of the planned Cardiotocograph (CTG) education package for 2017.

Deteriorating Patient

A deteriorating patient is someone who becomes acutely unwell in hospital. This deterioration is recognised by staff who monitor the patient's vital signs such as heart rate and blood pressure, and who will then deal with this deterioration by acting directly, or escalating issues to more senior staff when needed. Occasionally, a patient's deterioration is not identified, recognised, or not acted upon sufficiently rapidly and this can lead to sub-optimal care and a patient safety incident such as an unexpected cardiac arrest. By focusing on this area, we will improve the quality of care for all our patients.

Aims

- To reduce the number of cardiac arrests to less than one per 1,000 admissions at both Barnet and Royal Free Hospitals by 31 March 2018.

Our 2016/17 milestones:

Deteriorating Patient chosen priority	Progress to date
Five pilot wards have been identified across the trust (including obstetrics) where we will trial specific change interventions such as SBAR (Situation, Background, Assessment and Recommendation) handover quality, ward rounds, board rounds and safety huddles. These interventions will be measured so that staff receive timely feedback and PDSA cycles of improvement can be enacted. We will introduce ward-based metrics, such as ward cardiac arrest rates, so that staff can understand their baseline data and have real-time feedback on progress. We will undertake targeted case note review and audit of patient deaths (both unexpected and expected) in the pilot ward areas involving ward staff alongside members of the deteriorating patient workstream. Areas for improvement and lessons learnt will be shared back with ward staff.	We are drafting a communication bundle and are starting to define what to measure for handovers, ward rounds and board rounds and the risk and resuscitation team - PARRT - are testing a handover tool. We have observed a variety of handover and board rounds in pilot areas to develop understanding of the quality of staff–to-staff communication. We have undertaken 12 staff interviews at the Royal Free and Barnet Hospitals where strong themes have emerged and potential gaps have been identified. We have also hosted our first patient community focus group, with charity funding, where we tested narrative relating to clinical end of life discussions with patients and families. Coding of these interviews and discussions is being undertaken against the COM-B behavioural model to help narrow the focus on what to measure. Engagement with all cardiology MDT members has begun to scope barriers and levers to recognition, treatment and delivery of complex decision in cardiology patients. The clinical MDT on our cardiology ward has collaborated with PARRT to review processes around the recognition and management of the deteriorating patients. Initially a medical records review was undertaken relating to 31 patient deaths over a nine-month period (November 2015 – August 2016). This review identified 20 patient deaths that were expected, and 11 where resuscitation was undertaken, i.e. the death was not planned for. Of these 11 patients, four patients died less than 24 hours after PCI (Percutaneous Coronary Intervention) and the other seven had multiple co-morbidities. No problems in care or service delivery were identified as contributing to these patient deaths. These reviews identified the following themes that have been shared with consultants, cardiac Cath-lab and ward staff: • Delayed recognition of poor trajectories of chronic conditions • Delayed end of life decision making • All those patients who died following cardiac arrest were in a 'non-shockable' rhythm, which is indicative of expected very poor clinical outcomes, most often resulting in death. The initial planning phase on 10 west has identified team communication processes and lack of opportunity for MDT to make shared decisions as areas for improvement. Rapid PDSA cycles have commenced to re-design the content and structure of information on the ward white boards. These boards display significant pieces of clinical and social information to support anticipatory care planning discussions and help facilitate a planned weekly MDT meeting, supported by PARRT and palliative care teams. Recent testing has provided shared knowledge and learning around: • Early identification of complex patients with chronic poor trajectory of health conditions e.g. prompting questions of the number of admissions in past six months?

Deteriorating Patient chosen priority	Progress to date
	• Timely identification of patients that require MDT discussion e.g. complex social and medical needs have been highlighted. • How to better recognise patients ready for discharge, prompting discussion of potential discharge date and synchronising care packages accordingly.

Sepsis

Aims

- To reduce by 50% severe sepsis-related serious incidents across all sites to zero in 2017/18.
- To increase survival by 50% for those patients on the sepsis bundle across all sites.

Our 2016/17 milestones:

Sepsis chosen priority	Progress to date
We will use PDSA cycles to improve our compliance in the newer pilot ward areas such as Barnet Hospital's emergency department and maternity. We will test the behavioural theory-identified recommended modifications for improvement: standardisation of education sessions, partnership agreement, and frequently asked questions guidance in our pilot ward and measure this in practice. We will further develop the sepsis champion role in pilot areas to enable long term sustainability in all 10 pilot wards.	Over 2015/16 there was four serious incidents relating to sepsis, with an additional incident in 2016/17 to date. The majority of these incidents occurred in Barnet Hospital and so this has influenced our drive for sepsis improvements in this location for 2016/17. The sepsis bundle is now implemented in 10 of our clinical areas, which includes our labour wards and emergency departments (ED). In August 2016 at Barnet ED compliance with the sepsis six bundle was 65% - the highest compliance since pilot launch. Tests of change have included using a sepsis stamp for documentation and a sepsis trolley to ensure prompt treatment. Three nurse champions have now been recruited, though a new consultant is needed as sepsis lead. The severe sepsis pathway has now been added to the ED admission booklet. The maternity sepsis team published their sepsis improvement poster at the Royal College of Obstetricians and Gynaecologists (RCOG) conference in June 2016. This collaborative piece of work outlined the success of Obstetric Sepsis 6 improvement work on the Royal Free and Barnet labour wards, highlighting the benefits of sharing and learning from each other. Sepsis pathway triggers and pathways have been standardised across the trust with the implementation of sepsis stickers and sepsis trollies. Feedback from maternity staff has been that the implementation of a Sepsis 6 pathway has improved and simplified the management of severely septic women in the maternity service.

	Barnet labour ward has celebrated an achievement of 100% compliance for all sepsis 6 within an hour in August. Monthly sepsis improvement meetings continue and champions are encouraged to attend and present their own data. UCL Partners (UCLP) Sepsis Collaborative hosted an informative measurement day on 21 September 2016. The Royal Free London champions presented our approach at the final UCLP collaborative summit event on 2 December 2016. To support the sepsis improvement work across both the Royal Free and Barnet Hospitals, an awareness day was set up to support the clinical teams involved. Sepsis champions showcased their experiences of Barnet labour ward and ED successes. The event was held at Barnet Hospital and about 40 doctors, nurses and nursing students attended. This event was well supported by the trust executive team. In the session staff gained knowledge on: • The use of behavioural science research in the sepsis improvement work (COM-B model) • Current NICE guidance • Role of a sepsis champion • How to manage sepsis with a multi-professional team – demonstrated by simulation Joe Adams, one of our patients, has been treated at the trust for sepsis many times, and he kindly agreed to create a short video that documents his journey over the past 10 years as a patient. This video uses the power of transformational storytelling to positively influence and educate clinical teams with the delivery of the sepsis care bundle. This video will be incorporated into future internal e-learning packages and sepsis awareness raising events. Joe kindly also attended the event and pro-actively answered questions from staff. As part of our sepsis programme, we are also including the 2016/17 national sepsis goals which focus on timely screening, identification and treatment for sepsis in the following areas: ED, acute inpatient settings and paediatrics. Data collection will include: sepsis screening and documentation with observations recorded, and severe sepsis/shock and timely IV antibiotics within 1 hour and review of IV antibiotics at 72 hours. Baseline and quarter three data has been submitted to our commissioners.

2.2 Priorities for improvement 2017/18

This section of the quality account details what the quality improvement priorities will be for the year ahead. All three priorities fall within the quality domain and were drawn from our local intelligence, engagement with the Commissioning for Quality and Innovation (CQUIN), performance and feedback following consultation with key stakeholders. Progress in achieving the priorities will be monitored at our board level committees and our trust board.

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 asked if there were any other priorities that the trust should consider for 2017/18.

In addition, we consulted with both in-patients and out-patients at Barnet and Chase Farm Hospitals to ascertain their views on the trust priorities. On the whole, the patients were in agreement with our proposed priorities but suggested that a focus on nutrition could be considered.

Step 1

- The initial proposed quality improvement priorities were generated following discussion at the associated committee and drawn from our intelligence and performance.
- Our stakeholders were invited to attend our consultation event.

Step 2

- The stakeholders event was held on 13 January 2017 and was attended by over 80 people.
- Attendees included members for our council of governors, joint overview and scrutiny health committee, healthwatch and commissioners.

Step 3

- Feedback from the consultation event was analysed and changes were made accordingly to our quality improvement priorities.
- The priorities were agreed and signed-off by our trust executive committee.

Priority 1: Improving patient experience - delivering a world class experience

The approach to improving the patient experience remains linked to the different strands of work which are ongoing within the trust. The patient experience strategy (2015-2019) outlined the vision of being strong leaders of positive patient experiences so we can effectively serve our communities.

Our proposed quality priorities for 2017/18 are:

- To achieve trust certification for the Information Standard by 2018
- Improve how patients, carers and families can provide feedback to the trust. Each service must have at least three ways of allowing feedback about a person's experience
- To systematically analyse the experience of bereaved families and friends
- To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy by 2018
- To recruit 30 Patient and Family Experience Partners*

*A partner is a person who:

- Wants to help enhance the quality of our hospitals care for all patients and family members.
- Gives advice to the hospital based on his or her own experience as a patient or family member
- Partners with hospital staff on how to improve the patient and family experience through short and/or long-term projects and volunteers his or her time.

Priority 2: Clinical effectiveness

The overarching plan for 2016/17 was that the clinical effectiveness priority will dovetail with the quality improvement initiatives. This would strengthen the delivery of the local and national effectiveness agenda and support the delivery of significant improvements in the quality of patient care.

By April 2018, the trust aims to deploy a trust-wide approach to managing unwarranted variations in clinical care, called Clinical Practice Groups (CPGs). CPGs interface very closely with the operating line.

The trust is also implementing a unified approach to Quality Improvement (QI) across the trust, which will equip and empower local teams to address opportunities to improve the quality of care they deliver both within and outside the scope of CPGs.

The trust's priority is also to have at least 50 QI projects in place by the end of April 2018. The projects are required to have core features, which include a clear aim, change logic, ongoing PDSA and measurement linked to learning (see appendix a. for more details).

Therefore it was proposed that the 2016/17 clinical effectiveness priority on dementia would not be retained during 2017/18 as a specific quality priority as the trust has made significant improvements during 2016/17.

Our proposed quality priorities for 2017/18 are:

- To improve key effectiveness metric(s) relevant to 20 priority pathways by deploying multi-professional pathway teams to reduce unwarranted variation.

- Each pathway team to deploy a standardised approach to design and execution, within the umbrella of the CPGs.

Note: We are currently selecting our priority pathways and the metrics will be specific to the pathways selected.

Priority 3: Our focus for safety

The trust has set an ambitious target to become a zero avoidable harm organisation by 2020; initially reducing the level of avoidable harm by 50% by March 2018. The targets for safety follow a three-year plan, with discrete deliverables for 2017/18.

Our proposed quality priorities for 2017/18 are:

Falls

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days.
- To reduce by 20% the proportion of patients that experience moderate harm or above from falls.

Acute Kidney Injury (AKI)

- To increase by 25% the survival for inpatients with AKI.
- To increase by 25% the proportion of patients who recover renal function from 68% to 85%.
- To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days.
- To measure and improve patient experience and wellness scores.

Safer Surgery

- To improve compliance to 95% with each of the five steps to safer surgery.
- To reduce by at least 50% the number of surgical never events from 9 to 4.

Deteriorating Patient

- To reduce the number of cardiac arrests to less than one per 1,000 admissions.
- To reduce by 50%, the number of incidents resulting in a claim relating to deterioration of the unborn baby from a mean of two per year to a mean of one per year.

Sepsis

- To reduce by 50% severe sepsis-related serious incidents across all sites from one to zero.
- To increase survival by 50% for those patients on the sepsis bundle across all sites from 83% to 91%.

Overview of our key achievements

The Royal Free Hospital achieved the **highest** risk-adjusted **survival rates at 5 years** for **first adult kidney transplant** **in London, and better than the national average**	The Royal Free Hospital is in the **top 20 performing hospitals** nationally for **adult patients with type 1 diabetes** **receiving all 8 best practice recommended care processes**	**Our stroke patients receive a world class stroke service** with Barnet and Royal Free Hospitals amongst the **top 18% of teams** nationally
The Royal Free Hospital is **the 3rd best performing hospital** nationally for **paediatric diabetes** patients **receiving all 7 best practice recommended processes**	The Trust participated in **50** national audits and confidential enquiries	**Better than national and London** risk-adjusted **mortality at 90-days and 2-years** for **bowel cancer** surgery at Barnet Hospital
The Royal Free Hospital is in the **best 25% of hospitals** nationally for **diabetes care in pregnant women** for **blood glucose control for pregnancies in the first trimester and at 24 weeks+**	**More major trauma patients** presenting at the emergency department at Barnet and Royal Free Hospitals **survive compared to expected** based on the severity of their injury	**0% rate of stroke/ death reported for patients undergoing a carotid endarterectomy** at the Royal Free Hospital
Barnet Hospital **Intensive Care Unit**: • Achieved **best ratings for all RAG-rated quality indicators** • **Improved compared to previous year for 5/7 indicators** (reduction of high risk sepsis admissions, out of hours discharges to the wards and risk-adjusted mortality) • Has significantly fewer **unplanned readmissions within 48 hours than nationally**	Barnet and Royal Free Hospitals are both in the **best 25% of hospitals** nationally **for 5 best practice care process or outcomes** for **hip fracture** patients, including **best practice tariff achieved** at Barnet Hospital and **overall hospital length of stay** at Royal Free Hospital	The Royal Free Paediatric emergency department: • Is in the **best 25% of hospitals** nationally for **4/5 best practice criteria relating to vital signs** • **For all cases** where abnormal vital signs were present the **clinician recognised the abnormal vital signs and they were acted upon appropriately**

2.3 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 trust. Where relevant we have provided additional information for local context to the information in the statutory statements.

Review of services

Quality is monitored in each of our four clinical divisions, with regular reviews of safety, clinical effectiveness and patient experience. Assurance is provided from each division to our strategic quality committee.

During 2016/17, the trust provided and/or sub-contracted xx relevant health services.

The trust has reviewed all the data available on the quality of care in xx of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents xxx of the total income generated from the provision of relevant health services by the trust for 2016/17.

(Final data to be added)

Participating in clinical audits and national confidential enquiries

The trust continues to participate in clinical audit programmes and has integrated this within our quality improvement programme. We continue to review our clinical audit processes, ensuring we have evidence of improvements made to practice.

During 2016/17 42 national clinical audits and 8 national confidential enquiries covered relevant health services that the trust provides.

During that period the trust participated in 100% (42/42) of national clinical audits and 100% (8/8) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the trust was eligible to participate in, and took part in, during 2016/17 are listed in table 2:

The national clinical audits and national confidential enquiries that the trust participated in, and for which data collection was completed during 2016/17, 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.

Table 2: Participation in national clinical audits and national confidential enquiries, including validated participation rates provided to the trust by the audit supplier in 2016/17

*Validated participation rates for 2016/17 have not been made available by the audit provider. These figures relate to the most recent audit period, as indicated, for which validated participation rates are available.

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
British Association of Endocrine and Thyroid Surgeons (BAETS)	√*	x	x BH	
		√	√ CFH	n= 543 (CF and RF) *2010/14
		√	√ RFH	
British Association of Urological Surgeons (BAUS): nephrectomy audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n= 566 (130%) (BH and RF) *2013/15
BAUS: percutaneous nephrolithotomy (PCNL)	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 84 *2014/15
BAUS: stress urinary incontinence	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 12 *2014/15
British Thoracic Society (BTS): adult asthma	√	√	√ BH	n=13 (100%)
		x	x CFH	
		√	√ RFH	n=31 (100%)
BTS: paediatric pneumonia	x	√	√ BH	Audit due for completion 2017/18
		x	x CFH	
		√	√ RFH	Audit due for completion 2017/18
Cancer: national bowel cancer audit	√*	√	√ BH	n= 146 (108%) *2014/15
		x	x CFH	
		√	√ RFH	n= 80 (84%)
Cancer: national lung cancer audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n = 314 (BH and RF) *2015
Cancer: national oesophago-gastric cancer audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n= 194 (81-90%) (BH and RF) *2012/ 15
Cancer: national prostate cancer audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n = 342 (82%) (BH and RF) *2014/15
Chronic obstructive pulmonary disease (COPD) audit programme: secondary care	x	√	√ BH	Audit due for completion 2017/18
		x	x CFH	
		√	√ RFH	Audit due for completion 2017/18
COPD audit programme: pulmonary rehabilitation	x	x	x BH	
		x	x CFH	
		√	√ RFH	Audit due for completion 2017/18
Dementia: national audit of dementia	√	√	√ BH	Organisational Audit: n=1 (100%) Clinical Audit: n=55 Carer Questionnaire: n=61 Paper Staff Questionnaire: n=55 Online Staff Questionnaire: n= 63
		x	x CFH	
		√	√ RFH	Organisational Audit: n=1 (100%) Clinical Audit: n=55 Carer Questionnaire: n=76

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
				Paper Staff Questionnaire: n=56 Online Staff Questionnaire: n= 65
Diabetes: national diabetes audit (NDA)	√*	√	√ BH	n= 718 *2015/16
		√	√ CFH	n= 548 *2015/16
		√	√ RFH	n= 1726 *2015/16
Diabetes: national footcare in diabetes audit	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 56 *2014/16
Diabetes: national diabetes in-patient audit (NaDIA)	√	√	√ BH	n= 57
		x	x CFH	
		√	√ RFH	n= 103
Diabetes: national diabetes transition audit	x	√	√ BH	NEW – first round of audit
		√	√ CFH	
		√	√ RFH	
Diabetes: national paediatric diabetes audit (NPDA)	√*	√	√ BH	n= 119 *2015/16
		√	√ CFH	n= 60 *2015/16
		√	√ RFH	n= 60 *2015/16
Diabetes: national pregnancy in diabetes (NPID)	√*	√	√ BH	n= 26 *2015
		x	x CFH	
		√	√ RFH	n= 37 *2015
Falls and fragility fractures audit programme (FFFAP): fracture liaison service database	√	√	√ BH	NEW – first round of audit
		x	x CFH	
		x	x RFH	
FFFAP: national hip fracture database	√*	√	√ BH	n= 370 (92.9%) *2015
		x	x CFH	
		√	√ RFH	n= 190 (85.4%) *2015
Heart: national audit of percutaneous coronary interventions	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 829 *2014
Heart: cardiac rhythm management	√*	√	√ BH	n= 304 *2015/16
		x	x CFH	
		√	√ RFH	n= 167 *2015/16
Heart: myocardial infarction national audit project (MINAP)	√*	√	√ BH	n= 304 *2014/15
		x	x CFH	
		√	√ RFH	n= 289*2014/15
Heart: national heart failure audit	√*	√	√ BH	n= 402 (81%) *2014/15
		x	x CFH	
		√	√ RFH	n= 260 (76%) *2014/15
Intensive care national audit and research centre (ICNARC): national cardiac arrest audit (NCAA)	√*	√	√ BH	n=121 *2015/16
		x	x CFH	
		√	√ RFH	n=320 *2015/16
ICNARC: case mix programme: adult critical care	√*	√	√ BH	n=1017 *2015/16
		x	x CFH	
		√	√ RFH	n=1628 *2015/16
Inflammatory bowel disease (IBD): biological therapy audit Adult services	x	√	√ BH	Transition to IBD Registry. Next audit round due for completion 2017/18
		x	x CFH	
		√	√ RFH	Transition to IBD Registry. Next audit round due for completion 2017/18

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
IBD: biological therapy audit Paediatric services	x	x	x BH	
		x	x CFH	
		√	√ RFH	Transition to IBD Registry. Next audit round due for completion 2017/18
National comparative audit of blood transfusion programme: re-audit of patient blood management in scheduled surgery	√*	√	√ BH	n= 23
		√	√ CFH	n= 8
		√	√ RFH	n= 23 *2015
National comparative audit of blood transfusion programme: re-audit of red cell and platelet transfusion in adult haematology patients	√*	√	√ BH	n= 32 *Jan-16
		x	x CFH	
		x	x RFH	
National elective surgery PROMs: four operations	√*	√	√ BH	n=748 (74.3%) *Apr-14/Mar-15
		√	√ CFH	
		√	√ RFH	
National emergency laparotomy audit (NELA)	√*	√	√ BH	n= 10 *2014/15
		x	x CFH	
		√	√ RFH	n= 92 *2014/15
National joint registry (NJR)	√*	√	√ BH	n= 42 * data to Dec-15
		√	√ CFH	n= 573 * data to Dec-15
		√	√ RFH	n= 427 * data to Dec-15
National neonatal audit programme (NNAP)	√*	√	√ BH	n=1255 *2015
		x	x CFH	
		√	√ RFH	n=368 *2015
National pulmonary hypertension audit	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 1080 *2014/15
National vascular registry	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 257 *2015
National ophthalmology audit: adult cataract surgery	√	√	√ BH	NEW – first round of audit
		√	√ CFH	
		√	√ RFH	
Renal replacement therapy (renal registry)	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 229 *2014
Royal College of Emergency Medicine (RCEM): asthma (adults and children)	√	√	√ BH	n=101 (100%)
		x	x CFH	
		√	√ RFH	n=117 (100%)
RCEM: severe sepsis and septic shock-care in emergency departments	√	√	√ BH	n=101 (100%)
		x	x CFH	
		√	√ RFH	n=81 (100%)
Sentinel stroke national audit programme (SSNAP)	√*	√	√ BH	Case ascertainment = 90+% *2015/16
		x	x CFH	
		√	√ RFH	Case ascertainment = 90+% *2015/16
Trauma audit research network (TARN)	√*	√	√ BH	Case ascertainment = 66% *2015
		x	x CFH	
		√	√ RFH	Case ascertainment = 75-94% *2015

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
Rheumatoid and early inflammatory arthritis	x	√	x BH	Audit did not collect data in 2016/17
		√	x CFH	
		√	x RFH	
Adult cardiac surgery	√*	x	x	
Congenital heart disease	√*	x	x	
Chronic kidney disease in primary care	√*	x	x	
Mental health clinical outcome review programme	√*	x	x	
PICANet	√*	x	x	
Prescribing observatory for mental health	√*	x	x	
Specialist rehabilitation for patients with complex needs	√*	x	x	
UK Cystic fibrosis registry	√*	x	x	
National lung cancer audit consultant-level data	√*	x	x	
National oesophago-gastric cancer audit - consultant-level data	√*	x	x	
National neurosurgical audit programme - consultant-level data	√*	x	x	

The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2016/17:

National audit title
7-day service audit
BTS: smoking cessation
Maternity and perinatal audit
National audit of cardiac rehabilitation
National complicated diverticulitis audit (CAD)
NHSBT: kidney transplantation
NHSBT: liver transplantation
Potential donor
RCEM: consultant sign-off
Royal College of Anaesthetists: national of perioperative anaphylaxis
The iBRA-2 study: a national prospective multi-centre audit of the impact of immediate breast reconstruction on the delivery of adjuvant therapy

National confidential enquiries for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%)
Medical and surgical clinical outcomes review programme: physical and mental health care of mental health patients	√	√	√ BH	Clinical Questionnaire and casenotes: n= 15/15 (100%) Psychiatric Liaison Questionnaire: 5/5 (100%)
		√	√ CFH	
		√	√ RFH	

National confidential enquiries for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%)
in acute hospitals				Organisational Audit: n= 3/3 (100%)
Medical and surgical clinical outcomes review programme: non-invasive ventilation	√	√	√ BH	Clinical Questionnaire and Casenotes: n= 5/5 (100%) Organisational Audit: n= 2/2 (100%)
		x	x CFH	
		√	√ RFH	
Medical and surgical clinical outcomes review programme: acute pancreatitis	√	√	√ BH	Clinical Questionnaire: n= 10/10 (100%) Casenotes: n=10/10 (100%) Organisational Audit: n= 3/3 (100%)
		x	x CFH	
		√	√ RFH	
Maternal, newborn and infant: maternal programme	√*	√	√ BH	100%
		x	x CFH	
		√	√ RFH	Case ascertainment = 100% *2015
Maternal, newborn and infant: perinatal programme	√*	√	√ BH	Case ascertainment = 100% *2015
		x	x CFH	
		√	√ RFH	Case ascertainment = 100% *2015
Learning disability review programme (LeDer)	x	√	√ BH	Enquiry due for completion 2017/18
		√	√CFH	
		√	√ RFH	
Child health clinical outcomes review programme: young people's mental health	x	√	√ BH	Enquiry due for completion 2017/18
		√	√CFH	
		√	√ RFH	
Child health clinical outcomes review programme: chronic neurodisability	x	√	√ BH	Enquiry due for completion 2017/18
		√	√CFH	
		√	√ RFH	

The reports of 49 national clinical audits were reviewed by the provider in 2016/17 and the trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

- We will continue to scrutinise and share learning from national audit reports at our corporate committee (clinical governance and clinical risk committee)
- We will use outcomes from national clinical audits to help us prioritise pathway work in our Clinical Practice Groups across our new group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

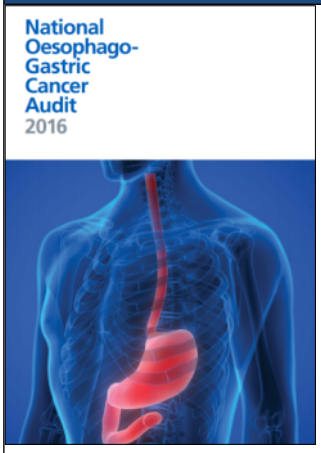
Table 3: Details of specific actions undertaken as the result of a national clinical audit

National clinical audit	Actions to improve quality
British Association of Endocrine and Thyroid Surgeons (BAETS) **Published:** Jan-16 **Reporting period:** 01/07/10 – 30/06/14 **Site:** Royal Free & Chase Farm	Data was submitted to the registry by three consultants who work across sites – none of whom have been identified as outliers. During the audit period the trust data shows that there were no post-operative deaths, that length of stay was the same or better than the national average and that better than national average rates were achieved for related re-admission, re-exploration for bleeding and late hypocalcaemia.

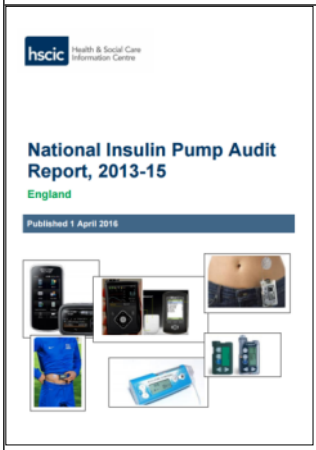
National clinical audit	Actions to improve quality
British Association of Urological Surgeons (BAUS) - nephrectomy audit **Published:** Sep-16 **Reporting period:** Barnet: 2013 and Royal Free: 2013-15 **Site:** Royal Free and Barnet	Neither the trust nor any of the eight consultants who submitted data to the audit are identified as outliers for complication rate, transfusion rate or mortality. Royal Free – No deaths were reported during the audit period, and the complication and transfusion rates are better than the national average. Barnet – The transfusion rate and mortality rate is 0. The complication rate is within control limits and not identified as an outlier.
BAUS - percutaneous nephrolithotomy (PCNL) audit **Published:** May-16 **Reporting period:** 2014-15 **Site:** Royal Free only	The data shows that the trust achieved a transfusion rate of 0% during the audit period, and that the post-operative length of stay is in line with the national average.
British Thoracic Society Better lung health for all **British Thoracic Society (BTS): adult asthma audit** **Published:** Feb-17 **Reporting period**: 01/09/16 - 31/10/16 **Site:** Royal Free and Barnet	Asthma is a common lung condition that causes occasional breathing difficulties. It affects people of all ages and often starts in childhood, although it can also appear for the first time in adults (*source: NHS Choices*). The performance of the respiratory team in the audit demonstrates areas of excellence in the care provided to our patients with the most recently published data showing that above average performance was provided at Barnet and Royal Free Hospitals for the following best practice criteria: • Awareness that patients with severe asthma and one or more adverse psychosocial factors are at risk of death. • Supplementary oxygen is provided to hypoxaemic patients with acute severe asthma to maintain an SpO_2 level of 94-98%. • People presenting with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation. • People with asthma who present with an exacerbation of their symptoms receive an objective assessment of severity at the time of presentation. • Hospital follow up arranged. In addition the Royal Free achieved above average performance for the asthma care bundle used and patients receiving each care bundle element (inhaler technique, medication review, written action plan and triggers considered). Barnet Hospital achieved above average performance for the smoking status recorded. Royal Free is in line with the national average for this criteria. No patient deaths were recorded and length of stay is similar to the national average.

National clinical audit	Actions to improve quality
British Thoracic Society Better lung health for all **BTS: national smoking cessation audit** **Published:** Nov-16 **Reporting period:** 01/04/16 – 31/05/16 **Site:** Royal Free and Barnet	Millions of people attend hospital as inpatients and outpatients each year, many of whom will be current smokers and at significant risk of development, or exacerbation of, tobacco-related disease. Treating tobacco dependence in hospitals therefore represents a significant opportunity to improve the lung and general health of our patients (*source: national audit report*). Our performance in the national audit demonstrates excellence in the care provided to our patients, with the most recently published data showing above average performance for smoking status recorded at the Royal Free Hospital; and for current smokers asked if they would like help to stop smoking at both the Royal Free and Barnet Hospitals. In addition the trust provides all organisational standards of best practice measured by the audit. Improvements made at the Royal Free Hospital to increase accurate recording and increase referrals include implementing annual education for junior doctors about the importance of accurate recording; sending reminders to staff on recording accurately; undertaking audits on ward performance with regards to the percentage of patients with smoking status recorded as 'unable to assess' and providing feedback on this to the junior doctors; and having a pharmacy lead. The implementation of electronic prescribing will further improve documentation. At Barnet Hospital audits on recording smoking status are undertaken. In addition pharmacy lead on improving its recording of patients smoking status, providing very brief advice (VBA), referral to smoking cessation services and education.
British Thoracic Society Better lung health for all **BTS paediatric asthma** **Published:** Nov-16 **Reporting period:** 01/11/15 – 30/11/15 **Site:** Royal Free and Barnet	Acute attacks of asthma are amongst the most common medical reasons for hospital admissions in children in the UK (*source: national audit report*). The performance in the audit demonstrates excellence in the quality of care provided to our patients across sites with the most recently published data showing that for: • Initial treatment of asthma: both sites provided above average care for provision of oxygen, treatment with a beta agonist, and treatment with ipratropium bromide. • Discharge planning: at Royal Free 100% of patients had a written asthma plan in place at discharge.
Cancer: national bowel cancer audit **Published:** Dec-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet **Data quality:** Barnet Hospital achieved the top 'green' rating for case	Bowel cancer is a major cause of illness, disability and death in the United Kingdom (UK) (*source: national audit report*). The performance of the trust in the audit demonstrates areas of excellence in our care, with the most recent published data showing better than average performance at both hospital sites for the proportion of patients seen by a clinical nurse specialist, major surgery carried out as a planned procedure and laparoscopic ('keyhole') surgery attempted. The audit data also demonstrates excellent outcomes for our patients. In particular, at Barnet Hospital the adjusted 90-day mortality, adjusted 30-day

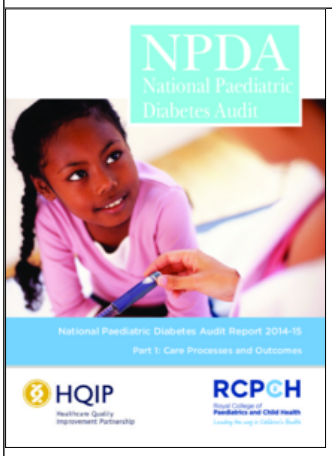
National clinical audit	Actions to improve quality
ascertainment and all four data completeness items reported by the audit. Royal Free Hospital achieved the top 'green' rating for all four criteria relating to data quality except pre-treatment staging which received an 'amber' rating. During the multidisciplinary meeting the pre-treatment staging is sometimes not available and therefore goes unrecorded. The new merged IT system will address this issue. All patients who underwent major surgery at both sites had their ASA recorded to allow risk-adjustment.	unplanned re-admission and two-year mortality rates are better than the national and network averages. The abdominoperineal resection (APER) rate is also better than the national average and the adjusted 18-month stoma rate while just above the national average is within control limits. At the Royal Free Hospital the audit again demonstrates better than average outcomes for 90-day mortality and 30-day unplanned readmissions, with the APER and 18-month stoma rates in line with the national average. The two-year mortality rate for patients seen at the Royal Free was identified as an outlier by the national audit. An internal mortality review was completed for 23 patients who underwent surgery during the audit period 01/04/12 to 31/03/13. From those patients, 13 underwent palliative surgery from the outset (disease was too advanced for surgery treatment) and death was not unexpected; three patients died due to peri-operative complications and death was unexpected although unrelated to the treatment; and a further seven died from causes unrelated to colorectal cancer or colorectal cancer surgery. No quality of care issues were identified through the mortality review.
Cancer: national lung cancer audit **Published:** Jan-17 **Reporting period:** 01/01/2015 – 31/12/15 **Site:** Royal Free and Barnet **Data quality:** Using a multitude of data feeds (Cancer Outcomes and Services Dataset feed, pathology reports, radiology reports, treatment events and death certificates) the national audit has identified an additional 6,000 lung cancer cases in England compared with historical national lung cancer audit records, an increase of 20%. Of the 314 cases assigned to us in the 2015 audit report, 220 were recorded as trust first seen and entered by the local teams. An additional 94 cases have also been allocated via the RCP algorithm and will be reviewed for appropriateness by the local teams once the patient-level data is received.	Lung cancer is the second most common cancer in the UK after breast cancer, and is the commonest cause of cancer-related death. Current survival rates for lung cancer are the second lowest out of 20 common cancers in England and Wales (*source: national audit report*). Trust-level performance in the audit demonstrates good practice and areas of excellence, with the most recently published data showing that performance is equal to or exceeds the recommended level for the: • Stage completeness i.e. the extent of the cancer, such as how large the tumour is and whether it has spread. • Pathological diagnosis. This is the preferred means of diagnosis, as it is more accurate and helps to determine the most appropriate form of treatment. Trust performance for pathological diagnosis has both improved compared to the previous patient cohort (2014 data) and is statistically better than the national average. • The use of chemotherapy for both non-small-cell lung cancer (NSCLC) patients and small-cell lung cancer (SCLSC) patients. Patient outcome is in line with the national average for survival to one year.

National clinical audit	Actions to improve quality
 **Cancer: national oesophago gastric cancer audit (NOGCA)** **Published:** Sep-16 **Reporting period:** 01/04/12 – 31/03/15 **Site:** Royal Free and Barnet	Oesophago-gastric cancer is the fifth most common cancer in the UK, affecting around 16,000 people each year. Overall, survival in England and Wales is poor, with only 15% of oesophageal cancer patients and 19% of gastric cancer patients surviving five years after diagnosis (*source: national audit report*). Patients diagnosed with high-grade Glandular Dysplasia (HGD) at Royal Free and Barnet Hospitals are referred to University College London Hospital (UCLH) for surgery. Excellence in terms of quality of care and data quality are demonstrated by our performance in the most recently published report, with the data showing that the trust achieved the top 'green' rating for adjusted rate of diagnosis after emergency admission, referral source and case ascertainment.
 **Cancer: national prostate cancer audit (NPCA)** **Published:** Feb-17 (revised data) **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet **Data quality:** Areas highlighted for improvement by the national audit report include data completeness across key data items, specialist multidisciplinary team data items and External Beam Radiation Therapy (EBRT) (myelodysplastic syndromes	Prostate cancer is the most frequently diagnosed solid cancer in men and the second most common cause of cancer-related death in the UK (*source: national audit report*). The quality of care received by patients at the trust is demonstrated by an above average performance achieved for all patient reported experience measures (PREMS) for radical prostatectomy patients – with 100% rating their overall care as excellent, and 100% reporting they were involved in decisions about their care and provided information about their condition and treatment. The experience reported by radical radiotherapy - EBRT - patients was mixed. The data is currently under review within the specialty and an action plan is in development to improve further.

National clinical audit	Actions to improve quality
(MDS)-3) data items.	
Diabetes: national diabetes audit (NDA): care processes and treatment targets **Published:** Jan-16 **Reporting period:** 2013/14 and 14/15 **Site:** Royal Free and Barnet **Data quality:** We believe that some of our care processes were not captured reliably in our data submission for 2013/14. We made improvements to our data processes for 2014/15, including the introduction of Diamond; a diabetes IT management system, at the Royal Free Hospital. This improved data is reflected in the most recent NDA report published in January 2017. The IT system will be rolled out across our other sites in 2017; accompanied by a data validation and cleaning exercise across all sites prior to data submission.	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes with type 2 being far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2 (s*ource: NHS Choices – Diabetes*). At Barnet and Chase Farm Hospitals performance was lower than expected for the provision of each of the eight best practice care processes for patients with type 1 and type 2 diabetes; and fewer patients were achieving the three treatment targets compared to the national average. Performance at Royal Free was mixed for the provision of the eight best practice care processes and the achievement of the three treatment targets.
Diabetes: national diabetes audit (NDA): care processes and treatment targets **Published:** Jan-17 **Reporting period:** 2015/16 **Site:** Royal Free, Barnet and Chase Farm	The results of the latest National Diabetes Audit report demonstrate improvements since the 2014/15 audit. The audit measures performance against eight best practice care processes, against which: • Performance has improved at all three sites for patients with type 1 and type 2 diabetes for all individual measures and as a composite measure. • For patients with type 1 diabetes performance is average or higher than average for seven measures at Barnet and Chase Farm Hospitals. Performance for smoking status is lower than expected at both sites but has improved from 8.2% (2014/15) to 60.7% at Barnet and from 18.4% (2014/15) to 63.9% at Chase Farm. Royal Free performance is average or higher than average for each of the eight measures. Performance on a composite measure (i.e. provision of all eight measures) has improved from 30.9% to 56.5%, placing the Royal Free in the best quartile nationally. • For patients with type 2 diabetes performance in 2015/16 is average or higher than average for seven measures across all three sites. Whilst lower than average performance is reported for foot surveillance, performance has improved from 18.3% (2014/15) to 63.8% at Chase Farm and from 44.3% (2014/15) to 68.8% at Royal Free. Whilst lower

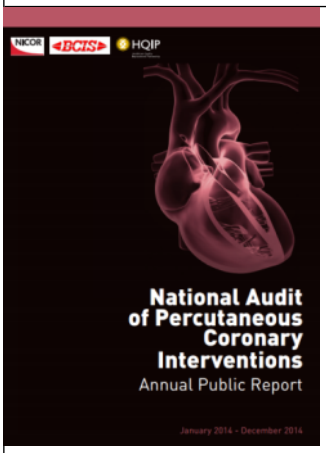
National clinical audit	Actions to improve quality
	than average performance is reported for smoking status at Barnet, performance has again improved from 5.6% (2014/15) to 52.6%. Actions are already planned to improve foot surveillance (see NDFA and NaDIA) and the documentation of smoking status (see BTS Smoking Cessation Audit). The percentage of patients with type 1 diabetes achieving all three treatment targets is above national average performance and has improved compared to previously at all 3 sites. Out of 96 participating sites nationally, Chase Farm is the second best performing trust for this measure, with the Royal Free fourth and Barnet 15th. The data is currently under review within the specialty and actions will be reported in next year's Quality Account.
 **Diabetes: national insulin pump audit** **Published:** Apr-16 **Reporting period:** 2013/14 and 14/15 **Site:** Royal Free and Barnet **Data quality** The trust has had challenges in the collection of data for this audit year due to limitations of the national Diamond diabetes data management system. Considerable work has been carried out internally and with the Diamond system developers to improve the quality and accuracy of data to reflect the quality of care provided.	Insulin pump therapy has a pivotal role to play in the management of type 1 diabetes; use in type 1 diabetes is associated with improved quality of life and glycaemic control in addition to reductions in hypoglycaemia, diabetic ketoacidosis (DKA) admissions and, according to more recent evidence, cardiovascular mortality (*source: national audit report*). The trust has now employed a specialist nurse lead for insulin pump therapy, which will further improve patient care quality, and data collection. Since joining in November 2016, the specialist nurse has reviewed the audit data and found that 60 patients with type 1 diabetes on insulin pump therapy had been incorrectly reported as type 2. Therefore 258 out of the 1,183 (22%) patients with type 1 diabetes were on insulin pumps in line with NICE best practice guidance, rather than 198 (7%) reported by the audit. The local review shows that more patients are receiving best practice care at the trust compared to 13.5% nationally.

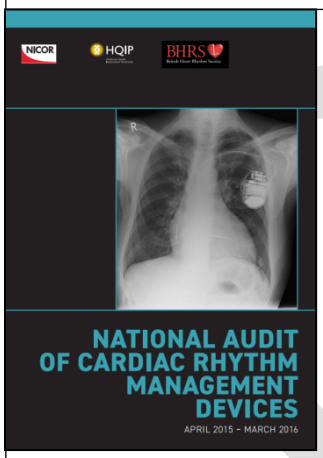
National clinical audit	Actions to improve quality
 **Diabetes: national diabetes foot care audit** **Published:** Mar-16 **Reporting period:** 14/07/14 – 10/04/15 **Site:** Royal Free **Data quality:** The service has reported the challenges experienced with the audit back to the audit provider. For example, patients must sign an initial consent form to be included in the audit. The leaflet that explains the audit is currently only available in English. The audit provider is investigating the feasibility of making the leaflets available in different languages. This would assist our participation in the audit as many of our patients do not have English as their first language.	The impact of diabetic foot disease on people with diabetes is profound. It can be associated with disability, amputation and premature mortality. Its cost to the health service is considerable (*source: national audit report*). Royal Free Hospital's performance in the national audit was mixed. Our diabetes team has submitted a bid to NHS England for a Multidisciplinary Diabetes Foot Team. This will enable the trust to implement a Hot Clinic and improve podiatry care to our in-patients.
Diabetes: national diabetes inpatient audit (NaDIA) **Published:** Jun-16 **Reporting period:** 21/09/15 – 25/09/15 **Site:** Royal Free and Barnet	The National Diabetes Inpatient Audit is a snapshot audit of diabetes inpatient care. Performance across sites is in line with or above national average: • At Royal Free Hospital for foot assessment (within 24 hours and during stay) and patients admitted with active foot disease seen by multidisciplinary foot care team (MDFT) within 24 hours. • At Barnet Hospital for appropriate blood glucose testing, good glucose days and patients admitted with active foot disease seen by MDFT within 24 hours. In addition performance against the patient safety indicators (medication, prescription, management and insulin errors) is better than the national average. Areas marked for improvement include reducing patient safety errors

National clinical audit	Actions to improve quality
	(medication, prescription, management and insulin) at the Royal Free, improving foot assessments at Barnet Hospital and reducing hypoglycaemic episodes across all sites. Action taken to reduce hypoglycaemic episodes includes the introduction of hypo boxes. In addition the diabetes team is working with the patient safety team to identify the underlying causes so that targeted action can be taken. The diabetes team is working with the podiatry service, and providing education to ward nurses to enable them to increase their provision of foot assessments. An NHS bid has also been submitted that, if successful, will include additional recruitment. The role will include assessing diabetic feet in the emergency department before the patient's admission to a ward.
 **Diabetes: national diabetes paediatric audit (NPDA)** **Published:** Jul-16 **Reporting period:** 2014/15 **Site:** Royal Free, Barnet and Chase Farm	Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly. High blood glucose levels over time may cause complications associated with diabetes including damage to small and large blood vessels and nerves. Over time this can result in blindness, kidney failure, heart disease, stroke and amputations. However, with good diabetes care and blood glucose control, the risks of complications are markedly reduced, enabling children and young people with diabetes to live a healthy, happy and longer life (*source: national audit report*). The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care provided to our patients with the most recently published data showing that the hospital is: • A positive outlier for all seven care processes performed for young people aged 12 years and older. • Above the national average for screening for thyroid disease and coeliac disease (Type 1 diabetes). Since the completion of the audit a new consultant has been appointed; additional paediatric diabetes specialist nurse and dietetic resources are now available; and an insulin pump service is offered at all three sites. This has always been in place at the Royal Free, and is being put in place at Barnet and Chase Farm hospitals, led by the newly-appointed consultant. In addition further discussions are underway to streamline the outpatient process across all three sites, and the use of volunteers and iPads to elicit feedback before a patient leaves the diabetes clinic will commence shortly.
Diabetes: national pregnancy in diabetes audit (NPID) **Published:** Oct-16 **Reporting period:** Pregnancies between 01/01/13 and 31/12/15 **Site:** Royal Free and Barnet	Most women with diabetes have healthy pregnancies and healthy babies. However, there are risks, and these sometimes cause serious health problems, either for the mother or the newborn child. So it is important expectant mothers with diabetes get the right care, support and information to help them and their baby stay well. For a healthy, safe pregnancy with diabetes, planning and care starts before conception (s*ource: NPID patient summary report*). The performance of the Royal Free Hospital in the audit demonstrates

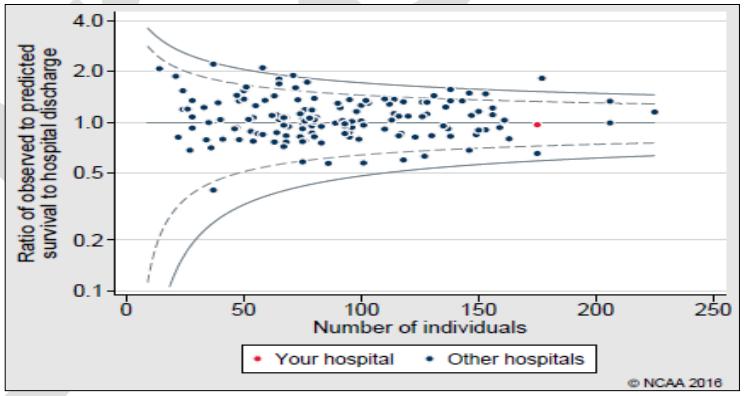
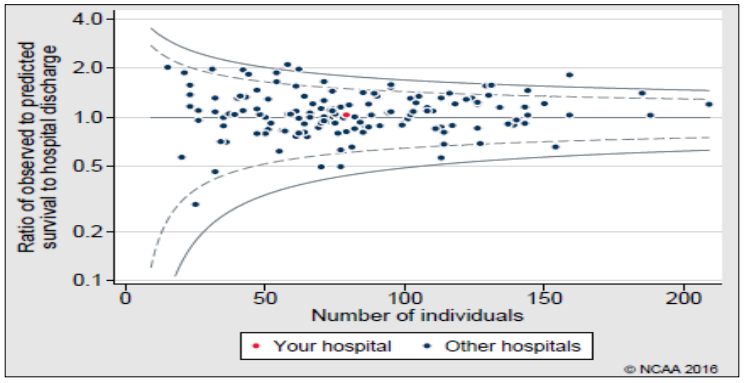
National clinical audit	Actions to improve quality
Data quality: The process of consenting for the audit has been changed for 2016 data. This should ensure that all data collected is submitted.	excellence in the quality of care provided to our patients with the most recently published data showing that the hospital is in the best quartile for blood glucose control (<48 mmol/mol) for pregnancies in the first trimester and at 24 weeks+. To improve practice further, the following actions will be undertaken: Barnet Hospital: • The process for the referral of patients with type 1 and type 2 diabetes to the joint endocrine clinics has been amended so that the GP referral letter is sent to the diabetes team, and will no longer be dependent on the antenatal booking midwife seeing the patient first. • Education will be provided to patients and GPs about the importance of early referral to the diabetes antenatal team. • A pathway is being drawn up to aid GPs in the early management and the referral of type 1 and type 2 diabetic patients. Royal Free Hospital: • Educating GPs about the importance of early referral. • Making GPs aware about the service of pre-conception counselling. • Developing a leaflet to give to type 1 and type 2 diabetes patients at postnatal discharge with advice for future pregnancies. • Making the patient and GPs aware of structured diabetes educational programmes.
End of life care audit (EOLCA): dying in hospital **Published:** Mar-16 **Reporting period:** 01/05/15 – 31/05/15 **Site:** Royal Free and Barnet	Nearly half of all deaths in England occur in hospitals – 22,3007 out of a total of 46,9975 in 2014 (*source: national audit report*). In 2016 the Care Quality Commission rated the provision of end of life care (EoLC) at the Trust as 'good' reporting that the EoLC team are a dedicated team providing holistic care for patients with palliative and EoLC care needs in line with national guidance. The quality of care provided to patients at the end of their life is also demonstrated by the trust-level performance in the national audit, which shows above average performance for three out of five clinical indicators of best practice: recognition that the patient would die; that the needs of the person important to the patient were asked about; and that a holistic assessment of the patients' needs was made in last 24 hours. Three out of eight organisational indicators were also met: bereaved relatives views sought; and formal training provided to both medical and nursing staff. In addition the audit data demonstrated improvements since the previous audit round in relation to communication with the family. The recommendations made by both the national audit and the NICE Quality Standard on EoLC for adults provide the evidence based upon which the Trusts' EoLC strategy has been developed. The strategy will drive the implementation of best practice care across the trust. In addition work is on-going with the Patient at Risk and Resuscitation Team (PARRT), as part of

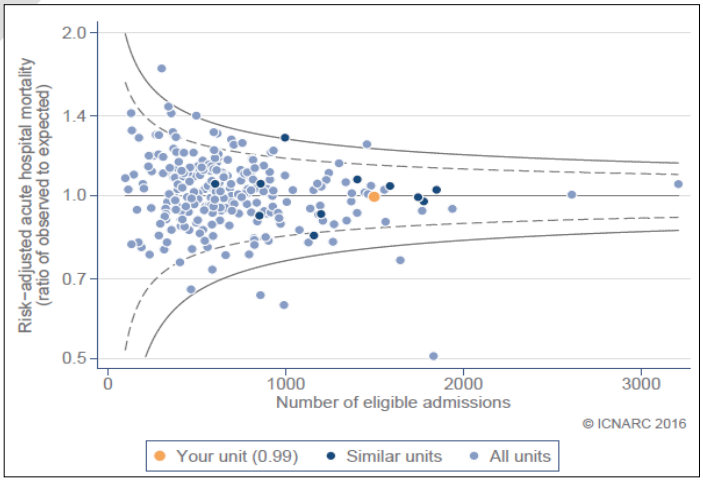
National clinical audit	Actions to improve quality
	the patient safety EoLC work stream on the deteriorating patient, to further improve the early identification of the dying patient. A seven-day palliative care service, which is already available at the Royal Free Hospital, will be available at Barnet Hospital from April 2017 following the recruitment of an additional clinical nurse specialist. Training is being developed on leading difficult conversations and accreditation for the course will be sought. Student nurse training provided in 2016 will be repeated in 2017. The curriculum is being rewritten to ensure students have the opportunity to care for dying patients, the development of a masters-level EoLC module is being looked into and clinical psychologist support for Barnet Hospital has been recruited.
 **Falls and fragility fracture programme (FFFAP): national hip fracture database (NHFD)** **Published:** Sep-16 **Reporting period:** 01/01/15 – 31/12/15 **Site:** Royal Free and Barnet **Data quality:** The absence of a final discharge destination is a constant challenge as our patients can be discharged to a number of locations, that may be different to their admitting location i.e. other hospital, care home, nursing home etc. Resources at present are limiting our ability to obtain this information for all patients.	For older people, hip fracture is the commonest serious injury; the commonest reason for emergency surgery; and the commonest cause of accidental death. Patients may remain in hospital for a number of weeks, leading to one and a half million bed days being used each year, which equates with the continuous occupation of over 4,000 NHS beds. Only a minority of patients will completely regain their previous abilities, most will encounter difficulty walking which increases dependency and means that a quarter will need long-term care. As a result, hip fracture is associated with a total cost to health and social services of over £1 billion per year (*source: national audit report*). Our performance in the national audit demonstrates excellence in the care provided to our patients with best quartile performance achieved by: • Barnet Hospital for mental test score recorded on admission, perioperative medical assessment provided, best practice tariff achievement, surgery on day of, or day after, admission and proportion of general anaesthetic with nerve blocks. • Royal Free Hospital for overall hospital length of stay and proportion of arthroplasties using techniques recommended by NICE (i.e. a cemented technique, sliding hip screw (SHS), intramedullary nail (IM)) and overall hospital length of stay. In addition, the risk-adjusted 30-day mortality rate at both Barnet and Royal Free Hospitals is better than the London average and similar to the national average. Whilst Barnet Hospital achieved the second lowest rate in London for hip fractures sustained as an in-patient, the rate at the Royal Free Hospital is similar to the London average and above the national average. A series of actions have been implemented as a result of the audit to improve patient care and outcomes further. At the Royal Free Hospital these include: • Ongoing work to improve education provided to junior medical staff involved in seeing patients on admission, which should improve the assessment of cognitive function on admission. • All hip fractures admitted during the week will be discussed at a multidisciplinary team and suitable patients will be offered total hip

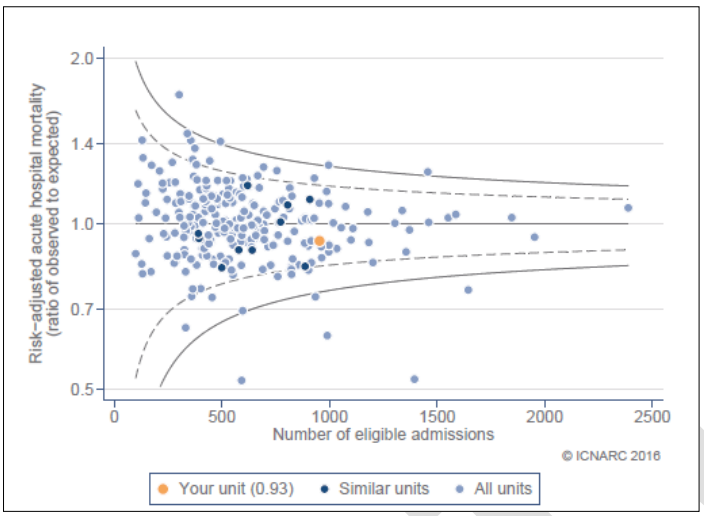
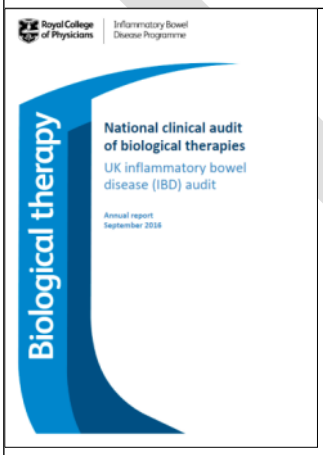
National clinical audit	Actions to improve quality
	replacement surgery. Day of admission will not impact the choice of therapy offered. • The lack of documentation on pressure ulcers has been highlighted to nursing staff and we believe this will address our documentation issues and we plan to audit this and other items on a periodic timescale. Barnet Hospital is the third busiest hip fracture unit in London. We have established a dedicated hip fracture physiotherapy team. To co-ordinate care and reduce the length of stay we are assessing patients earlier and discussing discharge planning every morning at the multi-disciplinary team meeting. We are also working on a number of quality improvement projects that will address haemoglobin check on day of surgery, mobilisation out of bed on day one and post-operative analgesia.
 **Heart: national audit of percutaneous coronary intervention (PCI)** (national audit and consultant-level data) **Published:** Mar-16 **Reporting period:** 01/01/14 – 31/12/14 **Site:** Royal Free	Coronary heart disease (CHD) is the largest cause of death and disability in the United Kingdom. It causes around 73,000 deaths in the UK each year and around one in five men and one in seven women will die from the disease. The PCI procedure works by mechanically improving blood flow to the heart. During the procedure, a small balloon is inserted which, when inflated widens the artery. In most cases a 'stent' - metal mesh scaffold - is implanted to keep the artery wall open (*source: national audit report*). The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care and outcomes for our patients. The most recently published data shows that the hospital is: • Within expected range for the risk-adjusted measures survival at 30-days post PCI procedure and major adverse cardiac and cerebrovascular event (e.g. death, stroke, myocardial infarction caused by PCI and the need for emergency cardiac surgery because of a complication of PCI). • A positive outlier for the time between the first call for professional help and the time that the PCI procedure is performed (call to balloon time less than 150 minutes). • Above the national average for all other call to balloon times, as well as door to balloon times for both direct admissions and inter-hospital transfers. • Performing more PCIs within 72 hours of arrival for non-ST-elevation myocardial infarction (nSTEMI) or unstable angina, i.e. patients with heart attacks where the electrocardiogram (ECG) does not show a typical pattern of ST elevation, than the national average. To improve patient outcomes further on-going training is in place to help increase the number of procedures where arterial access was via the radial artery; and a new London Procurement Partnership (LPP) arrangement is in place that will increase access to, and the use of drug eluting stents, at the Royal Free Hospital. In addition an enhanced pathway and tools are in development to improve the inpatient management of nSTEMIs.
	The national audit is a development of the national device registry which

National clinical audit	Actions to improve quality
Heart: national audit of cardiac rhythm management (CRM) devices **Published:** Aug-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet	was the first in the world and now documents approximately a million device procedures. It collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK to improve the quality of care provided (*source: national audit report*). The data published by the national audit shows that activity at the Royal Free and Barnet Hospitals exceeds the minimum number of recommended new pacemaker implants per year, and the number recommended for a training centre. In addition the Royal Free Hospital exceeds the minimum number of recommended new implantable cardioverter defibrillator (ICD) or cardiac resynchronization therapy (CRT) implants per year. Atrial based pacing in sinus node disease is recommended by the National Institute of Health and Care Excellence (NICE). The proportion of patients receiving atrial based pacing implants for sick sinus syndrome has increased at both sites compared to previous (2013/14) and is within expected range nationally. Since 2014 two dedicated CRM consultants have been in post and an increase in the use of dual chamber pacemakers is expected to be reflected in the 2016/17 dataset. In addition work is ongoing to increase capacity in the catheter laboratory to enable more procedures to be undertaken at the Trust.
 **Heart: national audit of cardiac rhythm management (CRM) devices** **Published:** Feb-17 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet **Data quality** The reported number of	The 2015/16 data published by the national audit shows that activity at the Royal Free and Barnet Hospitals continues to exceed the minimum number of recommended new pacemaker implants per year, and the number recommended for a training centre. The proportion of patients receiving atrial based pacing implants for sick sinus syndrome as recommended by NICE has improved from 73% (2014/15) to 100% (2015/16) at the Royal Free. Barnet remains at 86% and is within typical range achieved by NHS trusts nationally. A recent local audit conducted at Barnet Hospital covering the period October 2015 to October 2016 shows that the complication rate remains low at 3.7 % and in line with previous years despite the increase in number of procedures.

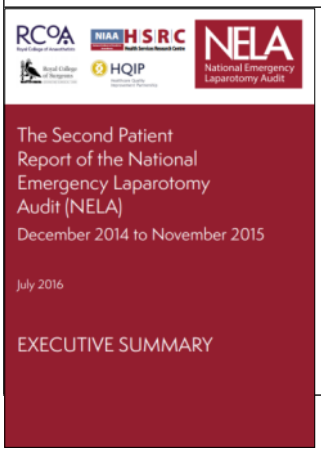
National clinical audit	Actions to improve quality
implantable cardioverter defibrillator (ICD) implants undertaken has been affected by data completeness issues and does not reflect clinical practice. This issue has been greater at Barnet than at Royal Free. The move of complex device implantation in November 2015 from Royal Free to Barnet has further exacerbated the issue. Cardiology is investigating how to resolve this.	
 **Heart: myocardial ischaemia national audit project (MINAP)** **Published:** Jan-17 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet	A heart attack occurs when the flow of blood to the heart is blocked, most often by a build-up of fat, cholesterol and other substances, which form a plaque in the arteries that feed the heart (coronary arteries). The interrupted blood flow can damage or destroy part of the heart muscle. This is known as a heart attack or myocardial infarction (MI). Typical symptoms include chest pain or discomfort, sweating, breathlessness, and sudden changes in blood pressure, heart rate, and heart rhythm, which may lead to collapse or sudden death (*source: national audit report*). The performance of the trust in the audit demonstrates areas of excellence in the quality of care provided to our patients with the most recently published data showing that the performance at both Barnet and Royal Free Hospitals is above the national average for the proportion of patients seen by a cardiologist, patients admitted to a cardiac ward and patients who received all secondary prevention medication for which they were eligible. In addition performance at Barnet Hospital has improved compared to previous (2013/14) for all three criteria, whilst Royal Free Hospital has either improved (percentage of patients admitted to cardiac ward) or remained consistently high (i.e. equal to or exceeding 99%). The average length of stay at both sites is in line with the national average for both non-ST-elevation myocardial infarction (nSTEMI) and ST-elevation myocardial infarction (STEMI) patients; and whilst the Royal Free performance for all five 'door to balloon time' and 'call to balloon time' criteria are above the national average, performance is lower for 4/5 criteria compared to previous (2013/14). This slight drop in performance reflects the increase in activity we are seeing and is something we will be watching carefully.
Heart: national heart failure audit **Published:** Jul-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet	Heart failure means that the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff (*source: NHS Choices*). Approximately 900,000 people in the United Kingdom have heart failure. It causes or complicates about 5% of all emergency hospital admissions in adults and consumes up to 2% of total NHS expenditure (*source: national audit report*).

National clinical audit	Actions to improve quality
	The performance of the heart failure team at both the Royal Free and Barnet Hospitals in the audit demonstrates excellence in care, with the most recently published data showing that for: • In-hospital care, both sites provided above average use of appropriate specialist diagnostics, care on cardiology ward and input from specialist. • On discharge, both sites provided above average care for heart failure medication in line with best practice, and specialist cardiology follow up. The data also demonstrates improvement, with the audit data showing that at the Royal Free Hospital performance has improved by at least 20% for three out of the four in-hospital care criteria - cardiology inpatient, input from consultant cardiologist and input from specialist. Performance at Barnet Hospital has remained consistently high for all four criteria. To improve further, an improved pathway of care, and discharge process are being implemented, and additional clinical nurse specialist support is being sought.
Intensive care national audit and research centre (ICNARC) - national cardiac arrest audit (NCAA) **Published:** Jun-16 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet	The national cardiac arrest audit collects data on in-hospital cardiac arrests in the UK and Ireland (*source: ICNARC website*). The total rate of in-hospital cardiac arrests and survival at Royal Free and Barnet are displayed below. The risk-adjusted survival data produced by the audit shows that survival at both the Royal Free and Barnet Hospitals is in line with expected (1.0).  Royal Free  Barnet

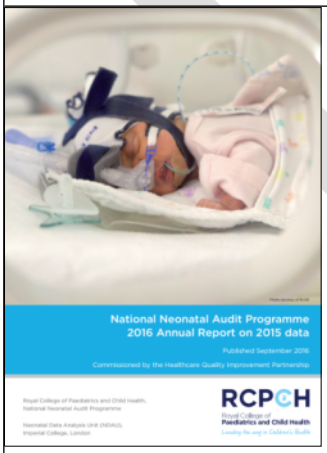
National clinical audit	Actions to improve quality
	This data has been used to drive local quality improvement activity to reduce the number of in-hospital cardiac arrests as part of the patient safety programme. A pilot is currently underway within cardiology at the Royal Free Hospital aimed at improving processes to identify and manage deteriorating patients. Current tests of change include the re-design and evaluation of team handover and recordkeeping and the trial of a weekly multi-disciplinary team meeting to assist complex decision-making.
ICNARC: case mix programme (CMP) **Published:** Jul-16 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet	The case mix programme is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland (*source: ICNARC website*). Trust-wide performance in the audit demonstrates excellence in quality, with the most recently published data showing that: • Barnet Hospital achieved a green rating (good to excellent) for 7/7 quality criteria reported by the audit. In addition performance improved for 5/7 criteria compared to previous results (2014/15). This includes the reduction of high risk sepsis admissions, out-of-hours discharges to the ward and risk-adjusted mortality. Performance for unplanned readmissions within 48 hours has improved compared to the previous year and the hospital is now a positive outlier for this criteria. • Royal Free Hospital achieved a green rating for 5/7 quality criteria. Delayed discharges from the Intensive Care Unit (ICU) at Barnet Hospital has been identified as an area for improvement and is now the subject of a local Commissioning for Quality and Innovation (CQUIN) target. The rate of unit-acquired infections in blood at Royal Free has been investigated as it appeared to be above the national average. It was thought that the length of stay of immunocompromised patients was associated with acquisition of infection. However, local review of patients admitted to ICU shows that the majority of patients suffered sepsis on the ward prior to admission to ICU. Improvement work is ongoing via the patient safety programme to improve the identification and treatment of patients with sepsis on the wards. Risk-adjusted mortality data shows that the mortality rate for the Royal Free and Barnet Hospitals is in line with expected (1.0).  Royal Free Hospital

National clinical audit	Actions to improve quality
	 Barnet Hospital
UK inflammatory bowel disease (IBD) audit **National clinical audit of biological therapies** (adult service) **Published:** Sep-16 **Reporting period:** 01/03/15 – 29/02/16 **Site:** Royal Free and Barnet	Over the last 10 years, biological therapies have transformed treatment for people with inflammatory bowel disease (IBD). Most of these drugs work by targeting a protein in the body called tumour necrosis factor alpha (TNFα). Overproduction of this protein is thought to be partly responsible for the chronic inflammation in people with IBD (*source: national audit report*). Insufficient cases were submitted in 2015/16 for detailed analysis by the national audit provider. Following the 2014/15 data collection period a number of actions were implemented to improve data input. Weekly multidisciplinary team meetings are held to capture the biologics data and, wherever possible, submit this information to the audit. We are in the process of appointing IBD nursing staff who, in addition to their clinical roles, will provide data management support in order to collect and input the relevant data.
 **UK IBD audit: national clinical audit of biological therapies** (paediatric service)	Ulcerative colitis (UC) is the most common type of inflammatory bowel disease (IBD); it is a lifelong, chronic, relapsing–remitting condition. Reported prevalence is as high as 505 per 100,000. This corresponds to 320,000 people in the UK with a diagnosis of UC. The cause of UC is unknown and, although it can develop at any age, the peak incidence is between the ages of 15 and 25 years, resulting in profound effects on education, work, social and family life. The three-month, per-patient cost for UC was calculated at £1211 in 2010, with the majority of this cost attributed to inpatient stays (*source: IBD national audit report*). The paediatric service did not participate in the national audit in 2015/16. Upon publication of the national report, the service compared its practice to the recommendations made, and in line with best practice the trust screens all patients prior to treatment with biological therapies (hepatitis B and tuberculosis); has clear arrangements in place for follow-up within three months; records the patients' disease activity score using a defined disease

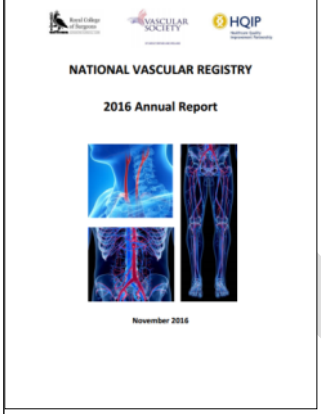
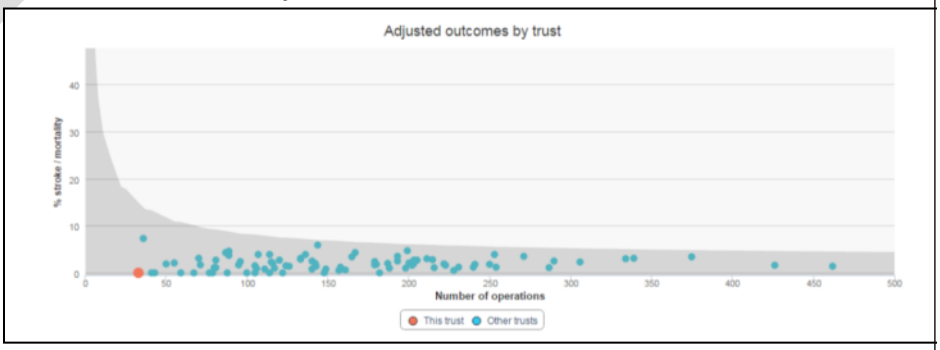
National clinical audit	Actions to improve quality
Published: Sep-16 **Reporting period:** 12/09/11 – 29/02/16 **Site:** Royal Free	activity index; has a reduction regime in place for all patients on steroids at first infusion; and records data on all patients on biologics, submitting it to the IBD Registry for national analysis.
National comparative audit of blood transfusion programme: audit of the use of blood in lower gastrointestinal bleeding **Published:** May-16 **Reporting period:** 01/09/15 – 01/12/15 **Site:** Royal Free and Barnet **Data quality:** The quality of the clinical data produced in the national audit report was affected by the low number of cases submitted nationally. In line with the majority of participating hospitals, a site-level report was not produced for the Royal Free due to the low number of cases. Actions are being put in place to address this issue.	Lower gastrointestinal bleeding accounts for up to 20% of hospital admissions for gastrointestinal bleeding a year in the UK (*source: national audit report*). Barnet Hospital demonstrated above average performance against the following audit standards: • All patients with lower gastrointestinal bleeding had a digital rectal examination (100%). • Platelet transfusion was offered to all eligible patients (100%). • Best practice procedures were performed for patients with rectal bleeding. • The cause and site of clinically significant lower gastrointestinal bleeding was determined following the early use (within 24 hours) of best practice procedures. Organisational audit demonstrates the provision of best practice services across both hospital sites.
National comparative audit of blood transfusion programme: audit of patient blood management in scheduled surgery **Published:** Summer-16 **Reporting period:** 01/02/15 – 30/04/15 **Site:** Royal Free, Barnet and Chase Farm **Data quality:** The quality of the clinical data produced by the audit was affected by the low number of cases submitted nationally.	Patient Blood Management (PBM) is a multidisciplinary, evidence-based approach to optimising the care of patients who might need a blood transfusion. National, regional and local audits in England consistently show inappropriate use of all blood components; 15-20% of red cells and 20-30% of platelets/plasma. Evidence shows that the implementation of PBM improves patient outcomes by focusing on measures for the avoidance of transfusion and reducing the inappropriate use of blood, and therefore can help reduce healthcare costs (*source: national audit report*). The hospital-level data produced by the audit has been reviewed locally and indicates that practice is in line with, or better than average, across sites against a number of criteria including: • Pre-operative anaemia optimisation (Barnet and Royal Free Hospitals). • Pre-operative anticoagulant and antiplatelet management (Royal Free Hospital). • Patient blood management in theatre and recovery (Chase Farm and Royal Free Hospitals). • Post-operative transfusion indicated (Barnet Hospital). • Patient blood management in the post-operative period (Chase Farm and Royal Free Hospitals).

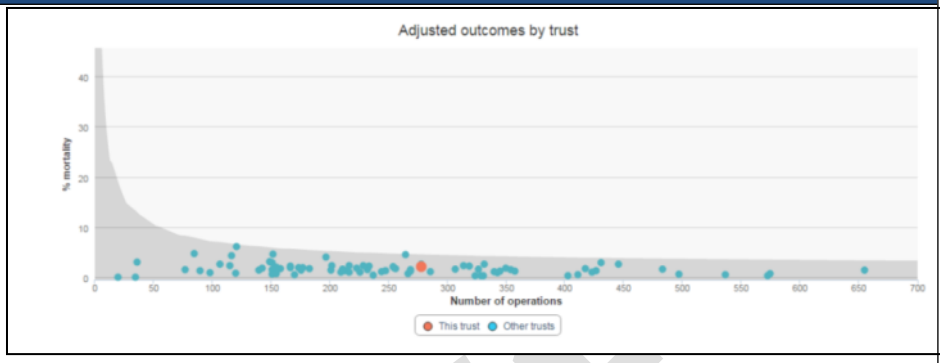
National clinical audit	Actions to improve quality
National comparative audit of blood transfusion programme: audit of red cell and platelet transfusion in adult haematology patients **Published:** Autumn-16 **Reporting period:** Jan-16 **Site:** Barnet	The audit aimed to examine the use of red cells and platelets in a sample of patients who had a known haematological condition and identify variation in practice and compare practice against guidelines (*source: hospital-level audit report*). A national audit report was not produced due to the small number of cases submitted nationally, which affected data quality and the audit supplier's ability to draw meaningful conclusions from the clinical data. Site-level data was however made available to participating trusts, which has been reviewed locally. Taking the small patient numbers into account, early indications show that good practice is being achieved against a number of criteria including: • Local written guidelines are available for the management of blood component transfusions in haematology patients. • Haemoglobin is measured within 24 hours prior to the transfusion of red cells if the patient is an inpatient or within 72 hours if the patient is a day patient • When platelets are prescribed for prophylactic use, this should not be more than one adult therapeutic dose.
National elective surgery PROMs: four operations **Published:** Aug-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Trust-level data	Patient Reported Outcomes Measures (PROMs) is a national programme organised by NHS England looking at a number of elective procedures. The latest available data shows the trust is within control limits for adjusted health gain for hip and knee replacement primary procedures. This data has been reviewed and when we compare our clinical data with the data produced by the National Joint Registry (NJR) and National Hip Fracture Database (NHFD) our performance is above average and shows good care. Therefore it appears that the data is related to patients mismatched expectations regarding their condition post-operative. To address this we have a Joint School, where patients are informed of what to expect post-surgery and can manage their expectations of pain and mobility. For more up to date PROMS information for hip and knee procedures see the summary below on NJR consultant-level data. For hernias and varicose veins the numbers submitted were too few to be benchmarked. However work is ongoing with the pre-assessment teams, who give out the PROMs questionnaires, to improve patient participation.
	More than 30,000 patients undergo an emergency laparotomy each year in NHS hospitals within England and Wales. The majority of patients undergoing emergency bowel surgery have potentially life-threatening conditions requiring prompt investigation and management. These procedures are associated with high rates of postoperative complications and death. Recent studies have reported that overall 15% of patients die within one month of having an emergency laparotomy (*source: national audit report*). The clinical pathway for patients undergoing emergency bowel surgery is complex, and requires input from clinicians from several specialties including emergency departments, acute admissions units,

National clinical audit	Actions to improve quality
National emergency laparotomy audit (NELA) **Published:** Jul-16 **Reporting period:** 01/12/14 – 30/11/15 **Site:** Royal Free and Barnet **Data quality:** At Barnet Hospital very few patients were entered into the audit. Since the completion of the audit we have implemented a number of actions to address this issue and our participation for the year has increased from 10 patients to over 100. To improve further a new pathway has been created to ensure that best practice criteria are followed and also documented in a timely manner. The audit database has been set up on all operating theatres' computers to facilitate the management of patient's data.	radiology, surgery, anaesthesia, operating theatres, critical care and elderly care. Unlike elective (planned) care, there is often limited time to investigate and prepare these patients before surgery. This creates challenges in the delivery of care on a day-to-day basis and in bringing about long-term service improvement. The trust's performance in the audit demonstrated areas of excellence. To improve further at Barnet Hospital the recording of the risk score (P-Possum score) prior to operation has been mandated, and this is already showing significant improvement. In addition a consultant anaesthetist and surgeon will always be present in theatre for high-risk patients. At the Royal Free Hospital we have employed a consultant in specialised surgical medicine who has extensive geriatric experience and assesses all our elderly patients. We have implemented a new operating theatre booking form where risk scoring is mandatory so risk of death is documented prior to theatre booking. We have also taken action to improve the pre-operative review by a consultant surgeon and anaesthetist when the risk of death is higher than 5%.
National joint registry (NJR) annual report **Published:** Sep-16 **Reporting period:** Various **Site:** Royal Free, Barnet and Chase Farm **Data quality:** The trust's performance in the national audit clearly demonstrates excellent data quality with all three hospitals achieving the top 'green' rating for linkability (records submitted to the registry with valid NHS number). The Royal Free Hospital also achieved the top 'green' rating for consent rate. Consent rate has been identified as an area for improvement at	Hip, knee, ankle, elbow and shoulder joint replacements are common and highly successful operations that bring many patients relief from pain and improved mobility. Thousands of these joint replacement operations take place in the UK every year (*source: national audit website*). The trust's performance in the national audit clearly demonstrates excellent outcomes and with all three hospitals achieving the top 'green' rating for 90-day mortality and revision rates for hips and knees. To ensure our elderly patients have the best specialist input, our elderly care physicians are closely involved in the care of elective patients with more complicated health needs. The orthopaedic team at the Royal Free review their rate of cemented versus non cemented total hip replacement. We also continuously submit surgical site infection data to the Get it Right First Time (GIRFT) national surveillance team.

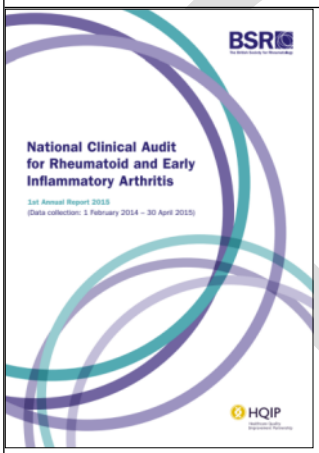
National clinical audit	Actions to improve quality
Barnet and Chase Farm Hospitals. Whilst consent to participate in the NJR is being taken appropriately for patients attending pre-assessment at Barnet Hospital, a copy of the consent form is not always received at Chase Farm Hospital for data entry into the NJR. Action is in place to improve this process and is being monitored.	
National joint registry (NJR) consultant-level outcomes **Published:** Jan-17 **Reporting period:** Various **Site:** Royal Free, Barnet and Chase Farm **Data quality:** In terms of data quality a better than expected rating was achieved for the Royal Free for consent rate and valid NHS number. This data also highlights consent as an ongoing area for improvement at Barnet. See section above for progress with actions to improve. The impact of these actions on data quality is expected to be shown in the 2017/18 data.	The latest consultant-level data from the national registry clearly demonstrates excellent outcomes with the Patient Reported Outcomes Measures (PROMs), 90-day mortality rate and revision rates within expected range for hip and knee surgery at Royal Free, Barnet and Chase Farm Hospitals.
 **National neonatal audit programme (NNAP)**	The national neonatal audit programme (NNAP) annual report summarises data which is collected from the NDAU (National Data Analysis Unit) database which takes data from the Badgernet system, used by all UK neonatal units, with data being added every day for each resident baby. The 2016 report reflects the 2015 data that was logged into the Badgernet system by either clinical, nursing or administrative staff on the trust's two neonatal sites – level 1 Special Care Baby Unit (SCBU) at Royal Free Hospital and the level 2 Neonatal Unit (NNU) at Barnet Hospital. The performance of the neonatal teams at Royal Free and Barnet Hospitals in NNAP demonstrates excellence in the quality of care provided to babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment. Teams on both sites have improved the proportion of babies who are receiving some mother's milk at discharge.

National clinical audit	Actions to improve quality
Published: Sep-16 **Reporting period:** 01/01/15 – 31/12/15 **Site:** Royal Free and Barnet	At the Royal Free Hospital site, the team have improved eye (retinopathy of prematurity) screening for eligible babies to ensure more babies are screened at the correct time for optimal prevention of visual problems following neonatal care. The Barnet NNU has eradicated variation from best practice altogether on this important care process, with 100% of babies being screened. The audit data also shows that fewer babies developed lung disease as a consequence of neonatal care (bronchopulmonary dysplasia) compared to other UK neonatal units. The neonatal team at the Royal Free site has also made some progress in the documentation of when parents are consulted within the first 24 hours. Both neonatal sites allow parents on the ward rounds, and all babies are seen by a consultant or senior registrar on the daily ward rounds. Therefore there is a robust process in place for ensuring parents are consulted promptly. However, historically, our documentation of this element of care has been poor. In the most recent report, there is an improvement in the documentation of the proportion of parents who had a consultation with a consultant neonatologist within 24 hours of their baby's admission and further quality improvement is already in place to ensure the accuracy of the data submitted going forward.
National audit of pulmonary hypertension **Published:** Feb-16 **Reporting period:** 2014/15 **Site:** Royal Free	Pulmonary hypertension is raised blood pressure within the pulmonary arteries, which are the blood vessels that supply the lungs. In the UK, around 6,000-7,000 people have pulmonary hypertension. It is also thought that more remain undiagnosed. Pulmonary hypertension can affect people of any age, although some types are more common in young women (*source: NHS Choices*). The performance of the Royal Free Hospital in the audit demonstrates excellence in care, with the most recently published data showing that in line with best practice more patients treated at the Royal Free Hospital are started on a phosphodiesterase 5 inhibitor before other pulmonary hypertension drugs compared to the national average since 2010/11, and all other centres nationally since 2012/13. Mortality outcomes for all trusts are within the predicted range. The audit has highlighted some areas that require further attention. The time from referral to diagnosis may reflect the special nature of the population referred to at the Royal Free, namely those with connective tissue disease. This is the only population where screening for the future development of pulmonary hypertension is possible. To improve patient care and outcomes a detailed audit of our referral pathways is being conducted with external funding and aided by external audit providers to identify whether delays in the referral process are occurring.

National clinical audit	Actions to improve quality
National vascular registry (NVR) consultant-level outcomes **Published:** Sep-16 **Reporting period:** • **AAA:** 01/01/11 to 31/12/15 • **Carotid:** 01/01/15 to 31/12/15 **Site:** Royal Free	An **abdominal aortic aneurysm (AAA)** is a swelling (aneurysm) of the aorta - the main blood vessel that leads away from the heart - down through the abdomen to the rest of the body. AAAs are most common in men aged over 65. A rupture accounts for more than 1 in 50 of all deaths in this group and a total of 6,000 deaths in England and Wales each year (*source: NHS Choices*). The latest consultant-level data published by the national registry shows that for elective infra-renal AAA repair the risk-adjusted mortality rate is within expected range for the trust, and for each individual surgeon that performs the procedure at the trust. The surgical team strives for the achievement of excellent outcomes, and to help achieve this, has changed the composition of each firm to ensure clinicians have maximal opportunities for shared experience and learning when managing infra-renal aortic disease. **Carotid endarterectomy** is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck. People who have previously had a stroke or a transient ischaemic attack (TIA) are at risk of having another stroke or TIA. Surgery can reduce the risk of a further stroke in people with severely narrowed carotid arteries by a third (*source: NHS Choices*). The latest consultant-level data from the national registry clearly demonstrates excellent outcomes, with a risk-adjusted 0% rate of stroke/ death for patients operated on at the Royal Free Hospital during the audit period at both trust-level, and for each individual surgeon performing the procedure.
 **National vascular registry (NVR) annual report** **Published:** Nov-16 **Reporting period:** 01/01/15 – 31/12/15 **Site:** Royal Free and Barnet	The latest annual report produced by the national registry shows excellent outcomes for the trust with a risk-adjusted stroke and/or death rate of 0% for carotid endarterectomy (see below). In addition the risk-adjusted in hospital mortality is within expected range for elective infra-renal abdominal aortic aneurysm (AAA) repair (see below), repair of ruptured AAA and lower limb revascularisation. **Carotid Endarterectomy**  **Elective Infra-Renal AAA Repair**

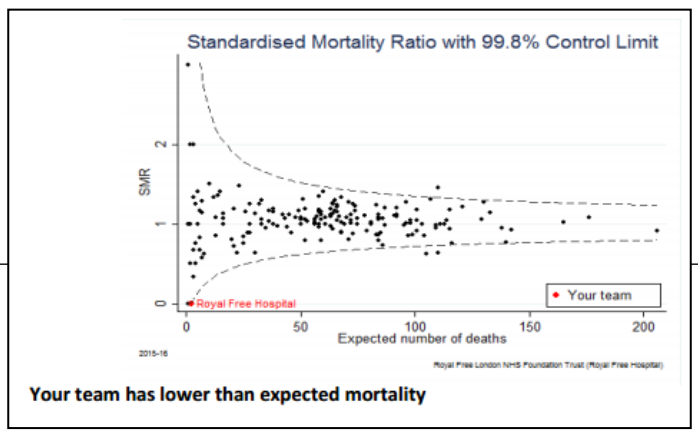
National clinical audit	Actions to improve quality
	 The audit identified that surgery for carotid endarterectomy is sometimes delayed beyond 14 days for some of our patients. We are working toward improving our surgical capacity to reduce these delays. The report also demonstrates excellence in patient care with above average performance for patients undergoing elective infra-renal AAA repair in the areas of receiving anaesthetic review and undergoing pre-operative CT/MR angiogram assessment. The vascular radiology and anaesthesia teams have worked hard to improve this part of the pathway. All aortic cases are discussed at the aortic multidisciplinary meeting, the timing of which was recently changed to accommodate as many clinicians as possible, making sure all our patients are discussed and reviewed by our specialists.

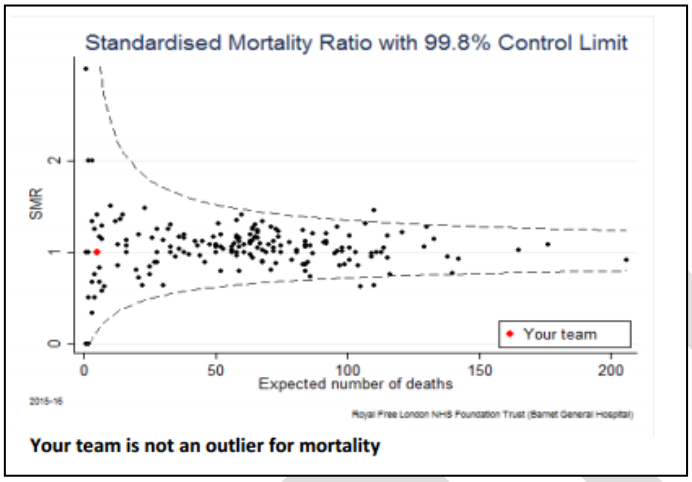
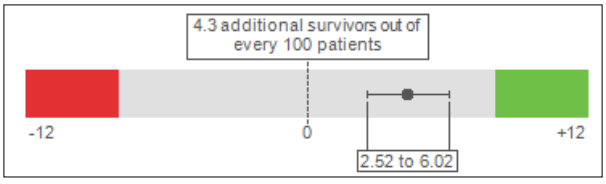
NHS Blood and Transplant: potential donor audit
 	
Published: Oct-16 (provisional data)
Reporting period: 01/04/16 – 30/09/16
Site: Trust-level data
	Trust-level performance in the audit demonstrates good practice and areas of excellence, with the most recently published data showing that:
	• The average number of organs donated per donor is above the national average. In particular donation after brainstem death (DBD) donors average 6.0 organs per donor compared to 3.8 nationally.
	• A statistically acceptable level was achieved for 8/9 measures of best practice (DBD and donation after circulatory death (DCD)), with the top gold rating achieved for:
	  ○ Referral to Senior Nurse-Organ Donation (DBD).
	  ○ Family approached with Senior Nurse-Organ Donation involved (DCD).
	  ○ Consent granted (DCD).
	• Neurological death tested (DBD) performance has improved from 50% (Apr-Sep 2015) to 89% (Apr-Sep 2016).
	
	To improve patient care a neurological death testing masterclass was given to all Intensive Care Unit (ICU) staff by the regional clinical lead for organ donation. Organ Donation Awareness Week and Medicine for Members events were held in September 2016 to raise awareness of organ donation to staff, patients, families and carers.
	
	To improve further we will recruit nursing and emergency department (ED) representation on the Organ Donation Committee; investigate the inclusion of organ donation on trust induction for medical and nursing staff; implement a trust wide teaching programme on nurse-led referral in ED and

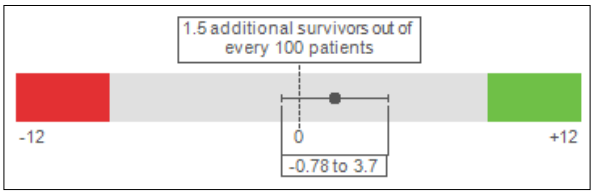
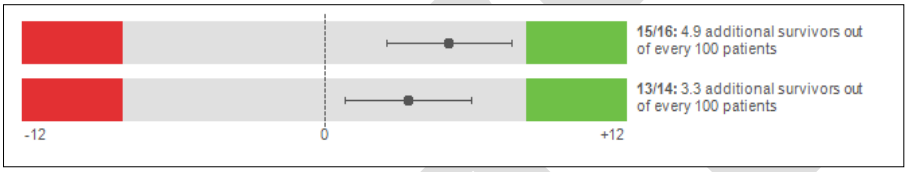
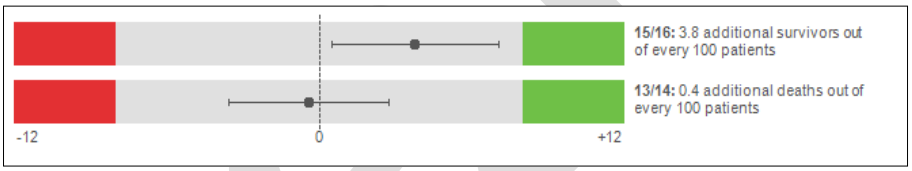
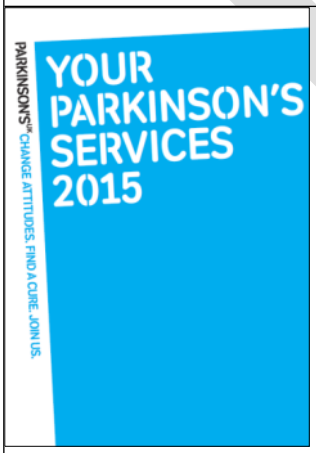
National clinical audit	Actions to improve quality
	ICU and implement training on breaking bad news – currently being developed at Barts Health NHS Trust.
 **UK renal registry** **Published:** Apr-16 **Reporting period:** Various **Site:** Royal Free and Barnet	The UK Renal Registry (UKRR) is part of the Renal Association, a not for profit organisation registered with the Charity Commission. The Registry is recognised as having one of the very few high quality clinical databases open to requests from researchers. The UKRR collects, analyses and reports on data from 71 adult and 13 paediatric renal centres nationally (*source: Renal Registry website*). **First adult kidney transplant:** The risk-adjusted five year patient and graft survival rates for both deceased and living donors at the Royal Free remained high in comparison to the previous report, and are above the national average and all other London centres, whilst the one year survival rates are in line with both the national and peer figures. **Adult patients on renal replacement therapy:** The one year after 90-day age adjusted survival for incident renal replacement therapy patients in the 2013 cohort at Royal Free (91.6%) is similar to the national average (91.4%). **Rate of infectious episodes in patients with established renal failure:** The rates of methicillin-resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA) and clostridium difficile infection (CDI) per 100 dialysis patient years is better than the national average. The rate for Escherichia coli (E.Coli) has reduced from 2.21 to 1.90, but remains just above the national average (1.90 vs. 1.49).
 **National clinical audit for rheumatoid and early inflammatory arthritis** **Published:** Oct-16 **Reporting period:** 01/02/14 – 30/04/15 **Site:** Royal Free and Barnet	Rheumatic diseases, including inflammatory arthritis, account for significant ill health and disability, and cost, to the NHS, social care and wider economy. Dramatic advances have been made in the treatment of inflammatory arthritis by effective use of traditional disease modifying agents (DMARDs) as well as the introduction of newer biological therapies (*source: national audit report*). The performance of the rheumatology team in the audit demonstrates above average care for: • Assessment within three weeks of referral for people with suspected early inflammatory arthritis (EIA). • Effective treatment offered to people with newly diagnosed rheumatoid arthritis within six weeks of referral. • Monthly treatment escalation offered to people with active rheumatoid arthritis until the disease is controlled to an agreed target. • Advice received within one working day of contacting the rheumatology service for people with rheumatoid arthritis and disease flares or possible drug related side effects.

National clinical audit	Actions to improve quality
	To improve patient care and management further, an early inflammatory arthritis (EIA) service has been set up at all three sites and four community hospitals. A standardised referral form and EIA treatment plan have been developed. Care processes have been re-organised to allow for timely patient review so that disease-modifying medication can be started by the clinical nurse specialist or consultant as soon as possible. Telephone consultation slots have been introduced, patient information leaflets are available, and patients are encouraged to access the National Rheumatoid Arthritis Society resources. The improvement work at the Royal Free has been recognised as exemplary by the British Rheumatology Society in its national audit report. A strong team of clinical nurse specialists, strong IT and good team working are keys to our success. Good IT support includes an electronic referral form for EIA which is available to all the local clinical commissioning groups. Consultant electronic triage allows blood results to be checked once referrals are received and ordered if not already available prior to the patient's first appointment. The electronic patient record allows immediate access to all relevant patient information on all peripheral sites, and for (most) GP-ordered tests to be available to hospital clinicians.
Royal College of Emergency Medicine (RCEM): venous thromboembolism (VTE) risk in lower limb immobilisation **Published:** Jun-16 **Reporting period:** 2015/16 **Site:** Royal Free and Barnet	VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called deep vein thrombosis (DVT). If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism (PE). Collectively these are known as VTE and can be life threatening if not treated quickly. Patients who are treated for lower limb injuries and put into plaster casts are at significant risk of developing VTE (s*ource: national audit report press release*). The performance of the Royal Free Hospital in the audit demonstrates excellence in care provided, with the most recently published data showing that if a need for thromboprophylaxis is indicated, there was written evidence of the patient receiving or being referred for treatment. To improve further, VTE training and a VTE sticker have been introduced at the Royal Free. A re-audit will be undertaken 2017/18 to assess their impact on practice. To improve practice across sites the Royal Free VTE assessment pathway for patients immobilised with lower limb casts has been rolled out at Barnet and Chase Farm Hospitals.

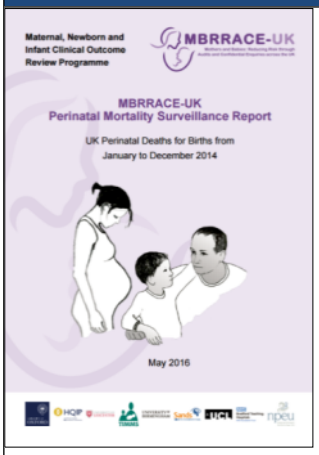
National clinical audit	Actions to improve quality
 **RCEM: vital signs in children** **Published:** Jun-16 **Reporting period:** 2015/16 **Site:** Royal Free and Barnet	Vital signs are important to record in children presenting at the Emergency Department (ED) because, if abnormal, they indicate that a patient may be at risk of a disease process with an increased risk of morbidity and mortality. The detection of abnormal vital signs, appropriate escalation and response can avoid patient deterioration and improve patient outcomes (*source: national audit report*). The performance of the Royal Free Hospital in the audit demonstrates excellence in care provided, with the most recently published data showing that: • A formal vital signs scoring system was used for 100% of patients. • Performance was in the best quartile nationally for 4/6 audit criteria, including complete set of vital signs measured and recorded, a further complete set of vital signs recorded within 60 minutes of the first set if abnormal vital signs were present, evidence the clinician recognised the abnormal vital signs (100% achieved), and that abnormal vital signs (if present) were acted upon in all cases (100% achieved). Since the completion of the audit the new paediatric ED has opened at the Royal Free Hospital, which includes an extra triage nurse. To improve further a common approach to the Paediatric Early Warning System (PEWS) will be implemented across all trust ED and Urgent Care sites. As such the patient documentation chart has been updated to include the PEWS and is currently being piloted at the Royal Free Hospital, prior to adoption across all our sites.
RCEM: procedural sedation in adults **Published:** Jun-16 **Reporting period:** 2015/16 **Site:** Royal Free and Barnet	The delivery of safe sedation is a key component of the skill-set of any emergency medicine physician. Newer agents, better monitoring and a larger caseload have substantially changed sedation practice in the Emergency Department (ED) over the last few years. Patients have benefited from this change in practice. Better sedation/analgesia has increased the success rate of many procedures, shorter-acting agents have allowed same day discharge of most patients and formal training and audit has promoted best practice and reduced the likelihood of complications. Sedating patients safely in EDs reduces admissions, pressure on theatre and costs. Importantly, no deaths were recorded as a consequence of a sedation performed in an ED in the national audit (*source: national audit report*). In line with the national picture, mixed results were achieved for the audit across sites. To improve documentation the Royal College of Emergency Medicine (RCEM) procedural sedation proforma has been adapted and will be rolled out at the Royal Free Hospital. A patient information leaflet has also been developed to be given out at discharge in line with best practice standards. To be re-audited locally 2017/18.

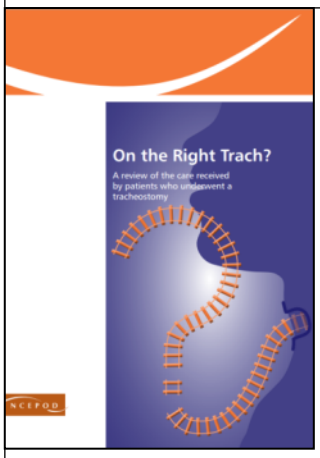
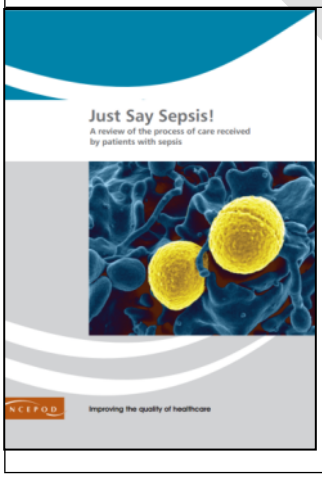
National clinical audit	Actions to improve quality
	At Barnet Hospital: • Teaching given to middle grade and senior doctors via the ED teaching programme now includes the use of end tidal CO_2 capnography in the non-ventilated patient, re-enforces the use of applicable guidelines in practice and teaching, and reiterates that procedural sedation must take place in resuscitation room only. • Compatible nasal prongs for end tidal CO_2 monitoring kit ordered into stock and used in all procedural sedation and other suitable cases (non-ventilated patients requiring end tidal CO_2 monitoring). • Implemented the RCEM document 'Pharmacological agents for procedural sedation and analgesia in the Emergency Department', which includes The World Society for Intravenous Anaesthesia (World SIVA) 'Reporting tool for sedation related adverse events' and the 'Post sedation advice information for patients'.
Sentinel stroke national audit programme (SSNAP) **Clinical audit** **Published:** Oct-16 **Reporting period:** 01/04/16 – 31/06/16 **Site:** Royal Free and Barnet **Organisational audit** **Published:** Sep-16 **Reporting period:** Services as of 01/07/16 **Site:** Royal Free and Barnet **Mortality data** **Published:** Jan-17 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet	A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off (*source: NHS Choices*). Stroke remains the third commonest cause of death and the most common cause of complex disability in the UK, and can occur at any age. More than 80,000 people each year are admitted to hospital with a stroke in England, Wales, and Northern Ireland and while most people are elderly, a significant proportion are of working age, and of course stroke can affect children and young people too (*source: national audit report*). Performance in the clinical audit demonstrates excellence in quality of care provided at the Royal Free and Barnet Hospitals, with the most recently published data showing that: • Both hospitals are providing a world class stroke service – achieving an 'A' rating for overall performance (SSNAP level), placing them amongst the top 18% performing teams nationally. • Both sites achieved an 'A' rating for case ascertainment. Performance in the organisational audit clearly demonstrates the provision of best practice services, with the Royal Free Hospital meeting 9/10 key indicators of best practice, placing the stroke team within the top 10 performing teams nationally. Barnet Hospital met 7/10 key indicators of best practice, placing them within the top third of teams nationally. No deaths were recorded at Royal Free Hospital during the audit period, which is lower than expected. The number of deaths at Barnet Hospital equalled the number expected, and is not identified as an outlier.  Royal Free

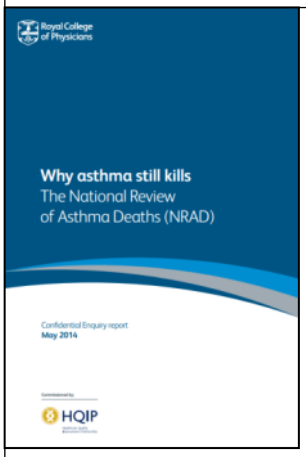
National clinical audit	Actions to improve quality
	 Barnet The multidisciplinary team regularly reviews the quarterly audit data to identify improvement actions. This has included encouraging the participation of health partners across North Central London in the audit, which has helped improve audit compliance around the referral process to early supported discharge. Multidisciplinary team meetings have led to an improved assessment process and the implementation of group therapy sessions. Multidisciplinary mortality and morbidity meetings have been set up across sites to discuss all stroke deaths to ensure learning is captured and fed back into improving clinical practice. Work is ongoing with the ambulance service to ensure patients are admitted to the appropriate hospital. To improve further the stroke team is actively seeking a full-time stroke co-ordinator at Barnet Hospital to assist in the identification and management of stroke patients.
TARN THE TRAUMA AUDIT & RESEARCH NETWORK **Trauma audit and research network (TARN) – online survival data** **Data quality:** TARN data entry shows good performance on data accreditation and completeness at the Royal Free Hospital.	Every year across England and Wales, 12,500 people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life (*source: TARN website*). The latest data shows that more patients presenting at both the Royal Free and Barnet Hospitals are surviving compared to expected (1.0) based on the severity of their injury. **Rate of survival: January 01 2013 – December 31 2016** Royal Free 

National clinical audit	Actions to improve quality
	Barnet  **Rate of survival: Yearly figures** Royal Free  Barnet  Royal Free: To improve the care provided to trauma patients the following actions are in progress; ward nurses are receiving training to provide basic swallowing assessments out of hours and proposals have been made to senior management and the trauma network on how to develop the trauma and rehabilitation coordinator roles which are much needed. Multi-specialty trauma governance mortality and morbidity meetings have been set up; the trauma calls have been rejuvenated and training is beginning to be implemented with a trauma team members course planned this year. Barnet: Additional specialist trainee (Grade 3) cover has been put in place to support junior staff 24 hours a day, 7 days a week. All middle grade doctors have received advanced trauma life support training and nursing staff have the opportunity to undertake a university accredited trauma module as well as Focused Assessment with Sonography (FAST) ultrasound training.
 **UK Parkinson's audit**	Parkinson's disease is a condition in which parts of the brain become progressively damaged over many years. One person in every 500 has Parkinson's. That's about 127,000 people in the UK. Symptoms and how quickly they progress are different for everyone. There's currently no cure, but drugs and treatments are available to manage many of the symptoms (*source: Parkinson's UK website*). Performance in the clinical audit demonstrates excellence in quality of care provided at the Royal Free and Barnet Hospitals, with the most recently published data showing that above national average performance was identified for: • Discussion of end-of-life care issues and care planning, and information offered about, or have set up a, lasting power of attorney with the elderly care team.

National clinical audit	Actions to improve quality
• Elderly care: clinical report • Neurology: clinical report and PREMs report • Therapies: clinical report **Published:** Aug-16 **Reporting period:** 2015/16 **Site:** Elderly care: Royal Free Neurology and Therapies: Royal Free and Barnet	• Patient reviewed by a specialist within the last year – 100% achieved for neurology services across sites. • Conversation with the patient and/or carer and/or provision of written information regarding potential side effects for any new medications – elderly care team and neurology services across sites. For patients referred to physiotherapy above national average performance was demonstrated for: • Time from referral to initial assessment for urgent or routine cases. • Reports made back to the referrer/other key people at the conclusion of the intervention period (or interim reports where treatment lasts a longer time). • Where a goal plan was included in the notes, outcome measures were used. The patient experience questionnaire showed that overall patients were happy with the quality of services at both sites, and that in comparison to the national average more neurology patients at both hospital sites felt involved in decisions about their care and listened to. Patients were happy with the amount of time available to them and at Barnet Hospital patients were happy with the level of information provided on Parkinson's disease, new medications and side effects, how to access support and information, and the role of social work for people with Parkinson's and their carers. Actions planned to improve performance further include: • Parkinson's UK information leaflets will be routinely available at the elderly care Parkinson's disease clinic, to supplement existing signposting to the Parkinson's UK website. • In the Neurology Parkinson's disease clinic, blood pressure and weight are now measured at all appointments. To improve the quality of information given to, and discussions with, the patient an information leaflet is being developed that will include information on the Parkinson's support worker, side effects of medications, bone health, driving and end of life care which will supplement the Parkinson's UK leaflets. A checklist of important issues to be discussed with the patient is also being developed as an aide memoir. • In addition, work is ongoing to improve the integrated care pathway for Parkinson's disease via London's Parkinson's Disease Excellence Network, University College London (UCL) Partners Parkinson's Disease Pathway redesign and Frailty Hub. Once the pathway of care is confirmed it will be included in the patient information making the care provided inside the hospital and across the network easier to navigate.

National confidential enquiry	Actions to improve
 **Mothers and babies: reducing risk through audit and confidential enquiries across the UK (MBRRACE-UK): perinatal mortality report: 2014 births** **Published:** May-16 **Reporting period:** 01/01/14 – 31/12/14 **Site:** Royal Free and Barnet	The work of the trust in providing excellent care to mothers and their babies is exemplified by our performance in the May-16 MBRRACE-UK report which clearly demonstrates excellent outcomes, with the data showing that: • The mortality rate for neonatal and extended perinatal deaths at the trust is more than 10% lower than the average for similar trusts and health boards. • The stillbirth rate is nearly 10% lower than the average for similar trusts and health boards. This is despite the local population having a high proportion of mothers with demographics associated with poorer outcomes. To improve patient care further, the team is reviewing and implementing a continuity of care pathway and introducing further measures to reduce the stillbirth rate. Midwives are working in hubs alongside other specialists in the community to reduce variation and improve co-ordination of care. The trust forms part of the National Maternal and Neonatal Health Safety Collaborative focusing on improving outcomes in perinatal mortality and morbidity nationally.
MBRRACE-UK: saving lives, improving mothers' care - surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2009-14 **Published:** Dec-16 **Reporting period:** Various **Site:** Royal Free and Barnet	The trust makes continuous efforts to ensure that standards for the care of women, and ongoing work to reduce maternal deaths, continues to be part of the quality agenda of maternity services. Maternity services have benchmarked the current services against the report MBRRACE-UK: Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. These include the following areas: • The services across both Royal Free and Barnet Hospitals possess co-located obstetric and cardiac services. There are multi-disciplinary care plans and pathways for women with cardiac disease to support effective interdisciplinary working and communication. • Both Royal Free and Barnet Hospitals have Early Pregnancy and Gynaecology Assessment Units (Monday to Saturday) and a full range of maternity services (24/7) to assess this category of women. • It is established practice across the trust's maternity services that unwell antenatal women are only transferred to other units with on-site obstetric cover. • The consultant led maternity units across both sites have readily available, and seven days a week, access to an electrocardiogram (ECG) machine and echocardiography, as well as staff who can interpret ECGs.

National confidential enquiry	Actions to improve
	The recommendations of the report focus on messages for critical care, lessons for early pregnancy care and caring for women with hypertensive disorders in pregnancy and lessons on cardiovascular disease. There is work going on within maternity services to incorporate these key messages into local cross site guidance as well as to share these messages during local clinical audit and governance meetings.
 **National confidential enquiry into patient outcome and death (NCEPOD):** **Tracheostomy care: on the right trach?** **Published:** Jun-14 **Annual update on progress:** Feb-17 **Site:** Royal Free and Barnet	A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe. If necessary, the tube can be connected to an oxygen supply and a breathing machine called a ventilator. The tube can also be used to remove any fluid that's built up in the throat and windpipe (*source: NHS Choices*). Barnet Hospital is fully compliant with 20 out of 25 recommendations. This is an improvement from 13 in 2016. Actions implemented over the course of the last year include the provision of training (including blocked/ displaced tubes and airways) to all multidisciplinary staff. The Patient at Risk and Resuscitation Team (PARRT) attend the tracheostomy ward round with physiotherapy and the Ear, Nose and Throat clinical nurse specialist weekly. Speech language therapy referrals are made for all swallow impairments and patients with high risk factors. To further improve, staff training and competency levels will be taken into account at patient allocation meetings and all patients undergoing a tracheostomy without a trial of extubation will have the reason clearly documented in the notes. The Royal Free Hospital is fully compliant with 23 out of 25 recommendations. This is an improvement from 21 in 2016. Actions implemented over the course of the last year include the availability of capnography on all wards to confirm tube placement, supply of end-of-bed tracheostomy packs including a summary of care, safety and information posters, and a weaning plan from PARRT. To further improve, the Hospital IT system Cerner will be modified to enable the collection of electronic information on percutaneous tracheostomy insertion in the Intensive Care Unit (ICU) and ICU consultants will use the World Health Organisation checklist and document consent for all percutaneous tracheostomies.
	Sepsis is a systemic inflammatory response to microbial infection, causing damage to organs, then shock and ultimately death. The international prevalence is estimated at 300 per 100,000, suggesting that there are around 200,000 cases a year in the UK alone (*source: NCEPOD report*) The implementation of the study recommendations is being led by the sepsis work stream group, which is also leading on the sepsis work being undertaken as part of the Patient Safety Programme (PSP). For more information on the PSP work see Part 2: Priorities for Improvement. In relation to the NCEPOD study, the trust is currently fully compliant with 15 out of 19 applicable recommendations. To further improve the care provided to our patients with sepsis, local guidelines are in development to ensure

National confidential enquiry	Actions to improve
NCEPOD: sepsis: just say sepsis! **Published:** Nov-15 **Annual update on progress:** Oct-16 **Site:** Royal Free and Barnet	surgical site bundles are in place for any invasive procedure. The development of a video is being considered for patients and their relatives regarding the recognition of sepsis, its long-term complications, recovery and risk of occurrence. The head of coding has joined the sepsis work stream group and the need to include sepsis on the death certificate, when diagnosed, in addition to the underlying source of infection, will be added to staff education and training.
 **The national review of asthma deaths (NRAD)** Adults **Published:** May-14 **Annual Update on Progress:** Feb-17 **Site:** Royal Free and Barnet	It is not clear why the number of deaths per year from asthma in the UK has not reduced significantly from around 1,200 for many years, even though it is widely accepted that there are preventable factors in 90% of deaths. The aim of the project was to understand why people of all ages die from asthma so that recommendations could be made to prevent deaths from asthma in the future (*source: national review report*). The respiratory team has moved to full compliance with the implementation of 14 out of 14 applicable recommendations. In line with best practice, the trust has a designated consultant with a special interest in severe asthma. At both Barnet and the Royal Free Hospitals a clinical nurse specialist liaises with the emergency department reviewing asthma patients and arranging follow up. Every asthmatic has a personal asthma action plan, asthmatics in the out-patient clinic are usually seen more frequently than yearly, which exceeds the best practice target. Factors that trigger or exacerbate asthma and an assessment of recent asthma control form part of a standard asthma clinic review. Staff are aware of the features that increase the risk of asthma attacks and death, including the significance of concurrent psychological and mental health issues and refer patients where necessary to the health psychologist. Every patient staff are concerned about are referred to either our nurse specialist or to their GP practice nurse to go through inhaler technique. At every out-patient clinic appointment patients are asked about their adherence to therapy (GP prescription records or exhaled nitric oxide levels are sometimes checked to help this process) and patients are told how important their inhaled steroids are. Patients are not prescribed with a single agent long-acting beta-agonists. Patient self-management forms part of a standard asthma clinic review, which is also encouraged by our asthma clinical nurse specialists; and every patient attending clinic or admitted to hospital will be asked about their smoking history/exposure.

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, which will provide better outcomes for our patients.

The reports of 18 local clinical audits* were reviewed by the provider in 2016/17 and we intend to take the following actions to improve the quality of healthcare provided.

(* the local audits undertaken relate to the divisional priority quality improvement projects)

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 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 table 4)

Table 4: Details of specific actions undertaken as the result of a local clinical audit

Local clinical audit	Actions to improve quality
Surgery and Associated Services	
The anderson criteria: A model for improving patient handover and safety Divisional priority audit 2016/17	This audit was not undertaken in 2016/17. During the financial period the service's priorities changed to focus on improving its submission to the National Emergency Laparotomy Audit (NELA), which it has done over the past year across all sites. This audit is planned to be undertaken once the service is confident of sustained submissions to NELA.
Closing the loop: strategies to minimise preoperative delay in emergency general surgery at the Royal Free Hospital (re-audit) Divisional priority audit 2016/17	This audit focuses on issues highlighted by the National Audit of Emergency Laparotomy (NELA), assessing the extent to which emergency general surgery patients were facing unacceptable delays for surgery and whether or not this had improved following reconfiguration of emergency services. It is well recognised that delaying emergency general surgery operations, especially for patients with sepsis, results in poorer patient outcomes, including higher complication and mortality rates. Even for those without sepsis, delayed surgery leads to unnecessary prolongation of patient discomfort, recovery and hospital stay resulting in a significant cost for the NHS. The results of the latest audit demonstrate significant improvements compared to the first round with 96% of patients meeting the Royal College of Surgeons (RCS) time to treat recommendations. Only four cases (4%) exceeded the recommendations - a significant reduction from 25% identified in the first round of audit. None of the patients identified as exceeding the RCS time to treat recommendations were operated on at the weekend or out of hours. One of the areas identified as good practice was the reconfiguration of the emergency service with theatre access, which occurred after the first audit, and included separating the trauma and orthopaedic list from the main emergency theatre. This has resulted in improved compliance with the best practice standards set by RCS and the national confidential enquiry into patient outcome and death (NCEPOD). There is no evidence from this audit that emergency general surgical patients are disadvantaged by current weekend working practices. For patients admitted between 8am and 6pm on a week day the mean time between the decision to operate and the start of operation was 8.48 hours, compared to 7.95 hours for patients admitted out of hours which shows virtually no difference.
Ultrasound diagnosis of "U" classification thyroid nodules Divisional priority audit 2016/17	The U classification is essential in establishing correct pathways for the management of thyroid nodules by stratifying risk. Its increased use results in fewer fine-needle aspiration's (FNAs), fewer ultrasonograms (US), less clinic appointments and better patient experience, which result in lower costs to the trust. The quality improvement project used PDSA (plan, do, study and act) methodology to assess the percentage of ultrasound reports using the U classification for thyroid nodules between March 2015 and June 2016 following the implementation of a series of

Local clinical audit	Actions to improve quality
	interventions to improve practice. The data shows an improvement in the use of U classification from 23% to 88% over the audit period. This has been driven by the implementation of regular interventions to educate staff and promote the use of the U classification including discussions with radiologists, an update to the thyroid protocol (oral and maxillofacial surgery (OMFS) clinical rooms), a request to specify U classification on all orders by OMFS and Ear, Nose and Throat (ENT) clinicians, training provided to OMFS dental core trainees and the U classification laminated and put up on the wall in the radiology treatment rooms as a visual aid.
Virtual fracture clinic cross site comparison May-16 Divisional priority audit 2016/17	The virtual fracture clinic at Barnet Hospital was set up to mirror the clinic at the Royal Free Hospital. This audit compared the service plan assumptions to the actual challenges faced by the clinic following implementation at Barnet and aimed to address any issues found. The data analysis showed a number of improvements to the fracture clinic waiting area, patient flow and the discharge rate, which has improved from 23% to 34%. The audit also showed that the increase in demand for the service was not being met. Funds have now been agreed to resource three extra part-time sessions on a Monday, Tuesday and Friday. Additional administrative support for clinical staff has also been agreed for four hours a day and early talks are in progress regarding the implementation of an IT system to underpin the virtual fracture clinic process.
Swabs, needles and instrument count Divisional priority audit 2016/17	Following serious incidents in 2015/16 regarding retained swabs and needles, a new policy has been implemented in all theatres across the organisation and all staff have been assessed to ensure they are following the policy and are fully competent. Theatre areas are also doing monthly observational audits of swabs, needles and instrument count, using PDSA (plan, do, study, act) methodology. Results are reviewed locally by matrons and actions put in place to try to address any issues. Measurement then takes place again to check if the actions have been successful in solving these issues. The data is regularly reviewed at the monthly Safer Surgery Board meeting and later this year we will analyse all data to assess our improvement progress. Further action to improve will then be taken as required.
Transplant and Specialist Services (TASS)	
A local audit of tuberous sclerosis specialist service at the Royal Free Hospital for patients presenting with renal angiomyolipomas (AMLs)	Tuberous sclerosis is a multi-system genetic disorder, causing benign tumours to grow. This condition can affect any organ, but most commonly presents in the heart, lungs, kidneys, skin and eyes. The audit demonstrated excellent patient care. All patients referred to the clinic with renal AMLs had an individual care plan in place, all patients had the appropriate follow up arranged and all patients that required specialist input had been referred and an appointment arranged. To ensure patients have their renal scan ordered appropriately once a patient has been reviewed in clinic, a decision will be made as to when their imaging is next due for

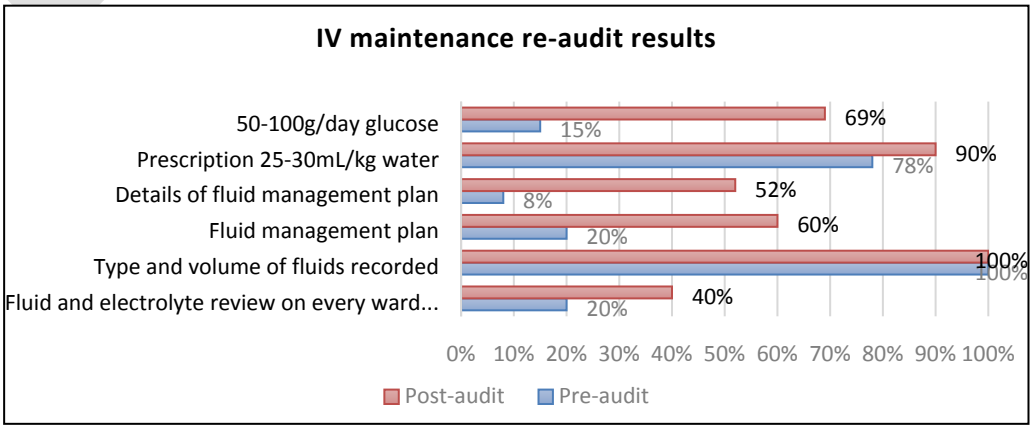
Local clinical audit	Actions to improve quality
Divisional priority audit 2016/17	review. This will be clearly documented in the patient notes and booked as soon as possible. Work is ongoing with the scanning department to ensure scans are booked in a timely manner. Some patients are needle phobic and are not keen to have blood tests. To improve the documentation of eGFR, the importance of recording clinical decisions to omit blood tests has been discussed with the renal genetics team (i.e. patient choice). Following the recent relaxation of the eligibility criteria for the genome project, it is now possible to enrol suitable patients with tuberous sclerosis complex (TSC). The study team has been informed and patients are now being approached at their clinic appointments.
Audit of fatigue syndrome presenting with joint hypermobility syndrome (JHS) on referral to service Divisional priority audit 2016/17	The initial screening 5-part JHS questionnaire has been posted to 160 prospective patients, of which 102 (64%) have been completed and returned. 69 of these report benign JHS, and these will be assessed further to confirm chronic fatigue syndrome and JHS using the Beighton and Brighton criteria for JHS diagnosis. 17 further patients who have either already been assessed and/or re-assessed by the physician in clinic post therapy for fatigue, or re-assessed by a graded exercise therapist for further fatigue treatment, have been diagnosed according to Beighton and Brighton criteria. These numbers are already higher than expected. The completion of this audit has been a challenge, with limited time and resource. However, we are committed to complete the audit and all data should be collected by the end of April 2017, which will allow analysis to be completed by the end of June 2017. Joint physician and physiotherapy clinics are being arranged to confirm the diagnoses in March and April 2017. The American Association of Rheumatologists will shortly release a new definition and criteria for some classes of JHS. This will be taken into account in the analysis, and we hope that the new criteria will be available before our planned audit completion date.
Renal dialysis patient reported experience measures (PREM) 2016-17: Patient experience and satisfaction with dialysis Divisional priority audit 2016/17	Whilst PREM data has been collected by the renal dialysis specialty for a number of years the short renal-specific PREM questionnaire has been used to examine patients' experience of and satisfaction with their dialysis treatment every year since 2013. The findings of the latest review are very similar to those in previous years and show that: • Nearly half of all respondents perceived their health to be good, very good or excellent, yet bodily pain remains an ongoing difficulty for patients. • More than half of respondents reported to have experienced at least moderate levels of bodily pain in the month prior to completing the questionnaire. However, although over one third of patients who had experienced pain had had no analgesia prescribed for them, patients experiencing severe or very severe pain reported taking medication for pain 'very often' suggesting that a number of respondents are likely to be taking medicines purchased over the counter.

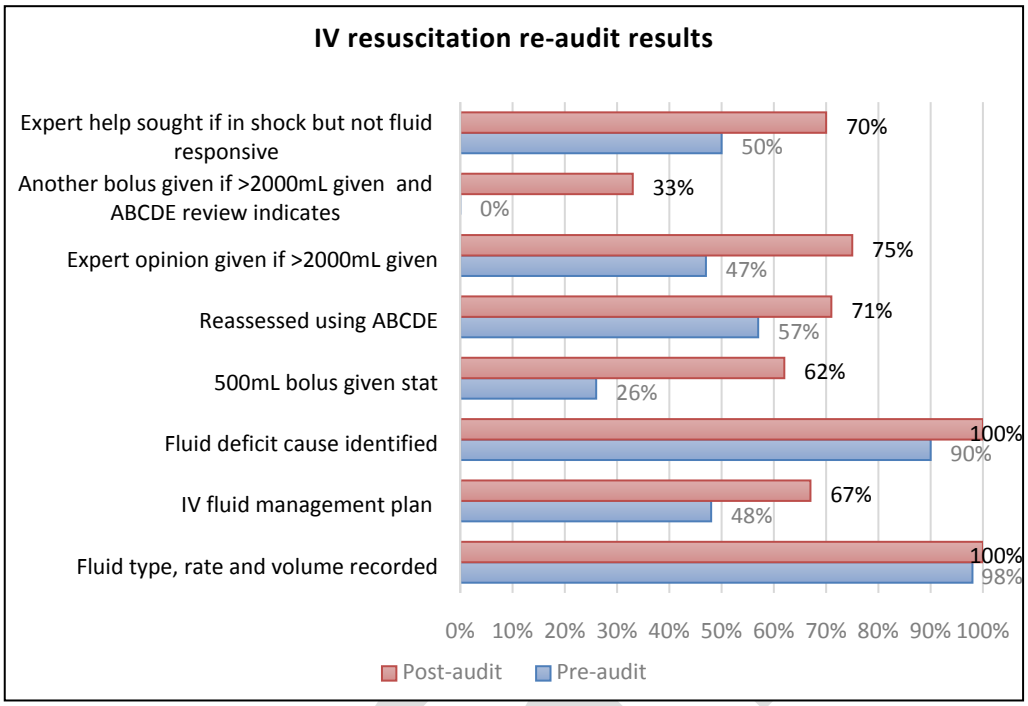
Local clinical audit	Actions to improve quality
	• Symptoms of depression were explored for the first time using Patient Health Questionnaire-9 (PHQ-9). Results indicated moderate levels of depressed mood with 39% of respondents experiencing moderately severe or severe symptoms of low mood, which could warrant antidepressant and/or psychological therapy. • Over the years, patient satisfaction has been consistently good with 59% of respondents scoring their care highly as an 8, 9 or 10. This year, far less variability in satisfaction was noted between dialysis units. • A number of positive comments commending the organisational qualities of their dialysis unit were received. The caring attitude of staff and the pleasant physical environment were also noted. Contrastingly, comments relating to the need for better patient-staff communication and more reliable transport, were frequently cited as suggestions for improvement. As a result of the audit a number of recommendations have been made and are in the process of being implemented: • Consultants should routinely enquire about patients' pain at each consultation. • Patients reporting psychological difficulties should be referred to the Renal Clinical Health Psychology service for assessment and treatment, or for signposting to more relevant mental health services. • Staff should attend the Trust's Sage and Thyme communication skills training course, which teaches staff to work effectively with patients in distress. To supplement this, dialysis staff should receive brief, accessible training to facilitate better understanding of common psychological problems experienced by patients receiving dialysis treatment. Training should be undertaken in dialysis units. To further improve practice, brief monthly training of dialysis staff in stress management and in the recognition of psychological distress in dialysis patients began at Tottenham Hale dialysis unit in September 2016. To be completed in June 2017.
Assessment of all patients who died within 30 days of chemotherapy Local audit of recommendations from the national confidential enquiry into patient outcome and death (NCEPOD) Divisional priority audit 2016/17	Undertaken periodically since 2009, the audit assesses our performance against the NCEPOD recommendations. The audit has already led to a number of improvements, including improved documentation of performance status, increased patient assessment by consultant staff and the development and implementation of a formal pathway for HIV positive patients. The most recent audit results show areas of excellent practice. All patients had systemic anti-cancer therapy (SACT) prescribed by a consultant or senior registrar, all prescriptions were checked by a senior pharmacist, all drugs that should have been dose-modified had the correct dose prescribed and performance status was generally well documented. Patient performance status is an important part of cancer care and treatment. It plays a role both in shaping prognosis and in determining the best treatment for a patient with cancer. Audit actions are in progress to improve the documentation of cause of death and to ensure that SACT related deaths in all patients are treated with curative intent, and all unexpected deaths and all deaths from neutropenia are discussed in depth at the mortality and morbidity meetings.
Adherence to treatment in the lupus and	Medicine compliance is an ongoing challenge with 35-50% of all medicines prescribed for long-term conditions not taken as recommended. This represents a personal and economic loss to patients, the healthcare system and society (*source: National Institute*

Local clinical audit	Actions to improve quality
vasculitis nephritis clinic Divisional priority audit 2016/17	*for Health and Clinical Excellence (NICE) clinical guideline 76: Medicines Adherence*). The specialist renal clinic at the Royal Free Hospital sees patients predominantly with vasculitis and systemic lupus erythematosus (SLE). These conditions are both characterized by their autoimmune nature, chronicity, multi-system involvement and polypharmacy, including long-term immunosuppression medication. Therefore issues surrounding adherence to treatment are particularly relevant to explore in these two groups. Poor adherence leads to poor clinical outcomes in patients with vasculitis and SLE, and the rates of non-adherence in SLE patients range from 3% to 76% depending on the assessment methods used, which are all subject to limitations. The aim of the audit was to assess patient self-reported adherence to prescribed treatment and perceived barriers to achieving medication adherence in this patient group. The survey findings demonstrated that the clinic was fully compliant with 16 out of the 19 NICE standards audited (84%), and partially compliant with 3 (16%). The audit data has been reviewed and a list of recommendations developed for action. These are: • The most common reason for non-adherence to the prescribed medications was "forgetfulness". To improve adherence the following have been recommended; the provision of practical tips and advice as part of an education session with the clinician or assisted by the pharmacy (such as dosset boxes/electronic reminders) and to identify patients with increased risk of forgetfulness and ensure they have access to additional support. • Keeping track of hospital appointments was one of the identified obstacles to adherence. This can be managed by further improving the hospital's notification and reminder services, aspiring to minimize outpatient appointments, and emphasising the importance of attendance and diarising for patients. • The major concern reported by patients was the immunosuppressants and their side effects. This can be addressed by enhancing education regarding the medication at the time of starting treatment and supporting the patients with provision of information leaflets and discussion about potential side effects and action plans if they experience them. Clear communication and correct direction to an appropriate helpline/advice line or to the clinic team will enhance confidence in treatment and prevent early discontinuation. • Flexible follow-up intervals and adjusting doses or changing medications as soon as patients start experiencing side effects will improve symptoms before they affect their adherence with medication. • Many of the medications prescribed for vasculitis and SLE patients are essential and cannot be minimized or stopped. Identifying personal barriers to treatment early during follow up consultations allows for intervention before adherence is affected. This should include specific questions about side effects and current adherence, adjusting dosing schedule/frequency to suit the patient, and considering an early change of medication where side effects are problematic.
Urgent Care	
In-patient falls Divisional priority audit 2016/17	The aim of the project is to reduce falls by 25%, as measured by incidents reported on DATIX by 31 March 2018. To date across the trust 33 PDSA (plan, do, study, act) cycles have been instigated - 17 completed, 15 in progress and 1 intervention abandoned. To reduce falls on: • **8 West:** A review of the toilet areas on the ward has been completed. A

Local clinical audit	Actions to improve quality
	thematic review (via staff focus groups) for falls prevention in patients with behavioural issues is being undertaken and all multidisciplinary team members are trialing writing their notes in the patient bays. • **Neurological rehabilitation centre:** A multidisciplinary falls assessment, falls care plan discussions at multidisciplinary team meetings and a multidisciplinary post-fall incident review have all been tested and implemented. The implementation of new falls documentation and toilet grab bags are in progress. • **Juniper Ward:** A shortened board meeting and inclusion of discussion on falls and risk management has been completed. The use of 4 A's Test (4AT), a short tool developed to increase rates of detection of delirium and cognitive impairment in acute general hospitals, and the use of bedside white boards are in progress. • **Medical Short Stay Unit:** Toilet grab bags have been implemented and testing is in progress on laminated pictorial mobility signs and staff education on falls prevention. • **Days since last harmful fall:** 8 West = more than 854 days, neurological rehabilitation centre = 487, Juniper Ward = 88 days and Medical Short Stay Unit = 24. The falls work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Deteriorating patient Divisional priority audit 2016/17	To achieve the project aim to reduce the number of cardiac arrests to less than one per 1,000 admissions by 31 March 2018, the following interventions have been tested using the PDSA (plan, do, study, act) methodology on 10 West: • Re-design and evaluation of the new team 'board round' content and function - trigger questions include current issue, recurrent hospital admissions, acute concerns, resuscitation status, clinical criteria for discharge, social criteria for discharge, estimated date of discharge and multidisciplinary team involvement. • The Patient at Risk and Resuscitation Team (PARRT), palliative care and parent team hold weekly multidisciplinary meetings – approximately six have been triggered to date. • Streaming nurse to nurse verbal handover. • Merging nursing, multidisciplinary team and medical written handover. The deteriorating patient work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Acute kidney injury (AKI) Divisional priority audit 2016/17	The aim of the project is to increase the number of patients who recover from AKI within 72 hours of admission by 25% by 31 March 2018. To meet this target: • A technology platform (AKI App) has been developed by DeepMind Health. It utilises the national mandated AKI detection algorithm and sends AKI alerts with other relevant data to the clinical responders. • 15 to 20 alerts are received a day with an average of 5-6 patients to be seen. Over 26 clinicians are currently using the device. • The Emergency Department (ED) and Medical Admissions Unit (MAU) teams actively participated in the process mapping of the AKI pathway; 'STREAMs' alerts have been designed and deployed; and further updates and upgrades have been made to the AKI App based on the testing phases in the ED and in patient areas. • An ED capability package is currently being developed. ED observations data for processes of taking blood samples, gaining blood results and escalation to

Local clinical audit	Actions to improve quality
	interventions is underway; and various iterations and changes have been made based on the feedback received. • A real time study is in progress to identify the time saved by clinical teams using the app over the computer. The AKI work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Sepsis Divisional priority audit 2016/17	The project aims for a 50% reduction in serious incidents related to sepsis. • It has been 280 days since the last sepsis related serious incident. • Since 2011 the total number of sepsis pathways started in the Emergency Departments (ED) at both hospital sites is 2500. • Current compliance with the provision of all six sepsis interventions within an hour is 80% at Barnet Hospital ED, and 66% at the Royal Free Hospital ED. • An E-learning video is being filmed with the ED champions that will include acute kidney injury (AKI) and neutropenic sepsis. • The use of a sepsis grab bag is being tested at Chase Farm Urgent Care Centre. • The ED and 8 North are both participating in the Sepsis Commissioning for Quality and Innovation (CQUIN) scheme. The sepsis work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Diabetes Divisional priority audit 2016/17	The aim of the project is for zero avoidable harm from hyperglycaemia and hypoglycaemia events in a pilot ward by 2018. The project is being undertaken on wards 10 West and 10 South. • Currently time to control hypoglycaemia in less than 30 minutes is achieved by 30% of patients, and in less than six hours by 76% of patients. • Collaborative support is being provided by staff from 10 West to 10 South. • Patient safety team to design confidence survey with 10W champions. • The trust aims to reduce incorrect medical record number mistypes to less than 19%. • PDSA (plan, do, study, act) methodology is currently being used to test the hypoglycaemia pathway with additional glucometer and timer on 10 West. The diabetes work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Improving quality of endobronchial ultrasound (EBUS) coding	A monthly submission of EBUS procedures is made to the head of clinical coding who then ensures that correct codes have been applied and provides training to coders to improve coding quality further. The monthly return also allows the trust to correct billing in time. Coding accuracy has improved from 50% (February 2016) to 100% (November and December 2016).
Improving the patient pathway for patients with breathlessness	The specialist complex unexplained breathlessness (CUB) clinic organises pre-visit investigations and uses a multidisciplinary team approach (physician, psychology and physiotherapy) in managing these patients. Compared to 'usual care' patients, the CUB clinic had a significantly shorter time from referral to discharge (CUB: 137 days vs. usual care 251 days), fewer clinic attendances (1.5 visits vs. 2.7 visits) and better patient related outcome measures for the criteria: better understanding of condition, greater confidence in ability to self-manage breathlessness, feel less distressed about my breathlessness and overall satisfaction. This is likely to result in whole system cost

Local clinical audit	Actions to improve quality
	reduction.
Outlying patients under acute medicine	An audit completed in 2012/2013 found that the average length of stay for outlying patients' (acute medicine patients not admitted onto the Medical Admissions Unit (MAU)) was 3.38 days longer than patients on the MAU. As a result of the audit, the following actions were implemented to improve the care provided to patients on outlying wards: • Dedicated outlier consultant ward round implemented Monday, Tuesday, Thursday and alternate Fridays. • Flexible staffing – increased use of ward team to cover outliers. The repeat audit undertaken in February 2016 demonstrated that there had been a reduction in the difference in mean length of stay to 0.47 days; however the length of stay of patients on outlying wards has increased and their discharge continues to occur later in the day. To improve consideration is being given to electronic and other improved handover, and bed management processes.
Improving HIV testing in acute medical admissions	HIV screening in acute medical admissions has been recommended in national guidance since 2008. Baseline data showed that 13% of patients less than 80 years old are being screened. The quality improvement methodology PDSA (plan, do, study, act) has been used to improve practice, which has included the introduction of stickers for notes, posters to educate staff and feedback of data collected by the team. Initial improvements were seen at launch, although these have been difficult to sustain. This is an ongoing quality improvement project, extended to August 2017.
IV fluid prescribing in acute medicine inpatients	The aim of the audit is to improve compliance with National Institute for Health and Clinical Excellence (NICE) guidance on IV fluid prescribing. To improve practice changes have been made to the drug charts in line with recommendations for fluid and electrolyte prescriptions and teaching has been provided as both formal sessions and ad-hoc for nurses and junior doctors. This has resulted in improvements across all criteria – see data below. To improve practice further the Step Up to Lead group are working on improved fluid prescribing in acute kidney injury (AKI) and complex patients and new fluid balance charts will be developed to improve documentation of fluid management plans. 

Local clinical audit	Actions to improve quality
	

Women's, Children's and Imaging	
Two person swab count audit Divisional priority audit 2016/17	This is an on-going quality improvement project led by the Royal Free and Barnet labour ward matrons in conjunction with the patient safety team. On-going observational audits continue and there have been a number of improvements made such as the introduction of white boards and a theatre checklist in the obstetric theatres on the Royal Free Hospital site. The process for counting swabs, needles and instruments has undergone a detailed process mapping exercise. Work is currently being undertaken in relation to cross site harmonisation of the operational theatre policy and revision of the perineal trauma and repair, including 3rd and 4th degree tears (OASIS) guideline, to align with the process mapping.
Post-menopausal bleeding management audit Divisional priority audit 2016/17	The aim of the audit, which commenced in January 2017, is to assess whether the pathway of care for women presenting with post-menopausal bleeding is being followed, and is appropriate given the presenting nature of their condition. A data collection proforma has been agreed for cross-site use. At the Royal Free, data collection has commenced and the audit is due for completion in June 2017. At Barnet Hospital, the audit is due to commence at the time of publication of this report.
Paediatrics early warning score (PEWS) cross-site Divisional priority audit 2016/17	This project aims to implement PEWS charts and monitor compliance and performance through PDSA (plan, do, study, act) cycles. This quality improvement project is linked to the Institute for Health Improvement work, and has been introduced at the Royal Free London involving a revision of the PEWS charts. The timescale for completion of the first PDSA cycle is expected to be quarter one 2017/18, with cross-site implementation by quarter two 2017/18. The first revision of the PEWS chart is undergoing piloting.
Neonatal safety	This project aims to introduce safety huddles to neonatal clinical areas on both sites.

Local clinical audit	Actions to improve quality
huddles Divisional priority audit 2016/17	This quality improvement project focuses on the development of the structure of the huddles and the recruitment of a representative from the core team, and champions in each area at both sites. The first improvement cycle has been launched and it is undergoing piloting in the neonatal settings.
Emergency CT head report authorisation (re-audit) Divisional priority audit 2016/17	The aim of the audit was to assess the process for CT head investigations to be reported in a timely fashion and subsequently authorised by a neuroradiologist, as per National Institute for Health and Clinical Excellence (NICE) guidance. It was undertaken at the Royal Free Hospital in quarter four 2016/17, comparing practice to the previous audit completed in quarter four 2015/16. The audit was completed at Barnet Hospital in January 2017. Key findings were: • For ward patients the average time to report was 2.16 hours with 46% within the one hour standard. • For ward patients the average time to endorse a report was 92.3 hours with 72% of all reports being endorsed at all and 9% of reports being endorsed within the one hour standard. • For Emergency Department patients the average time to report was 5.8 hours with 54% within the one hour standard. • For Emergency Department patients the average time to endorse a report was 21.1 hours with 74.4% of all reports being endorsed at all and 14% of reports being endorsed within the one hour standard. The limitations of the audit are that the option for endorsement drops off after 30 days; if the report is reviewed on PACS then there is no need to endorse the report and there is no trust guidance/protocol regarding endorsement. The following actions were recommended as a result of the re-audit and discussed at the Imaging Audit Presentation Day in January 2017 for implementation: • Formal trust guidance regarding endorsement target. • If there is no viewable report on PACS then this must be checked on the Powerchart. • Limiting access to the report unless willing to endorse. • Consider named person responsible for endorsing ('Nurse in Charge').
Novasure endometrial ablation	This project is linked to the introduction of a new interventional procedure. This audit is currently being undertaken on the Royal Free Hospital site since the finalisation of the methodology and standards by the gynaecology team. The results from this audit are anticipated to be available in April 2017. Discussions continue to determine the applicability of this intervention to Barnet Hospital site.
Truclear hysteroscopic tissue removal system	This new interventional procedure has been audited on the Barnet site, with a re-audit being undertaken and presented in December 2016 showing progress on the first audit on time taken, polyps removed, pain experienced by the women, and willingness to recommend the service to a friend. Following advice from senior colleagues, future plans include making the Truclear system available in day surgery and main theatres and training the nursing staff to set the machine. A similar prospective audit has begun at the Royal Free, with a report anticipated in May/June 2017.

Local clinical audit	Actions to improve quality
Percutaneous radiofrequency ablation (RFA) for lung cancer	This new interventional procedure has established datasets on both sites. The Royal Free site data has undergone analysis which found that: • There were 58 lung RFAs between December 2007 and June 2016. • 50% of these patients had no complications, 21 patients (36.2%) had complications but these had no clinical significance and eight patients (13.8%) had complications with some clinical significance. • In 47 patients (81%) track ablation was achieved. • 57 patients (98.3%) had a successful procedure. The Barnet Hospital site dataset is undergoing analysis.
Manual vacuum aspiration for termination	This new interventional procedure has been recently audited on the Royal Free site. • All 24 patients audited had a successful procedure and did not require further surgical or medical treatment. • Patient satisfaction was very high with 98% satisfied with their procedure. Only one was moderately satisfied with the procedure. • 95.9% would recommend this procedure to a friend and 4.1% would not recommend it. Of the 24 respondents only 19 answered the question on pain after procedure. Three out of 19 (15.8%) had pain for 2-3 days post procedure. As for pain during the procedure only 8.3% recorded the pain as moderate or more, while 91.7% recorded mild to minimal pain. 12.5% recorded no pain at all. These findings are in keeping with the evidence available in literature of 79% of patients experiencing minimal pain. No allergic reaction was noted in any of our patients and none required an overnight stay or Entonox for pain relief. Pain post procedure appeared to be the only complication. The complication rate was much less than that reported in the published literature where retained products, cervical rigidity, allergic reaction and false passage were highlighted although the numbers are small. This may well be due to routine use of cervical priming, screening for allergy at pre-assessment and ensuring completeness using an ultrasound post-procedure at the Royal Free Hospital site.
Fetal pillow	This new interventional procedure has been audited at Barnet Hospital site maternity unit and is the subject of a continuous audit managed by the clinical lead. The findings of the initial audit were: • There were eight cases where the fetal pillow was used and seven case notes were reviewed. • There were no major complications in relation to maternal or fetal outcomes. Although the numbers are small the results are promising and the fetal pillow is noted to be easy to use. A similar prospective audit began at the Royal Free site in November 2016, with the report anticipated in May/June 2017.
Engaging parents in 6 north safety culture (Royal Free only)	Multidisciplinary ward safety huddles to improve situation awareness have been embedded on the paediatric ward on Royal Free Hospital site (6 North) for the last two years. During these twice-daily huddles, children at risk of deterioration are identified and discussed by means of their paediatric early warning score (PEWS), clinician impression or parental concern. Parental concerns were identified as not being reliably

Local clinical audit	Actions to improve quality
	brought to the huddle by staff members or registered on the PEWS chart. The aim of the quality improvement project was to engage parents in the ward safety culture and to ensure any concerns regarding their child are highlighted to the multidisciplinary team as soon as possible. As part of the project, parents were engaged in the design of bedside safety information packs and daily plan whiteboards to improve communication with the multidisciplinary team and parents/carers. A traffic light system has recently been developed by frontline clinicians using the Model for Improvement to assess parental concerns: green - happy their child is getting better, amber- unsure they are getting better, and red - worried they are not getting better. An interview of 30 parents on the ward revealed that 12 felt their concerns were 'green', 12 were 'amber', and 6 were 'red', but none of the parents with 'red' concerns were highlighted at the huddle. The following actions for improvement have been implemented: • A traffic light concern chart has been put next to every bed on ward 6 North. This will open a discussion between the parent and the nurse to identify the concerns early. • The aim is for the traffic light data to be collected by the housekeeping staff (who visit every parent on their breakfast round) and brought to the morning safety huddle. Using the Model for Improvement, the service shall continue to measure the percentage of parental concerns that are discussed at the huddle and test our approach using PDSA (plan, do, study, act) cycles.
Paediatric intensive care retrievals to provide learning and feedback to the multidisiciplinary team	A multi-disciplinary team of anaesthetists, emergency physicians, paediatricians, Patient at Risk and Resuscitation Team (PARRT) nurses and the children's acute transfer service (CATS) is involved in the acute management and stabilisation of children being transferred from our Emergency Department (ED)/Ward 6N to a tertiary paediatric intensive care unit (PICU). This project focuses on the management of this patient group and the aims were to identify areas for improvement, share the learning and enhance patient safety and care. A modified version of the Rapid Evaluation Cardio-respiratory Arrest with Lessons for Learning (RECALL tool) has been used for analysis of children transferred from ED/Ward 6 North to PICU. This tool provides a structured template to review notes of children who deteriorate and identify areas for improvement. It focuses on assessment (recording of early warning scores), escalation in response to deterioration, clinical reviews at appropriate points, interventions implemented and additional information (staffing, parental concerns). The cases are analysed monthly by a multidisciplinary group and one case is identified to be presented at the clinical risk meeting (to highlight learning or excellent care). Learning is disseminated to the teams by email and displayed in clinical areas. The paediatric services have set up a new teaching session (last Friday of every month) providing feedback and learning themes. The services have also implemented the following: • Debriefs within a week of every CATS transfer (being documented on the high

Local clinical audit	Actions to improve quality
	dependency unit (HDU) patient forms). • Monitoring of the incidence of CATS transfers within our trust. • A new monthly clinical risk meeting focused on CATS liaison and transfers within the hospital. The initial feedback from trainee doctors prior to interventions was that they felt 'supported but anxious, stressed, worried, concerned, nervous, apprehensive, uncomfortable, frightened and uneasy'. Following two focused meetings to date, paediatric trainees are feeling less anxious and stressed about the retrievals and are keen for the teaching to continue. The following actions have been taken for improvement: • New monthly trust-wide newsletter to paediatric consultants, anaesthetic team and PARRT team. • New monthly learning topics newsletter to paediatricians and allied staff - placed on news boards and sent out as email. • A monthly CATS learning meeting. There are ongoing plans to continue this intervention and the dissemination of learning, and to widen the teaching sessions across the trust.
Asthma tool kit for clinic pilot for Royal Free Hospital site	There has been increased focus on asthma and as part of this quality improvement work there has been a pilot project on reducing the variability in assessment of wheeze/asthma patients in the allergy clinic on the Royal Free Hospital site. The aim is for 100% patients with wheeze/asthma to have structured documented assessment and a discharge plan as per British Thoracic Society (BTS)/National Institute for Health and Clinical Excellence (NICE) asthma guidelines i.e. correct assessment and discharge in the domains of smoking cessation, written asthma plan, flu vaccination recommendation and inhaler technique assessment. High levels of variation in practice were found in the first eight weeks of the audit and this was noted to be dependent on clinicians. Smoking cessation and flu vaccine recommendation were the areas which showed the greatest opportunity for improvement. As part of this quality improvement project ideas were collected from staff as to how to improve practice and it was agreed that a crib sheet would be helpful as a reminder to staff. This has been instituted and a further pilot is in progress to incorporate the crib sheet in the EDRM (electronic patient record system).
Too much huff, not enough puffs	This quality improvement project was initiated to improve the low confidence parents may have in managing wheeze at home, which can lead to unnecessary presentations to the Emergency Department (ED). The aim of the project is to ensure that all parents of children who have previously presented with wheeze have confidence to administer 10 puffs of Salbutamol to their child before bringing them to ED. 15 measures collected, 4/15 gave 10 puffs, 1/15 gave more than 10 puffs (15), 10/15 gave less than 10 puffs.

Local clinical audit	Actions to improve quality
	As part of this quality improvement project ideas were collected as to how to improve and the most popular idea amongst staff and parents was a sticker to put on inhaler boxes outlining a condensed wheeze plan. This sticker is in the process of being designed and printed.
Learning from excellence	This quality initiative was introduced with the aim to celebrate and learn from our everyday success, to share good practice and improve staff morale by embedding the little fixes we undertake to deliver high quality paediatric patient care. Electronic nominations via the IT incident reporting system DATIX were launched in November 2016 following successful implementation of paper nominations at Barnet Hospital paediatric department. There are now an increasing number of nominations from the Royal Free Hospital and work is underway to encourage nominations from other specialties.

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 healthcare both nationally and internationally.

Our participation in research helps to ensure that our clinical staff stay abreast of the latest treatment possibilities and 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. Patients are involved in research allowing our staff to provide 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 2016/17, that were recruited to participate in research approved by a research ethics committee was 11,725.

The figure includes 4,030 patients recruited into studies in the National Institute for Health Research (NIHR) portfolio and 7,695 patients recruited into studies that are not in the NIHR portfolio. This figure is higher than last year.

The trust is supporting a large research portfolio of over 700 studies, including both commercial and academic research. 183 new studies were approved in 2016/2017. The breadth of research taking place within the trust is far reaching and includes clinical and medical device trials, research involving human tissue, quantitative and qualitative, and observational research.

CQUIN Payment framework

A proportion of the trust income in 2016/17 was conditional on achieving quality improvement goals agreed between us, and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment Framework.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at xxxx weblink (further information to be included in the final report)

In 2016/17 a total of xxx of the trust's income was on the condition of achieving quality improvement and innovation goals xxx the final figure is still to be agreed with our commissioners.

CQUIN scheme priorities 2016/2017	Objective rationale
Staff health & well being	This national initiative made up of three areas of improvement: 1) Introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with musculoskeletal issues. 2) Healthy food for NHS staff, visitors and patients. 3) Improving the uptake of the flu vaccination for frontline staff.
Sepsis	Timely identification and treatment of sepsis in emergency departments and acute inpatient settings. Sepsis is a common and potentially life-threatening condition with around 32,000 deaths in England attributed to sepsis annually.
Antimicrobial	Reduction in antibiotic consumption across the trust and an empiric review of antibiotic prescriptions. Antimicrobial resistance has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver.
Discharge summaries	Improvement of discharge summaries in Accident and Emergency (A&E) and the Medical Admissions Unit. The trust has worked closely with Barnet Clinical Commissioning Group and local GPs to improve the accuracy and detail in its discharge summaries, which is important in providing better patient care and management of long terms conditions as well as reducing readmissions and A&E attendances.
Cancer referrals	Streamlining urgent GP referrals for suspected cancer for a first appointment within a target of two weeks for all cancers. Review of cancer patients waiting longer than 104 days from urgent GP referral to first definitive treatment. Ensuring efficient investigation, diagnosis and treatment of cancer is essential to ensuring a positive patient experience.
Maternal & child health	To embed a public health approach and implement a maternal and child health programme across the trust. Beginning at the first antenatal booking, through maternal health and paediatric care up to the age of sixteen. This affords huge potential to support, educate and refer patients early on for a range of health and

CQUIN scheme priorities 2016/2017	Objective rationale
	social risk factors and to help prevent future ill health.
Hepatitis C virus (HCV)	Supporting the infrastructure, governance and partnership working across healthcare providers working in HCV networks in their second and third years of operation to increase engagement with patients, rollout new clinical and cost effective treatment guidance, improve participation in clinical trials and enhance data collection.
Severe haemophilia	The HAEMTRACK patient reporting system is an electronic (or paper) patient-reported record of self-managed bleeding and blood product home therapy usage. This scheme aims to establish the use of the Haemtrack patient home therapy diary as an integral part of clinical care. The scheme offers financial support to all centres to improve recruitment and data quality, and to use Haemtrack as a one of the tools to optimise individual treatment.
Dose banding adult intravenous SACT	A national incentive to standardise the doses of SACT (Systemic Anticancer Therapy) in all units across England in order to increase safety, efficiency and to support the parity of care across all NHS providers of SACT in England.
Adult critical care (ACC) timely discharge	To reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays and improving flow.
Telemedicine	To improve patient experience by reducing the number of times a patient is required to attend a face-to-face outpatient appointment but instead has their follow-up care and advice conducted remotely.
Antiretroviral drug cost effective prescribing	The scheme has identified a number of switches of drug regimen making the best use of available antiretroviral drugs that have all been agreed by the clinical and patient leadership of the National HIV Clinical Reference Group Drugs Sub-Group. This ensures there is opportunity for clinicians to make choices of commissioned treatments which meet the needs of individual patients, whilst being able to maintain an effective overall approach to cost management.
Multisystem autoimmune rheumatic disease	This CQUIN is to support the development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases. This MDT arrangement will also enable longitudinal data collection, particularly of outcome measures using validated tools and the use of patient activation measurement (PAM).
Dental	Collection and submission of data on priority pathway procedures by tier, to participate in referral management and triage, and have active participation in Managed Clinical Networks (MCN).

Registration with the Care Quality Commission (CQC)

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

The CQC has not taken enforcement action against the trust during 2016/17. The trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC undertook a full comprehensive hospital inspection during the week 1-5 February 2016. The trust was rated good overall as a provider and rated good at each hospital site and for each core service at all sites, which is an unprecedented rating for a London trust. (See Part Three for further information on CQC)

Comments from the CQC

Professor Sir Mike Richards, the Chief Inspector of Hospitals

Professor Ted Baker, the Deputy Chief Inspector of Hospitals

Information on the quality of data

Good quality information ensures the effective delivery of patient care and is essential for quality improvements to be made. Improving information on the quality of our data includes specific measures such as recording ethnicity, and other equality data, which will improve patient care and increase value for money.

This section refers to data that we submit nationally.

The Patient's NHS number

A patient's NHS number is the key identifier for patient records. It is a unique 10- digit number, which is given to everyone who is registered with the NHS and allows staff to find patient records and provide our patients with safer care.

The Royal Free London NHS Foundation Trust submitted records during 2016/17 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 patients valid NHS numbers were:

% of records	2014/15	2015/16	2016/17
For admitted patient care	98.8%	98.6%	98.15%
For out-patient care	99.2%	98.6%	98.65%
For accident & emergency care	92.6%	94.4%	94.89%

General Medical Practice Code

Accuracy is essential when transferring clinical information from the trust to a patient's GP. The percentage of records which included the patient's valid General Medical Practice Code were:

% of records	2014/15	2015/16	2016/17
For admitted patient care	99.8%	99.95%	99.92%
For out-patient care	99.9%	99.96%	100%
For accident & emergency care	99.9%	99.94%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance assessment report overall score for 2016/7 was 66% and was graded satisfactory

	2014/15	2015/16	2016/17
Information governance assessment report score	70%	68%	66%
Overall grading	**satisfactory**	**satisfactory**	**satisfactory**

Payment by Results

The Royal Free London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission

Data quality

The trust continues to focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services.

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

We have recently implemented a revised data improvement strategy which sets out how data will be assured in the trust. The strategy sets out:

- A set of principles to support production, and assurance, of high quality data and its management and defines what high-quality data means in practice, along with the national and local information governance standards to which the trust works;

2.4 Reporting against core indicators

This section of the report presents our performance against eight core indicators, using data made available to the trust by NHS Digital. Indicators included in this report, show the national average and the performance of the highest and lowest NHS trust.

Areas covered will include:

1. Summary hospital-level mortality (SHMI)
2. Patient reported outcome measure scores (PROMS)
3. Emergency readmissions within 28 days
4. Responsiveness to the personal needs of our patients
5. Friends and Family test (Staff)
6. Venous thromboembolism (VTE)
7. C difficile
8. Patient safety incidents

Summary hospital-level mortality (SHMI)

Indicator:

(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period.

Royal Free Performance Jul 12 - Jun 13	Royal Free Performance Jul 13 - Jun 14	Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	National Average Performance Jul 15 - Jun 16	Highest Performing NHS Trust Performance Jul 15 - Jun 16	Lowest Performing NHS Trust Performance Jul 15 - Jun 16
0.8066 (lower than expected)	0.887 (lower than expected)	0.853 (lower than expected)	0.9053 (as expected)	**1.0** (as expected)	0.6939 (lower than expected)	1.1712 (higher than expected)

The trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.

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

The latest data available covers the 12 months to June 2016. During this period the Royal Free had a mortality risk score of 0.9053, which represents a risk of mortality 11.5% lower than expected for our case mix. This represents a mortality risk significantly below (better than) expected with the Royal Free ranked 19th out of 137 non-specialist acute trusts.

The trust has taken the following actions to improve the mortality risk score:
- 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.

https://indicators.hscic.gov.uk/webview/

Patient deaths with palliative care code

Indicator:

(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.

Royal Free Performance Jul 12 - Jun 13	Royal Free Performance Jul 13 - Jun 14	Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	National Average Performance Jul 15 - Jun 16	Highest Performing NHS Trust Performance Jul 15 - Jun 16	Lowest Performing NHS Trust Performance Jul 15 - Jun 16
24.8%	28.4%	25.4%	25.6%	**29.5%**	54.8%	0.1%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.

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 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 significant 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.

https://indicators.hscic.gov.uk/webview/

Patient reported outcome measures scores (PROMS)

Royal Free Performance 2012/13	Royal Free Performance 2013/2014	Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	National Average Performance 2015/2016	Highest Performing NHS Trust Performance 2015/2016	Lowest Performing NHS Trust Performance 2015/2016
Indicator: Groin hernia surgery						
0.07	Low number rule applies	Low number rule applies	Low number rule applies	**0.09**	0.16	0.02
Indicator: Varicose vein surgery						
0.08	Low number rule applies	Low number rule applies	**0.12**	**0.09**	0.15	0.02
Indicator: Hip replacement surgery						
0.38	0.38	0.74	**0.43**	**0.44**	0.51	0.32
Indicator: Knee replacement surgery						
0.26	0.30	0.68	**0.31**	**0.32**	0.40	0.20

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps hospitals measure and improve the quality of care provided.

http://content.digital.nhs.uk/proms

Emergency readmissions within 28 days

Indicator:

The percentage of patients readmitted to a one of our hospitals within 28 days of being discharged from our trust during the reporting period.

Royal Free Performance 2012/2013	Royal Free Performance 2013/2014	Royal Free Performance 2014/2015	Royal Free Performance Calendar Year 2016	National Average Performance 2015/2016	Highest Performing NHS Trust Performance 2015/2016	Lowest Performing NHS Trust Performance 2015/2016
Patients aged 0 to 15 years old						
4.31	4.03	NHS digital reports not available	**6.67%**	**8.77%**	10.73%	2.03%
Patients aged 16 years old or over						
8.21	7.52	NHS digital reports not available	**6.79%**	**8.00%**	11.03%	5.92%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from Dr Foster, a leading provider of healthcare variation analysis and clinical benchmarking, and compared to internal trust data. The Dr Foster data set used in this table shows our performance against non-specialist providers throughout England.

We carefully monitor the rate of emergency readmissions as a measure for quality of care and appropriateness

of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care.

The rate of readmissions at the trust for children is significantly lower (better) than expected with a relative risk of 17.31%. The readmission rate is ranked 38th lowest of the 136 non-specialist acute providers in England.

Comparatively, the rate of readmissions across the trust is 6.79% which is 10th lowest amongst non-specialist providers in England. The relative risk of a readmission within 28 days of a previous discharge is significantly lower than expected at 9.75%.

http://content.digital.nhs.uk/article/6965/Domain-3---Helping-people-to-recover-from-episodes-of-ill-health-or-following-injury

Responsiveness to the personal needs of our patients

Indicator:

The trust's responsiveness to the personal needs of its patients during the reporting period.

Royal Free Performance 2012/2013	Royal Free Performance 2013/2014	Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	National Average Performance 2015/2016	Highest Performing NHS Trust Performance 2015/2016	Lowest Performing NHS Trust Performance 2015/2016
65.6	67.4	68.6	69.9	**69.6**	86.2	58.9

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results.

The NHS has prioritised, through its commissioning strategy, an improvement in hospitals' responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is below (worse than) the national average.
https://indicators.hscic.gov.uk/webview/

Friends and Family Test (Staff)

Indicator:

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.

Royal Free Performance 2013	Royal Free Performance 2014	Royal Free Performance 2015	Royal Free Performance 2016	National Average Performance 2016	Highest Performing NHS Trust Performance 2016	Lowest Performing NHS Trust Performance 2016
76%	71%	72%	75%	**70%**	85%	49%

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.

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 a world class care programme embodying these core values; 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.

http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

Venous thromboembolism (VTE)

Indicator:

The percentage of patients who were admitted to hospital and risk assessed for venous thromboembolism during the reporting period.

Royal Free Performance Oct 13 - Dec 13	Royal Free Performance Oct 14 - Dec 14	Royal Free Performance Oct 15 - Dec 15	Royal Free Performance Oct 16 - Dec 16	National Average Performance Oct 16 - Dec 16	Highest Performing NHS Trust Performance Oct 16 - Dec 16	Lowest Performing NHS Trust Performance Oct 16 - Dec 16
98.0%	96.1%	97.1%	96.6%	**94.5%**	100.0%	76.5%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust

data.

The Venous Thromboembolism (VTE) data presented in this report is for the period July to September 2014 and October to December 2014. On 1 July 2014 the trust acquired Barnet and Chase Farm Hospitals NHS Trust. Therefore the period reported includes VTE data for all trust sites including the Royal Free, Barnet and Chase Farm Hospitals.

Many deaths in hospital result each year from Venous Thromboembolism (VTE), which are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE.

The trust performed better than the 95% national target and the national average, achieving 96.6%.

We intend to take the following actions to improve our VTE risk assessment rate:

- The trust reports its rate of hospital-acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee.
- Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings. In addition the thrombosis unit conduct a detailed clinical audit into each reported case of HAT. Findings were shared with the wider clinical community.

https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-201617/

C. difficile

Indicator:

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.

Royal Free Performance Oct 12 - Mar 13	Royal Free Performance Oct 13 - Mar 14	Royal Free Performance Oct 14 - Mar 15	Royal Free Performance Oct 15 - Mar 16	National Average Performance Oct 15 - Mar 16	Highest Performing NHS Trust Performance Oct 15 - Mar 16	Lowest Performing NHS Trust Performance Oct 15 - Mar 16
2,528 (6.3)	2,422 (6.9)	5,734 (34.7)	5,915 (36.5)	**3,643 (47.9)**	11,998 (40.9)	334 (16.1)

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre, compared to internal trust data, and data hosted by the Health Protection Agency.

Clostridium difficile can cause severe diarrhoea and vomiting. The infection has been known to spread within hospitals particularly during the winter months. Reducing the rate of Clostridium difficile infections is a key government target.

Royal Free London performance was significantly higher (worse) than the national average during 2012/13. While the rate has reduced significantly it remains above the national average during 2013/14. More recent internal trust data for the period 2014/15 demonstrates that for the period April 2014 to February 2015 the Royal Free Hospital had recorded 25 infections against a plan of 35 and was therefore compliant with its national trajectory. However it should be noted that during this period the trust acquired Barnet and Chase Farm Hospitals NHS Trust, and with those sites included the trust recorded more infections that its annual plan.

The trust intends to take the following actions to reduce the rate of C. difficile infections:

- In order to demonstrate robust governance and ensure performance improvement during 2013/14 the trust asked for independent scrutiny, via a national expert of our infection control processes. The trust also invited two other national experts to review adherence to infection control policy. The action plan arising from the reviews has been considered and fully implemented.
- In addition the trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code.

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data%20

Patient safety incidents

Indicator:

(a) The number and rate of patient safety incidents that occurred within the trust during the reporting period and;
(b) The number and percentage of such patient safety incidents that resulted in severe harm or death.

Royal Free Performance Oct 12 - Mar 13	Royal Free Performance Oct 13 - Mar 14	Royal Free Performance Oct 14 - Mar 15	Royal Free Performance Oct 15 - Mar 16	National Average Performance Oct 15 - Mar 16	Highest Performing NHS Trust Performance Oct 15 - Mar 16	Lowest Performing NHS Trust Performance Oct 15 - Mar 16
2,528 (6.3)	2,422 (6.9)	5,734 (34.7)	**5,915 (36.5)**	**3,643 (47.9)**	11,998 (40.9)	334 (16.1)
25 (0.99%)	22 (0.91%)	43 (0.75%)	**26 (0.44%)**	**20.09 (0.55%)**	0 (0.00%)	119 (3.00%)

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS).

The National Patient Safety Agency regards the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported significantly less incidents than the national average during October 2013 to March 14.

The trust has implemented a number of actions to improve the quality and coverage of reporting:

1) The trust purchased a web-based reporting tool with the aim of simplifying the process for staff to report incidents and to export data to NRLS. Experience from other trusts has indicated that the introduction of a web-based tool significantly increases the volume of forms submitted by staff. The web-based system went live during February 2013.

2) In addition the trust has developed a patient safety campaign with the aim of focusing on improving the patient safety culture, including encouraging staff to report incidents and providing timely feedback to staff on the outcomes and learning resulting from incident investigations.

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.

https://indicators.hscic.gov.uk/webview/

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 2016/17 against indicators and national priorities selected by the board in consultation with our stakeholders.

Our external auditors PricewaterhouseCoopers LLP (PwC) are required under NHS Improvement requirements for quality reports; *Detailed Guidance for External Assurance on Quality Reports'* to perform testing on two national indicators. A detailed definition and explanation of the criteria applied for the measurement of the indicators tested by PwC is included below.

(This section will be completed following external assurance from our auditors which will be undertaken in April 2017)

3.1 Overview of the quality of care in 2016/17

In 2016/17, the trust has continued to address some of the challenges it has faced since the acquisition of Barnet and Chase Farm Hospitals in July 2014. In the case of the 18 week Referral to Treatment (RTT) and 6 week diagnostics waiting time standards, significant progress has been made as a result of work to validate historically poor data and to clear backlogs. The trust returned to standard against diagnostics in March 2016 and we anticipate compliance for the year. It also returned to standard against RTT in June 2016 and has been compliant since.

The trust has continued work to improve our cancer pathways, with a full recovery programme for the 62-day GP referral to first treatment waiting times standard in operation since July 2016. Progress to date has seen performance sustained above 80% since November and the trust is working towards compliance with the 85% standard by the beginning of 2017/18. Particular progress has been made in ensuring prostate cancer patients receive diagnostic imaging and biopsies on the same day, significantly reducing waiting times.

Performance against the four hour Accident and Emergency (A&E) waiting time standard over 2016/17 has continued to be challenging and the trust is currently ranked 10th in comparison to other London A&E providers. The trust is working closely with its system partners to deliver a programme of work that will address these issues in 2017/18.

We are ranked between seventh and ninth best performing against the two main measures of mortality risk 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.

Our estate modernisation programme has continued with the first two phases of the new emergency department redevelopment being completed and open to the public. The new dedicated paediatric department, ambulatory emergency care and temporary short stay wards opened in August 2016 and the new waiting room and reception area were commissioned in February 2017. The Chase Farm Hospital new build is currently on schedule to open in autumn 2018.

Our focus for 2017/18 is to ensure that all parts of our trust can reach and maintain the standards of our best services. The group model developments, including the new clinical practice groups, will be core to delivering this. Our key challenge will be to return to compliance with the A&E four-hour standard while maintaining performance against the other waiting time standards.

3.2 Performance against key national indicators

The charts and commentary contained in this report represents the performance for all three of our hospitals (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 include in the quality accounts. The prescribed indicators data is sourced from the Health and Social Care Information Centre where in the majority of cases data is 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 of English teaching hospitals. The metrics reproduced in this section are a list of well-understood metrics that help measure clinical outcomes, operational efficiency, waiting times and patient safety.

The Trust presents a number of non-prescribed indicators that describe our performance on a number of indicators that cover; patient safety, clinical effectiveness and patient experience.

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) • Accident and Emergency 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

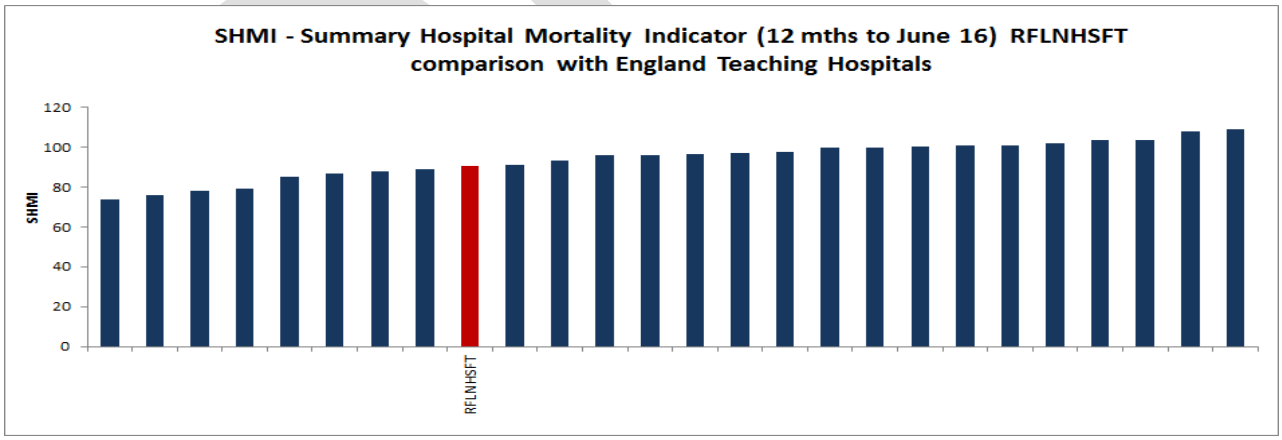
Summary of our performance against key national indicators

Our **SHMI** ratio was **90.53 or 9.47% better than expected.** For this period the Royal Free had the **9th** lowest relative risk of mortality amongst the 26 large England teaching hospitals	We recorded the **7th** lowest relative risk of mortality **(HSMR)** of any English teaching trust with a relative risk of mortality of **92.36** which is **7.64%** below (statistically significantly better than expected)	Against the 25 teaching trusts, the Trust is ranked **8th** lowest with **a rate of 1.21 MRSA bacteraemias per 100,000** bed days
For **C.diff**. the trust is ranked **23rd** out of **25** English Teaching Hospitals for the 12 month period to end January 2017 with **a reported rate of 41.8** per 100,000 bed days	The trust **returned to compliance** against the **(RTT)** incomplete pathway standard in **June 2016** and continues to maintain compliance	During the period April 2016 to January 2017, we achieved **87.92%** compliance against the **95% 4 hour standard** for our **A&E performance**

We **performed better than the national targets** in relation to the **two week** and **31** day cancer waiting time standards.	We treated **84.7%** of elective admissions as **day cases**; this was the **highest proportion** across the group of large teaching providers	We reported the **10th lowest** average **length of stay** across the large teaching provider peer group.
The trust **underperformed** against the **62** day cancer waiting time standard.	As a ratio, the trust rate of **0.2%** is the **eighth** lowest **rate of cancellations** across the English teaching hospitals peer group	**30%** of the **delayed transfers of care** observed across the trust were attributable to social care delays

Patient Safety

Summary Hospital Mortality Indicator (SHMI)

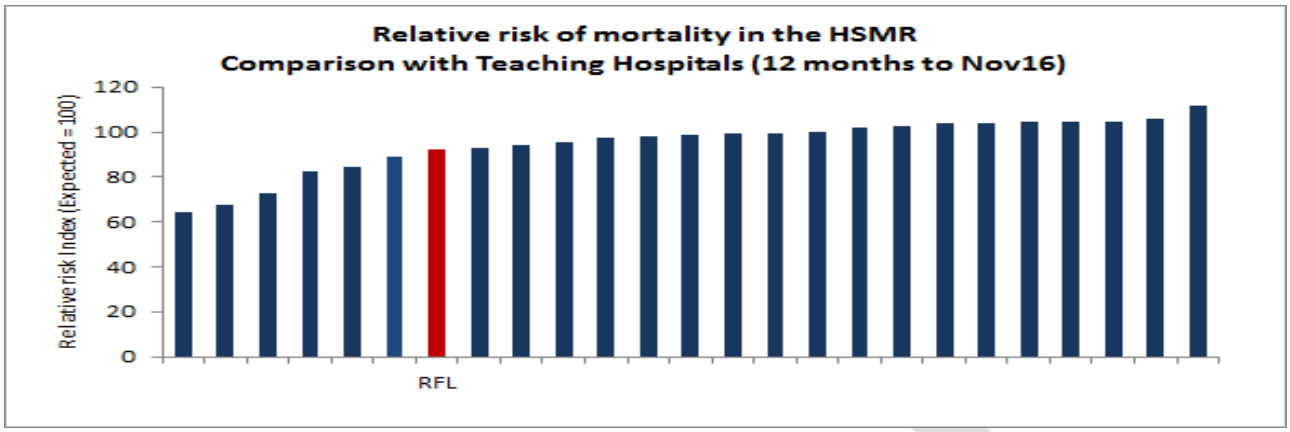


SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. This expression of mortality risk includes all diagnoses and mortality occurring up to 30 days post discharge.

The observed volume of deaths is shown alongside the expected number (casemix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better than) expected with a figure of 105 indicating a performance 5% higher (worse than) expected. SHMI data is presented for the 12-month period ending June 2016 and therefore covers the period post-acquisition of Barnet and Chase

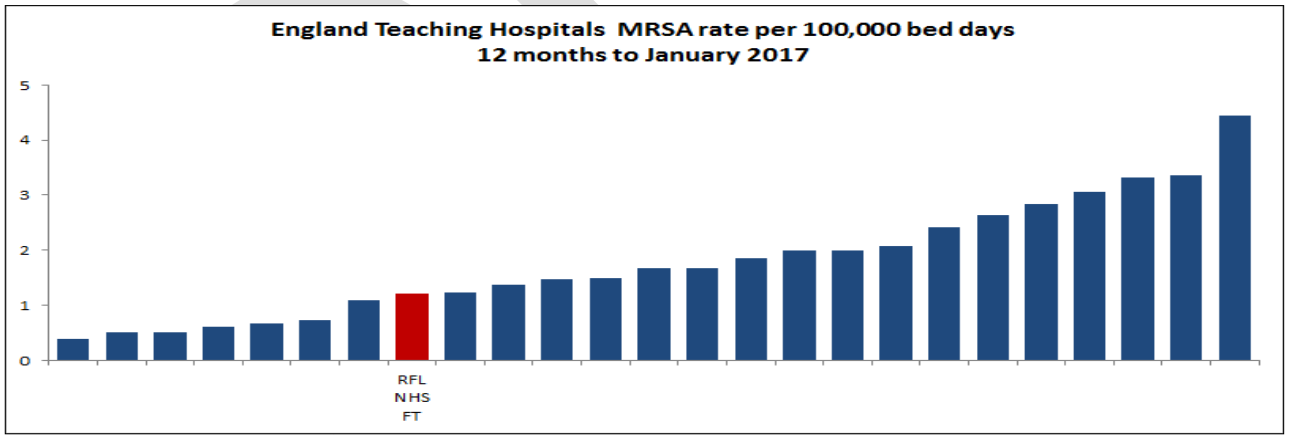
Farm Hospitals NHS Trust. During this time, the trust SHMI ratio was 90.53 or 9.47% better than expected and we had the 9th lowest relative risk amongst the 26 large English teaching hospitals (Data source: Dr Foster Intelligence/Health and Social Care Information Centre).

Hospital Standardised Mortality Ratio (HSMR)



The HSMR (Hospital Standardised Mortality Ratio) includes 56 diagnoses responsible for 80% of deaths and only includes in-hospital mortality. Data shows that for the 12 months to the end of November 2016, the trust recorded the 7th lowest relative risk of mortality of any English teaching trust with a relative risk of mortality of 92.36, which is 7.64% below (statistically significantly better than expected). (Data source: Dr Foster Intelligence/Health and Social Care Information Centre).

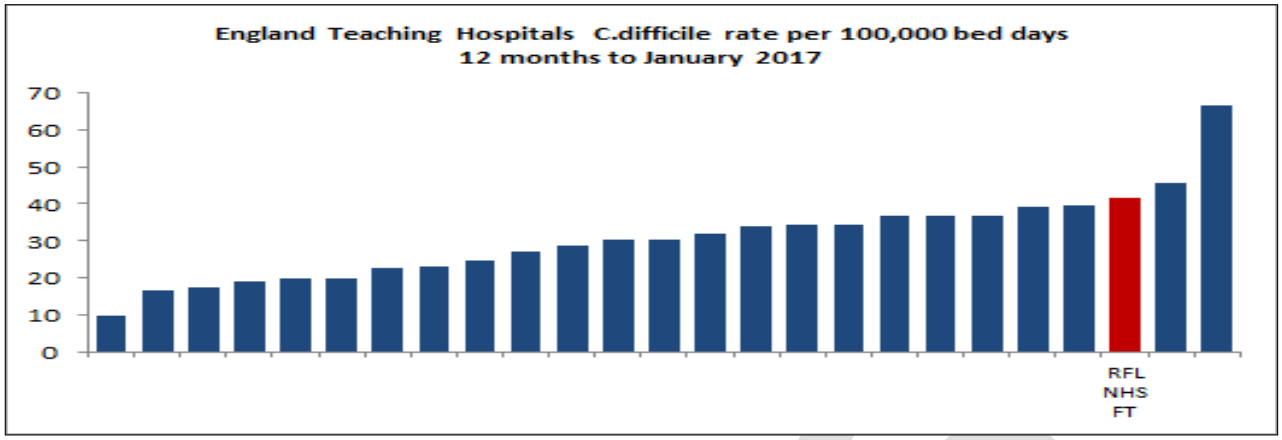
Methicillin-resistant staphylococcus aureus (MRSA)



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 12 months to the end of January 2017 the Royal Free London reported two MRSA bacteraemias. Against the 25 teaching trusts, the trust is ranked 8th lowest with a rate of 1.21 bacteraemias per 100,000 bed days (Data source: Public Health England).

C. difficile



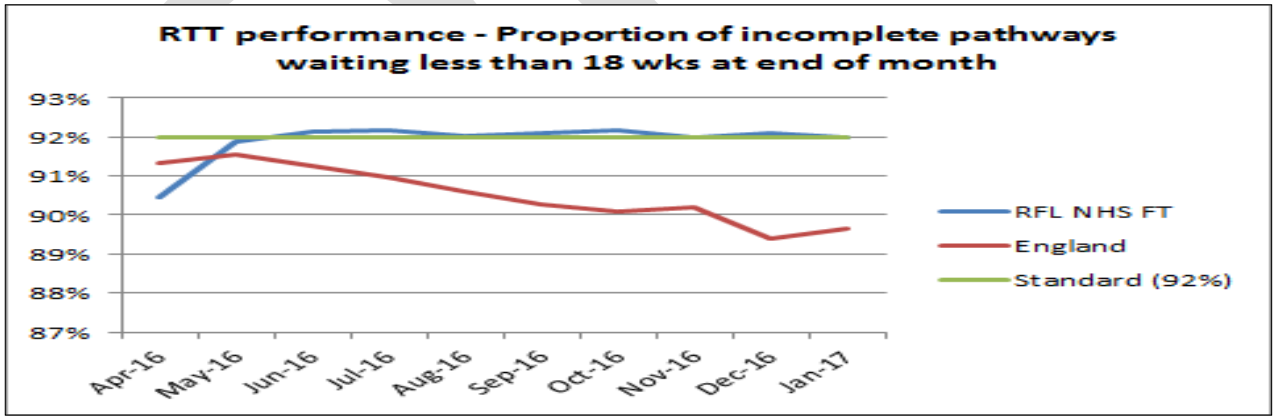
In relation to C. difficile the trust's regulator, Monitor, assesses performance for those infections deemed to result from lapses in care.

The trust has been compliant with its national trajectory for the entirety of 2015/16, ranked 23rd out of 25 English teaching hospitals for the 12-month period ending January 2017 with a reported rate of 41.8 per 100,000 bed days.

It is important to note that the objective for C. difficile cases in 2016-17 was rolled over from 2015-16 and remained at 66 cases. The rate represented by our numerical objective is 41.9 infections per 100,000 bed days. The Trust is therefore compliant with this objective for the most recent 12-month period for which data is available. (Data source: Public Health England).

Clinical Effectiveness

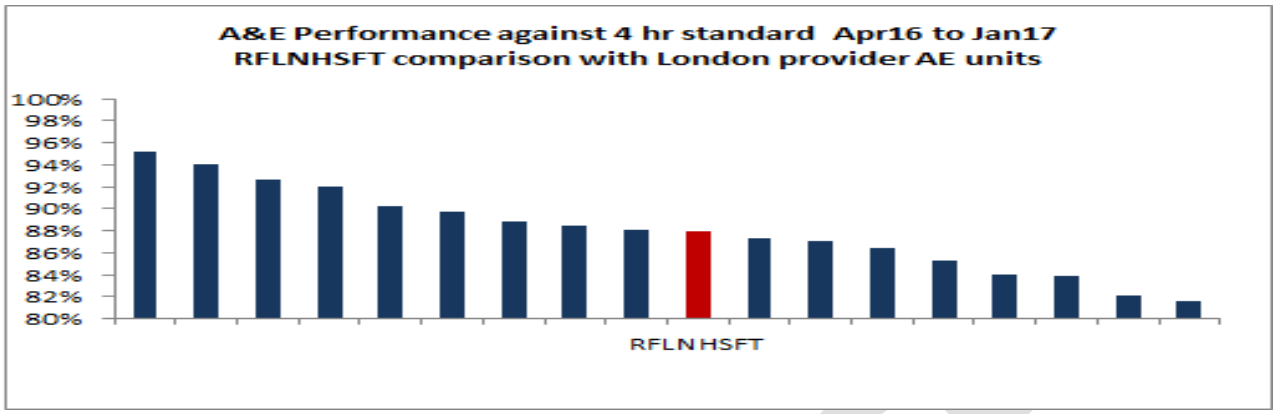
Referral to treatment (RTT)



In England, under the NHS Constitution, patients have the right to access consultant-led services within a maximum waiting time of 18 weeks. This is known as referral to treatment (RTT) and we report our performance to the Government on a monthly basis.

There is one single national measure of performance, incomplete pathways (patients waiting for treatment), with the expectation that 92% of patients will have been waiting less than 18 weeks at the end of each month. The trust returned to compliance against the incomplete pathway standard in June 2016 and continues to maintain compliance (Data source: National Health Service England).

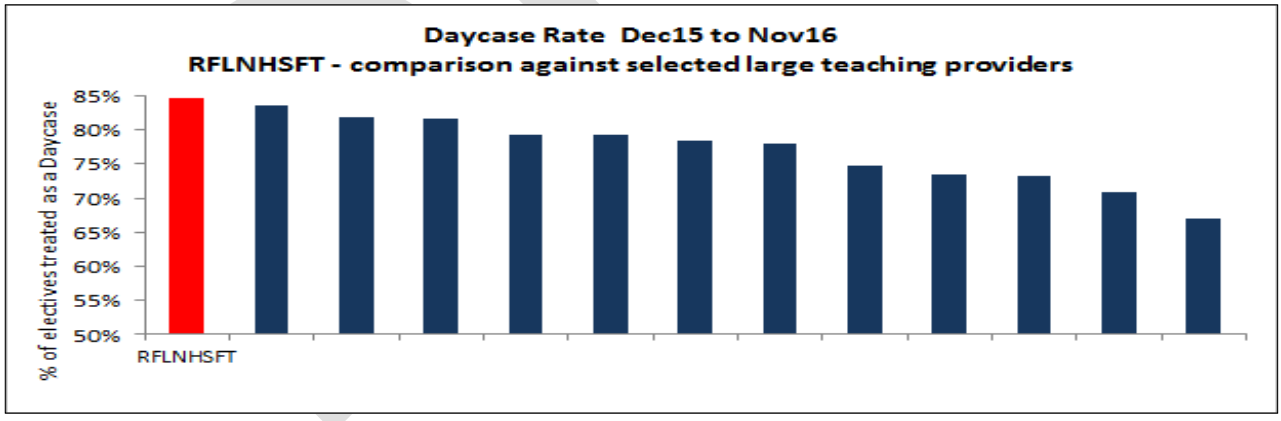
A&E performance



The graph summarises the Royal Free London's performance in relation to meeting the 4-hour maximum waiting 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 2016 to January 2017, the trust achieved 87.92% compliance against the 95% 4-hour standard. Pressure on A&E 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 A&E department. (Data source: National Health Service England).

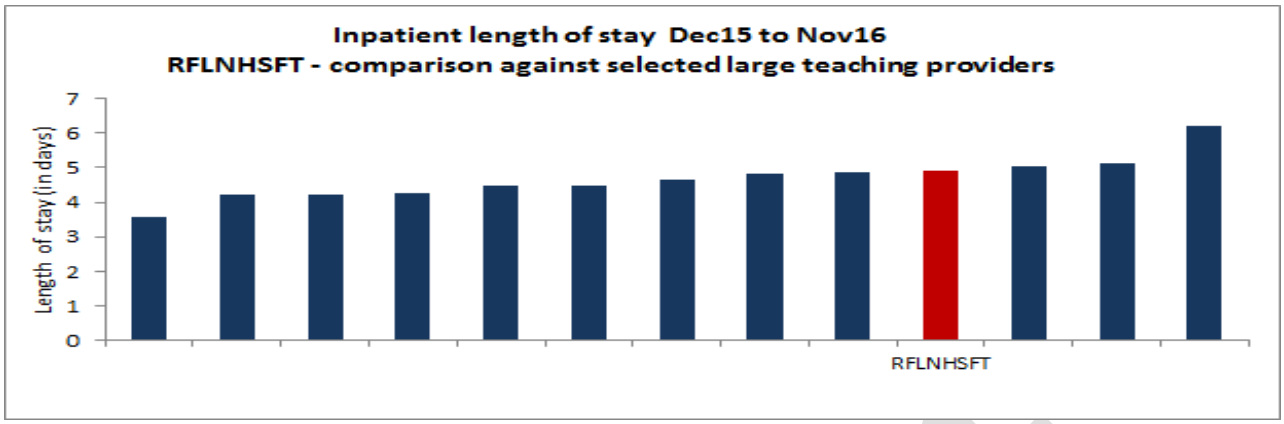
Day case rate



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 2015 to November 2016, the trust treated 84.7% of elective admissions as day cases, which was the highest proportion across the group of large teaching providers. (Data source: Dr Foster Intelligence Ltd).

In-patient length of stay

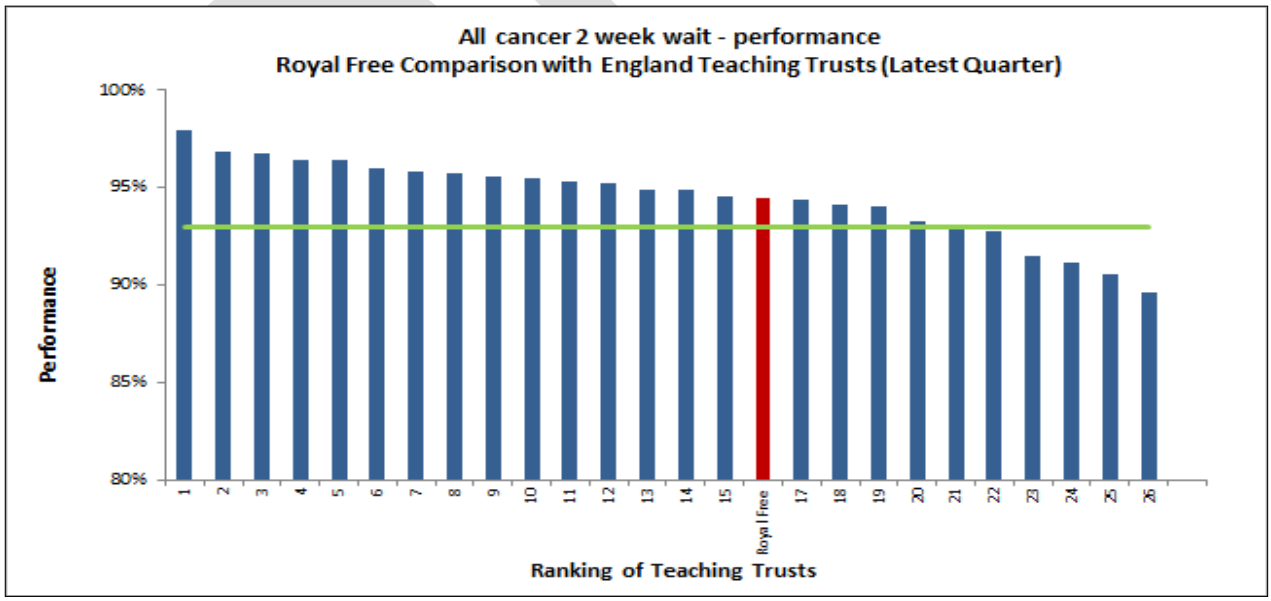


Length of stay is also an important efficiency indicator with, in most cases, a shorter length of stay being indicative of well-organised and effective care. A shorter length of stay can also result in better outcomes with a reduced infection risk. Between December 2015 and November 2016, the trust reported the 10th lowest average length of stay across the group of large teaching providers.

We can analyse our actual length of stay against an expected value once our acuity and patient demographic are taken into account. Our length of stay for this period was 4.9 days against an expected 5.5 days. (Data source: Dr Foster Intelligence Ltd).

Cancer waits

All cancer 2 week waits



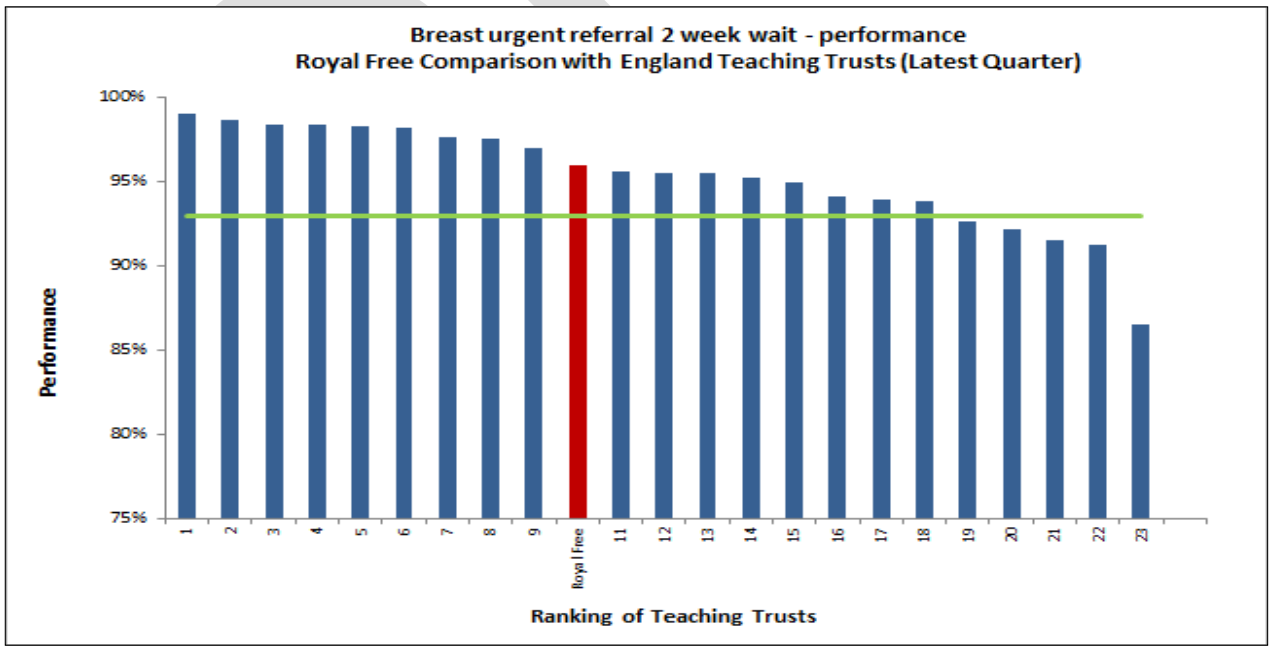
Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed diagnosed and treated the better the clinical outcomes and survival rates.

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.

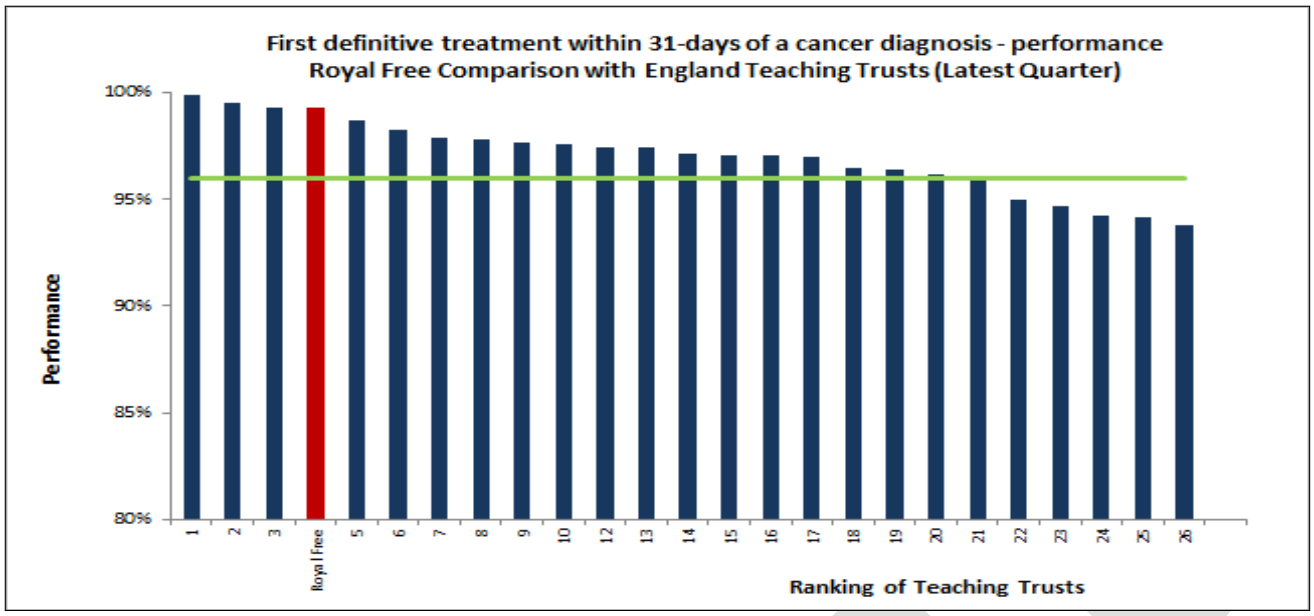
National data is provided for the period October 2015 to December 2015, which is the most recent available.

The trust performed better than the national targets in relation to the two-week wait and 31 day standards in this time period.

Breast Urgent referral two week waits



First definitive treatment within 31 days



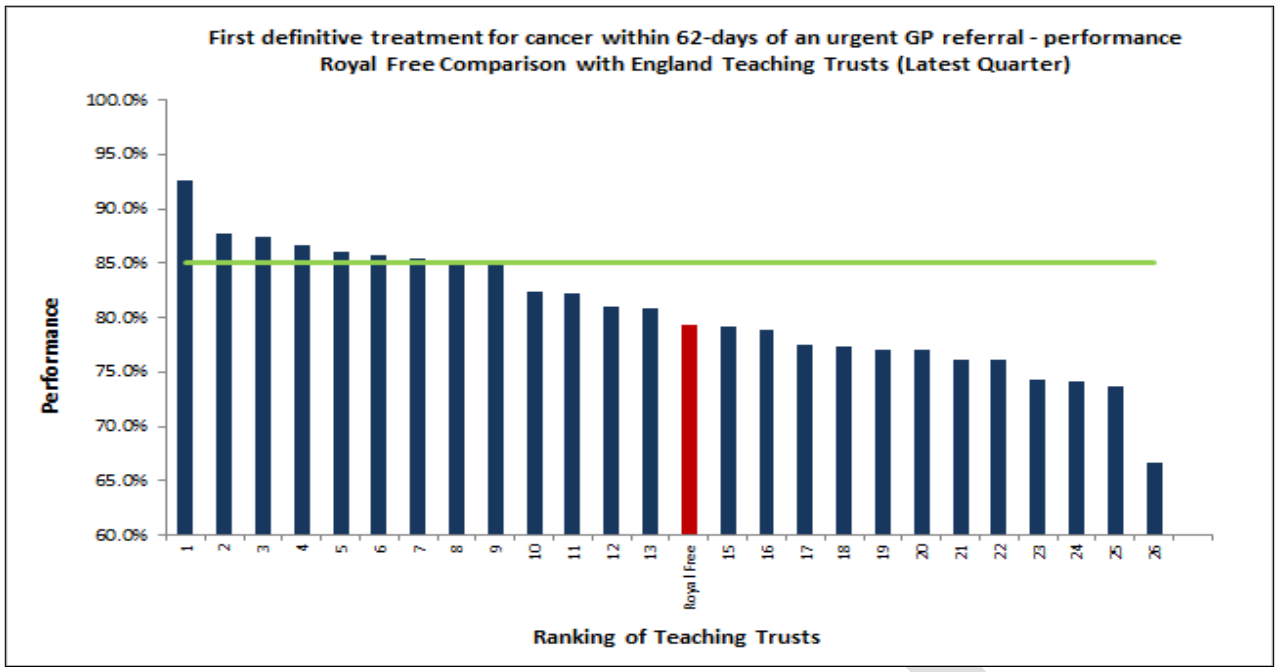
The trust underperformed against the 62 day standard.

Underperformance is being driven by a backlog across a number of tumour sites, most notably urology where there has been significant capacity issues in the diagnostic and tertiary centre surgical stages of treatment. 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 for initial referral to first appointment two-week waits and waits for diagnosis are improving as a result. However the trust is still working through a considerable backlog, which built up prior to the implementation of the improvement programmes.

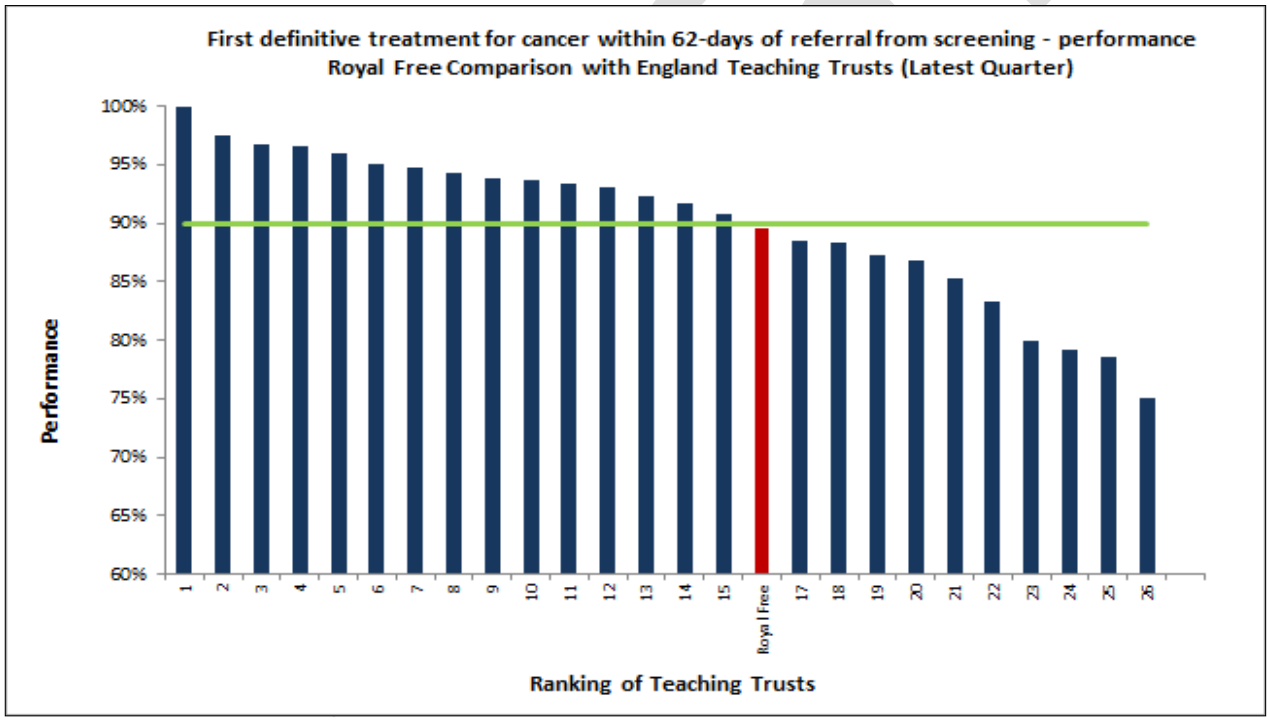
In response the trust has set out a detailed recovery plan to deliver a sustainable waiting list by the end of March 2016 and a return to national target compliance from April 2016.

The graphs present the trust performance compared to English teaching trusts and the relevant national target (Data source: National Health Service England).

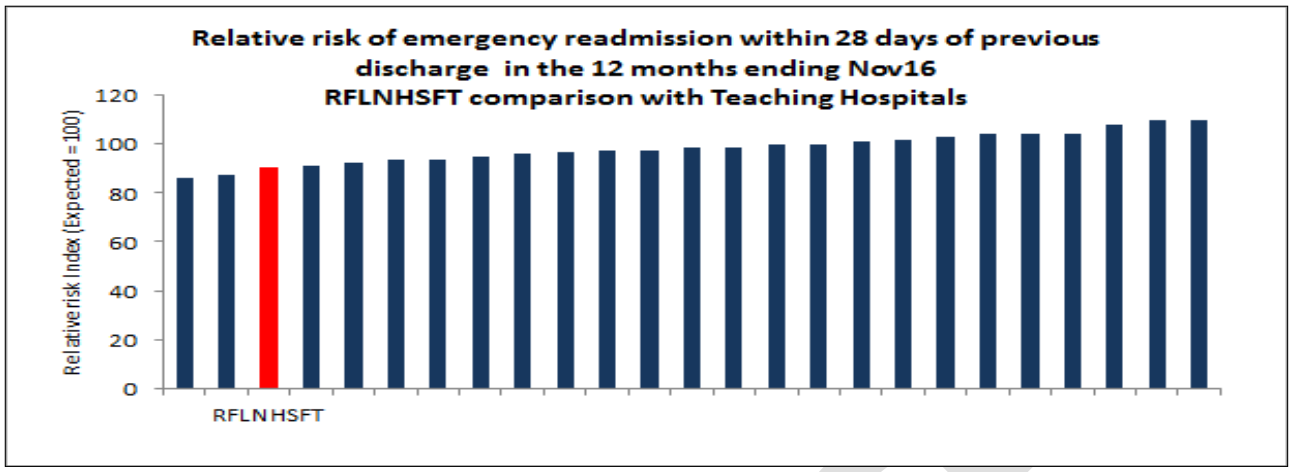
First definitive treatment within 62 days of an urgent GP referral



First definitive treatment within 62 days of referral from screening



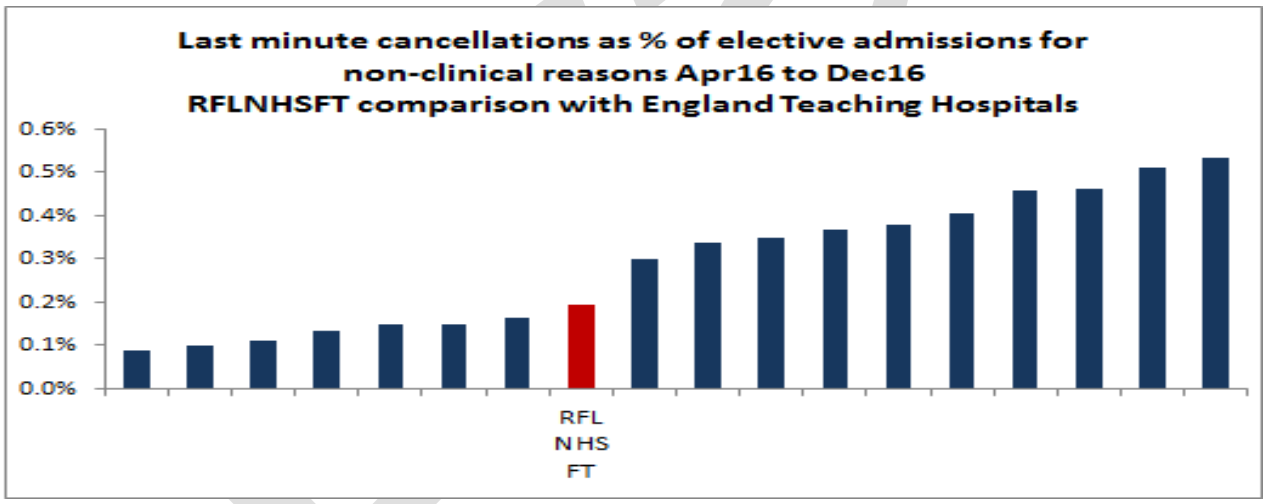
Readmissions



The 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 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 where the trust had the third lowest relative risk of readmission across the group of 25 English teaching hospitals (Data source: Dr Foster Ltd).

Patient experience indicators

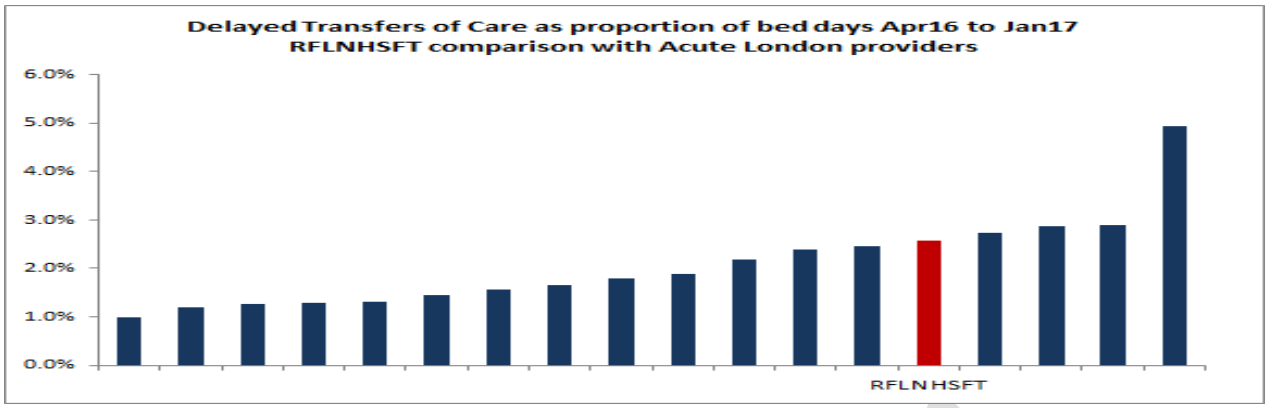
Last minute cancellations



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

From April 2016 to December 2016, the trust cancelled admission for 294 patients at the last minute for non-clinical reasons. This translates into a rate of 1.9 cancellations per 1,000 admissions. The trust rate of 0.2% is the eighth lowest rate of cancellations across the English teaching hospitals peer group (Data source: NHS England).

Delayed transfer of care



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 patient's transfer.

This causes a waste of hospital resources and inappropriate care for the patient. The aim, therefore, is to reduce the rate of delayed transfers. 30% of the delayed transfers of care observed across the trust were attributable to social care delays (Data source: NHS England).

Friends and family test (patients)

The Friends and Family Test (FFT) was introduced in April 2013. Its purpose is to track and improve patient experience of care. Across England the survey covers 4,500 NHS wards and 144 Accident and Emergency services.

We are not commissioned to provide community services under the auspices of a community services contract or any of those services that are associated with a community provider. However we do provide services in the community, largely out-patient and ambulatory, based across Camden, Barnet and Enfield.

(Data to follow)

3.3 Our local improvement plans

This section contains additional areas of our local improvement plans and data on our performance with our cancer targets.

This also includes:

- Chase Farm redevelopment
- Care Quality Commission (CQC)
- Patient safety
- NHS staff survey (KF21 and KF26)
- Complaints

Throughout 2016/17 we have undertaken additional measures to support our delivery of world class expertise and local care and plans are in place to drive this.

Chase Farm redevelopment - health and wellbeing programme

The acquisition of the Chase Farm Hospital site by the trust gave us an opportunity to help promote the health and wellbeing of the patients using our services, the staff working on the site and the local community.

The Public Health White Paper (2010) stressed the importance of joined up services and tackling the major causes of health and disability in our community. The Royal Free London is committed to working with partners not only to treat people in poor health, but to look at ways in which we can prevent ill health and improve outcomes for people.

We have developed a health and wellbeing plan for Chase Farm setting out our approach to improving the health and wellbeing of the population using Chase Farm Hospital and the community living around it.

To help deliver the plan we set up a multi-agency group with the following aim:

To oversee implementation and delivery of the health and wellbeing programme including joint working with partner agencies.

This includes the following:

1) The trust has a role to promote the health of the local population, its patients and staff.
2) A healthier environment is good for patients, staff and communities.
3) Working in partnership with the local council, NHS and third sector partners to ensure our programme of work reflects and supports local health need.

This group has membership from Chase Farm staff, the London Borough of Enfield public health team, a local councillor, and local charity groups including the London Borough of Enfield carers group, Health Watch Enfield and Macmillan cancer charity.

Outcomes achieved in 2016:

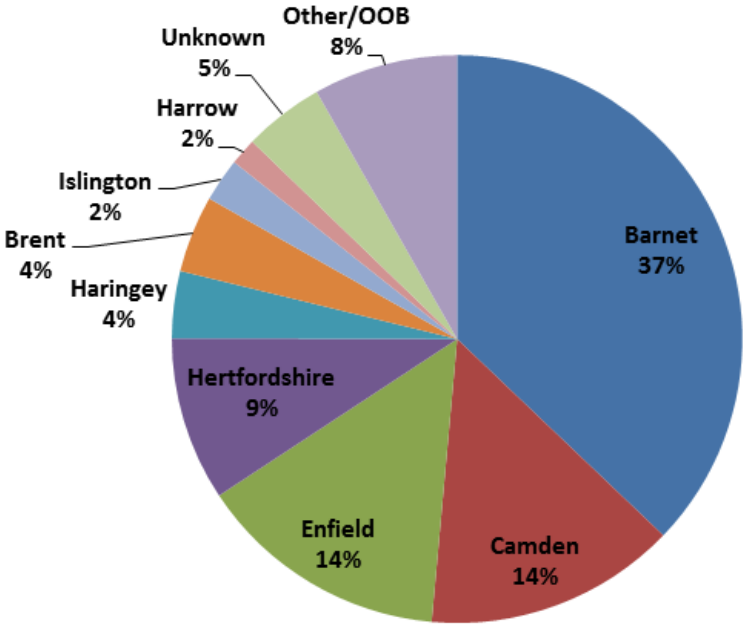
For patients:

- A stop smoking advisor for patients, staff and construction workers is in place. So far they have seen 288 referrals - 83 were Enfield residents and seven members of staff (three of whom are also Enfield residents).

- An Independent Domestic and Sexual Violence Advisor (IDSVA) is in place and training is taking place with staff to encourage them to ask about domestic abuse and refer patients. The service for Chase Farm has been in place since October 2016. Since then there has been 15 referrals from Chase Farm Hospital directly but in total 14% (525) of the service referrals are Enfield residents.

- The highest proportion of referrals comes from the trust's main catchment areas: Barnet, Camden, Enfield and Hertfordshire. Three in four of all referrals (75%) reside in one of these areas. 37% of referrals were from Barnet, 14% from Camden, 14% from Enfield and 9% from Hertfordshire.

Graph: Proportion of DV referrals by borough of residence: Q2 2015/16 to Q3 2016/17 (Source: Royal Free London)



Staff health initiatives:

- Initial discussions have begun on training staff on 'making every contact count' and introducing a social prescribing pilot at Chase Farm where people are linked up with support within the community.
- Weekly walk now in place for staff organised by Tottenham Hotspur Football Club and Macmillan (free piece of fruit for all walkers!).
- Weekly on site discounted yoga classes for staff – average of 14 participants per class.
- Weekly discounted pilates class now on site.
- Health checks for staff – 85 participants seen so far for checks on BMI, cholesterol, glucose and blood pressure. A health trainer who is present every Thursday has set a programme in place for 12 staff.
- New Year event to be held on 31 January where staff can sign up for a boot camp, Shape Up with Spurs, Slimming World vouchers, a free health check, the Royal Free Step Challenge and a walking trip to Mount Snowden.
- Healthy café offering free fruit if you spend £4 or more.

In September, as part of NHS Healthy Living Week, an outdoor green gym and café was opened at Chase Farm for patients, staff and visitors.

Service moves and improvements

Through working with Health Watch we have significantly improved disabled access for patients and carers at Chase Farm. In addition we have moved cardiology and echo services so they are now side by side. Our preoperative assessment area has been moved from a building in a poor state of repair to the Highlands building which is within the main body of the hospital.

Our very busy phlebotomy service has not only moved to much better facilities but has started an appointment service. For patients attending, waiting times are now much reduced leading to a far more responsive service, which in turn has reduced complaints.

The endoscopy service has moved to a brand new building in order to be able take on the additional demands created by the implementation of new screening programmes.

We have been limited in our improvements within the constraints of an old hospital site, but the new hospital build will enable care to be provided within first class facilities by 2018.

Community involvement

Throughout the year we have continued to liaise with community groups across Enfield and Hertfordshire, in particular to provide information about the developments at Chase Farm. We have engaged with Love Your Doorstep Enfield who connect with thousands of local residents through social media, updated twitter feeds, gone out to community patient groups, held Chase Farm stakeholder events, ensured the communication hub on site is well manned and produced a quarterly newsletter. In September we were represented at the Enfield show and many local residents visited our stand to find out more about the new hospital and the improvements underway at Chase Farm.

In addition the Royal Free Charity has engaged with us to increase the number of volunteers on site and has been successful in fundraising to provide a dementia garden and rehab garden facilities for patients. The mayor of Enfield took a particular interest and gave support to this work.

Our contractor, IHP, responsible for the new building is working with local schools regarding art projects connected with the new build. In addition we are involved with the open doors construction scheme where young people who are considering a career in the construction industry are able to register an interest to visit the site to learn more about opportunities available.

Lastly we have been working with a small local social enterprise company to promote communication further and to capture a record of the facilities provided on site and the progress of the new build throughout the seasons.

Care Quality Commission

The Care Quality Commission undertook a full comprehensive hospital inspection during the week 1-5 February 2016. The trust is rated good overall as a provider and good at each hospital site, and for each core service at all sites, which is an unprecedented rating for a London trust.

Royal Free London NHS Foundation Trust

Quality Report

Royal Free Hospital
Pond Street, London NW3 2QG
Tel: 020 7794 0500
Website: www.royalfree.nhs.uk

Date of inspection visit: 2 - 5 February 2016
Date of publication: 15/08/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

The trust was found to require improvement for the safety domain and for specialist community mental health services for children and young people (CAMHS) in the safe and responsive domain.

Our ratings for Royal Free Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Barnet Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Chase Farm

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

The trust has developed and submitted a responsive action plan in relation to the regulatory breaches concerning the suitability of the premises from which the current CAMHS are provided and for issues regarding privacy and dignity, notably inadequate soundproofing of consultation rooms.

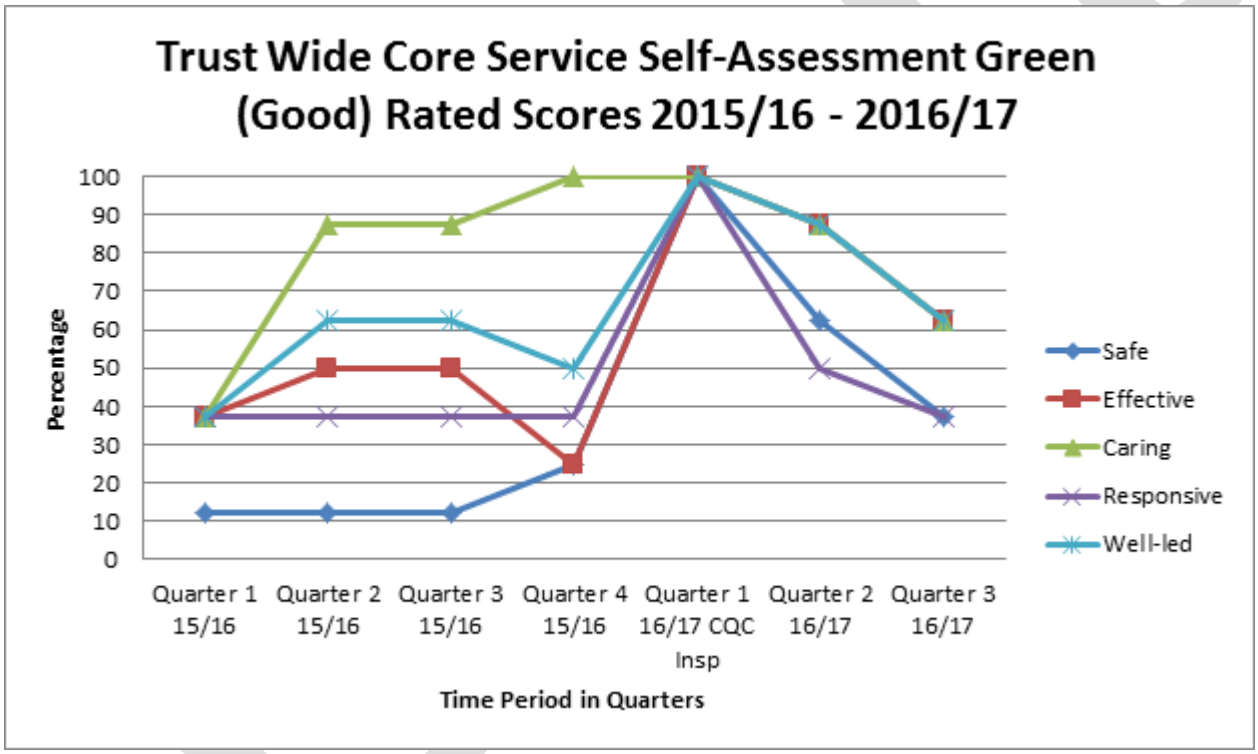
NHS Improvement is responsible for overseeing our improvement actions and will monitor the implementation through a quarterly forum. The responsive action plan is reported and monitored at the trust's patient safety committee.

To improve our services for children and young people within CAMHS, we intend to move this service to an alternative site within Hampstead, which will enable the provision of care to meet the needs of our users and provide appropriate privacy and dignity during their consultation. The new service will be located at Queen Mary House from May 2017.

Action planning for improvement:

The trust historical Care Quality Commission self-assessment process, initially introduced in 2010, has been a key driver earlier in the year in raising awareness of the trust comprehensive hospital inspection and was instrumental in the preparation for inspection as well as connecting the core service teams with their identified areas of improvement across services.

The quarterly self –assessment process is informed by the new model of inspection and is designed to encourage services to assess themselves and understand their compliance for their services. These arrangements require each clinical division to lead and embed assessing compliance for their core services across all trust locations. It also provided the opportunity for the core services to lead and develop responsive quality improvement initiatives across sites to further spread and share knowledge in areas of best practice amongst services in response to quality and safety outcomes.



Percentage scores are derived from the number of green scores identified for each of the eight core services reported throughout the 2015/16 and 2016/17 quarterly self-assessment executive panel review meetings.

Improving Patient safety

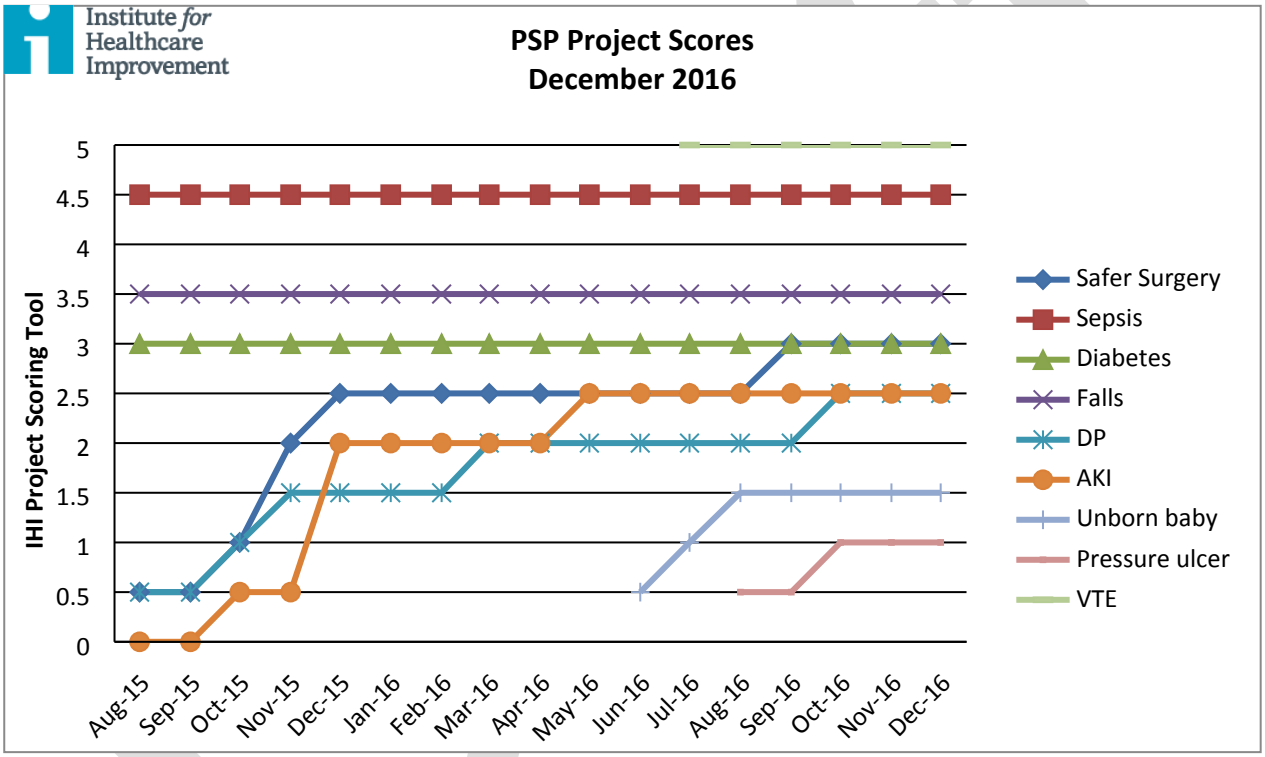
Patient safety programme

As shown through our quality account priorities, patient safety remains integral to the delivery of safe and effective care for our patients. The quality accounts patient safety priorities are based on phase 1 and 2 of the clinical patient safety programme workstreams. Our patient safety programme sets out actions that we will undertake in response to the five sign up to safety pledges via our local safety improvement plan.

Patient Safety Programme

The patient safety programme includes the development of improving patient safety capability, capacity and culture across the trust over three years from April 2015 to March 2018.

We have identified new pilot wards/areas for improvement work on falls, sepsis, deteriorating patient, diabetes, acute kidney injury, safer surgery and pressure ulcer prevention. Alongside this the trust is starting to implement the quality strategy to develop capacity and capability in quality improvement training for frontline staff. We know that in the recent staff survey on quality (Dec-16), patient safety was identified as a key area to enable quality improvement.
With investment in staff and training via the quality strategy, we expect there to be a significant improvement in this area over the next few years.



Implementing the duty of candour (DoC)

We have implemented the 'being open' policy 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 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.

All incidents which meet the duty of candour criteria are reviewed at our serious incident review panel, where assurance is provided that this duty has been met. For serious incidents, the duty of candour compliance is reported as part of the monthly quality report that is shared with our commissioners. This includes details as to the reason compliance with DoC is sometimes not possible, such as for a deceased patient with no next of kin.

For non-serious incidents (those graded moderate or above harm) we record whether DoC was met within 10 days, was not breached (i.e. it was not possible to meet DoC in 10 days due to a patient being unconscious), or was possibly breached. This information is available on Datix and reviewed each month, where assurance is sought from our divisional quality managers.

Patient safety improvement plan as part of the 'sign up to safety' campaign

The trust formally signed up to 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.

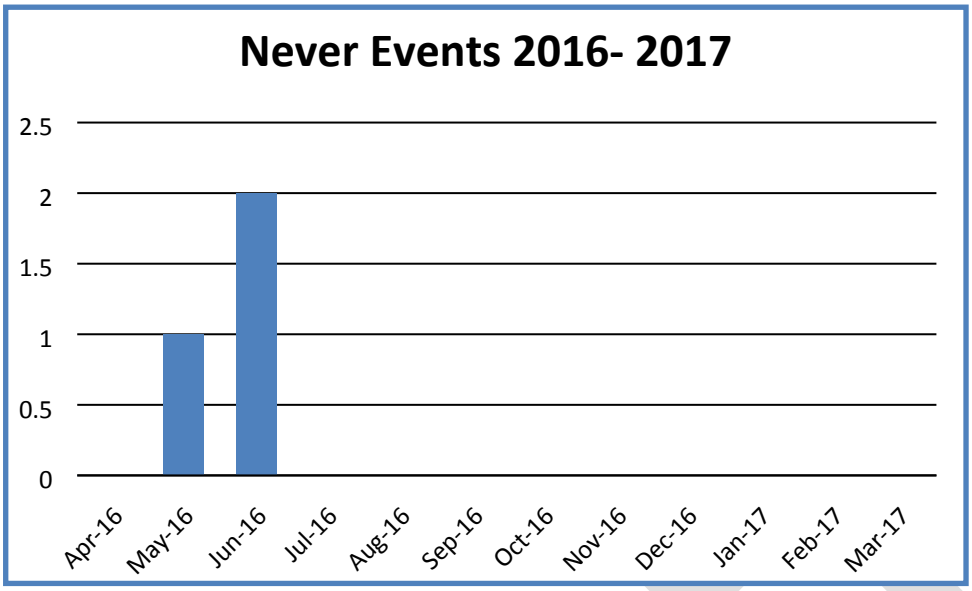
Never events

Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures had been put in place. The trust takes never events seriously and a full investigation is undertaken with the final report discussed at the serious incident review panel where final actions are agreed.

Unfortunately, we reported 10 never events during 2015/16, nine of which relate to surgery. During this reporting period (April 2016 - March 2017) we have reported three never events which occurred in May and June 2016.

In May 2016, the trust-wide never event; never again symposium was held. With over 70 participants, teams shared local never event stories and lessons learnt, through presentations, story boards, case studies and personal accounts.

By incorporating the findings of root cause analysis of previous never events and conducting a literature search of the relevant evidence base, the team has commenced observational data collection of distractions and interruptions. We are having active collaborative discussions with Loughborough University Human Factors team about the participation in the study of the processes that influence distractions and interruptions.



NHS staff survey results 2016

This section outlines the most recent NHS staff survey results for indicators KF21 and KF26 as requested by NHS England (medical directorate).

- KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion)
- KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months).

The 2016 survey also outlines the trust's Workforce Race Equality Standard (WRES) position compared with other acute trusts and differences from the previous year as below:

			Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	30%	24%	32%
		BME	35%	27%	36%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	85%	88%	84%
		BME	66%	76%	65%

The patient and staff experience committee (being replaced by the Leadership for Quality Improvement Committee) reviewed the staff survey results in January (pre-publication of the national picture) and a programme of engagement with staff, trade unions and others is underway that will inform changes to the trust's Staff Experience and Retention Plan (SERP).

Complaints

The trust recognises that in the majority of instances it is best to resolve issues as soon as possible. Our patient information leaflets and posters encourage concerns to be raised immediately with the person in charge of a patient's care. Alternatively, contact details are provided for the Patient Advice and Liaison Service (PALS) and complaints teams.

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 and safety boards.
- The quarterly report taken to the patient and staff experience committee.
- An annual complaints report taken to the July trust board.

The quarterly CLIPS (complaints, litigation, incidents, PALS and safety) report taken to the patient safety committee.

Annexes

Annex 1. Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

This will be completed in the final version of this report.

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 2016 to May 2017
    - papers relating to quality reported to the board over the period April 2016 to May 2017
    - feedback from commissioners dated ..
    - feedback from governors dated …
    - feedback from local Healthwatch organisations dated …
    - feedback from overview and scrutiny committee dated …
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated ….
    - the latest published Care Quality Commission (CGC) national adult in-patient survey dated …
    - the latest national staff survey dated…..
- the head of internal audit's annual opinion over the trust's control environment dated …
    - CQC Intelligent Monitoring report dated May 2015

- the Quality Report presents a balanced picture of the trust's performance over the period covered
- 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 and 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

.....Date.....Chairman

.....Date.....Chief Executive

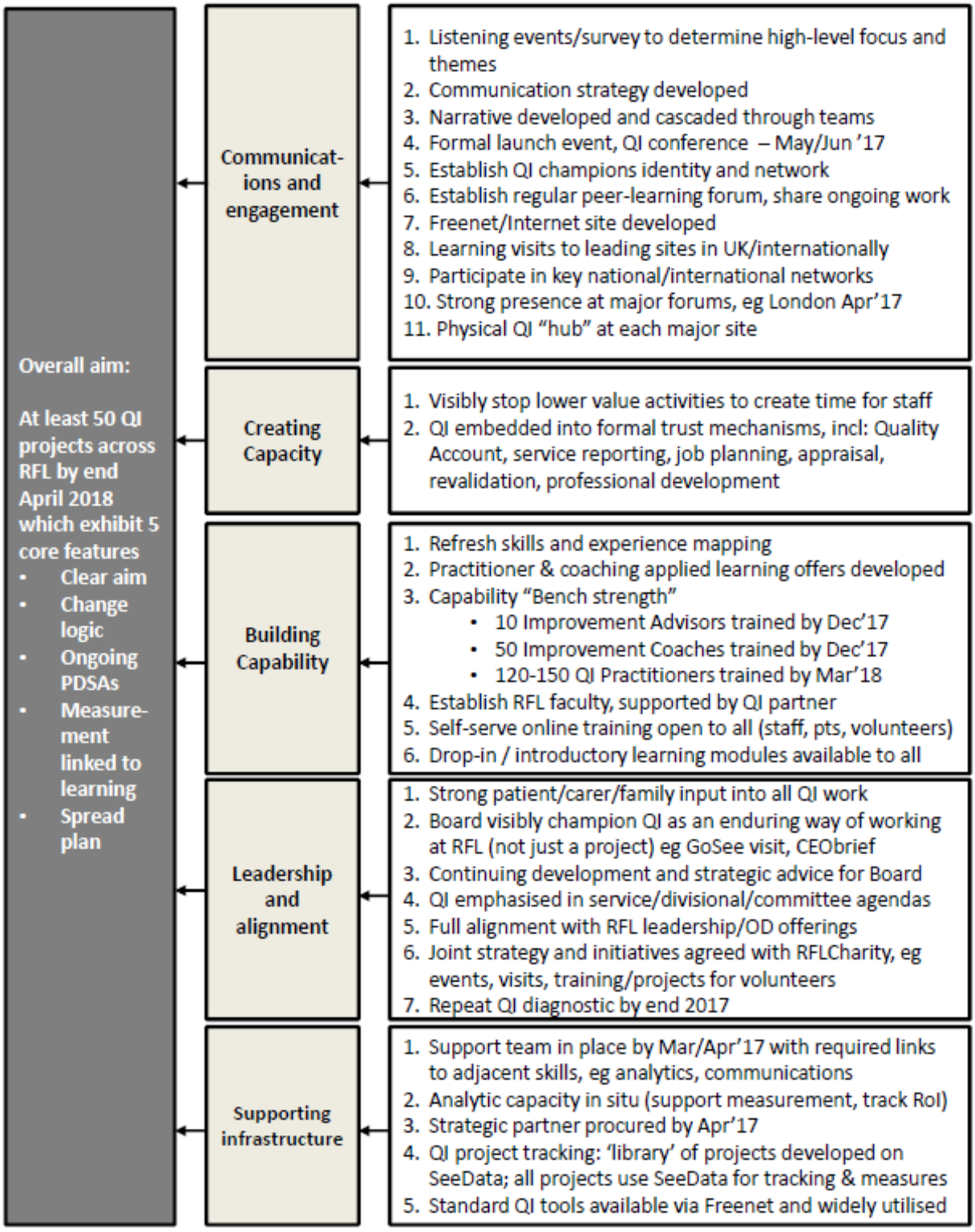
This will be completed in the final version of this report.

Annex 3. Limited assurance statement from external auditors

This will be added in the final version of this report.

Appendices

Appendix a: Royal Free London Quality Improvement Driver Diagram: toward 50 initiatives by end April 2018



Appendix b: responses to stakeholder comments

In response to comments received from commissioners, local healthwatch organisations and overview and scrutiny committees, we have outlined our responses in the following

This will be added to the final version of this report

Appendix c: glossary of definitions and terms used in 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 order • 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. Time out (stop moment)	Before the start of surgery: Team member introduction, Verbal confirmation of patient information Surgical/anaesthetic/nursing issues, Surgical site infection bundle, Thromboprophylaxis, Imaging 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

Glossary of Terms

Term	Explanation
CQC: Care Quality Commission	The independent regulator of all health and social care services in England
C-diff: Clostridium difficile	A type of bacterial infection that can affect the digestive system
Clinical Practice Group (CPG)	Permanent structures which the trust is developing to address unwarranted variation in care.
CQUIN: Commissioning for Quality and Innovation	CQUIN is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work
MDT: multi-disciplinary team	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.
Patient at Risk & Resuscitation Team (PARRT)	The Patient at Risk & Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP.
PEWS: paediatric early warning score	A scoring system allocated to a patient's (child's) physiological measurement. There are six simple physiological parameters: 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.
SHMI: summary hospital-level mortality Indicator	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.
UCLP: University College London Partners	UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).

VTE: venous thromboembolism	A blood clot that occurs in the vein

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London Borough of Barnet

Forward Plan of Key Decisions

May 2017

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AGENDA ITEM 8

Subject	Decision requested	Cabinet Member/ author	Consultation	Last date for reps	Documents to be considered
July 2017					
Streams Technology	Update on the new 'Streams' Technology being used at the Royal Free.				
Sustainability and Transformation Plan (STP)	Once the North Central London Sector Joint Health Overview and Scrutiny Committee has received latest report on the STP, Barnet HOSC have requested to receive an update report.				