MEETING
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
THURSDAY 24TH MAY, 2018
AT 7.00 PM
VENUE
HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

Membership to be Confirmed Following the meeting of Annual Council on Tuesday 22 May 2018.

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 Monday 21 May. Requests must be submitted to abigail.lewis@barnet.gov.uk

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

Andrew Charlwood – Head of Governance

Governance Services contact: Abigail Lewis: Abigail.lewis@barnet.gov.uk 0208 359 4369

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ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes	5 - 12
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.	Minutes of the North Central Sector London Joint Health Overview and Scrutiny Committee	13 - 22
8.	Minutes of the Barnet Health and Wellbeing Board	23 - 32
9.	Quality Accounts 2017-18	33 - 252
10.	Barnet Breastfeeding Support Service	253 - 262
11.	Health Overview and Scrutiny Forward Work Programme	263 - 264
12.	Any Other Items that the Chairman Decides are Urgent	

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Decisions of the Health Overview and Scrutiny Committee

5 February 2018

Members Present:-

AGENDA ITEM 1

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

Councillor Rohit Grover	Councillor Caroline Stock
Councillor Alison Moore	Councillor Laurie Williams
Councillor Ammar Naqvi	Councillor Val Duschinsky

Also in attendance

Councillor Anne Hutton (Substitute)
Councillor Helena Hart

Apologies for Absence

Councillor Philip Cohen

1. MINUTES (Agenda Item 1):

The Chairman of the Health Overview and Scrutiny Committee, Councillor Alison Cornelius welcomed all attendees to the meeting.

She noted two corrections to the previous minutes:

- On page 6 of the minutes, deletion of comma to read:
  Selina Rodrigues~~,~~ - Manager, Healthwatch Barnet

- Inclusion of the word 'the' in the penultimate paragraph to read:

*Ms. Clifford informed the Committee that one of the challenges facing dental care is that **the** level of UDAs had not been increased for many years despite the significant increase in the population*

Matters arising from the previous meeting:

- The Chairman noted that, following a request, the Committee had received information pertaining to the Capital Nurse Programme, Exit Interviews and CQC.
- It was noted that data for nurse retention statistics was still outstanding.

- Further information was also outstanding in respect of:
- The recruitment of 30 Patient and Family Experience Partners and an explanation of the role of a 'Partner' (p.5 of the previous minutes)
- The root cause analysis of the 47 cases of C.Diff across the Trust against a target of 39 cases. (p.5 of the previous minutes)
- details of the web-based survey to analyse the experience of bereaved families and friends.

- The Chairman provided an update in respect of the parking situation at Barnet Hospital. She informed the Committee that a planning application had been submitted to the Council which included the proposal to replace a cycling lane with 26 additional parking spaces. The Hospital had also applied to retain the portacabins for a further five years, but Chipping Barnet Area Planning Committee which met on 18 January 2018 had reduced this to six months.

The Chairman informed the Committee that she had received a letter from Kay Matthews, Chief Operating Operator, Barnet CCG, and Dr. Debbie Frost, Chair, Barnet CCG on issues surrounding the full utilisation of Finchley Memorial Hospital. The Chairman informed the Committee that the letter had highlighted the following points:

- Barnet CCG has been assisting the Royal Free London NHS Foundation Trust (RFL) to move the mobile service that the North London Breast Screening Service provides at Finchley Memorial Hospital into a new, purpose built unit on the site. Barnet CCG will continue to work with RFL and Community Health Partnerships (CHP) to have the service operational by June 2018. This will also assist with the CCG's plans to reduce the vacant space at FMH.
- The 17 bed Adams Ward at FMH is caring for patients who are ready to leave acute beds at Barnet and the Royal Free but who require ongoing assessment and individual discharge packages before returning home.
- The recent opening of Adams Ward and the new Breast Screening Unit will take the amount of space let to NHS providers at Finchley from 75% to approximately 90%.

Following the update from the Chairman, the Committee asked the following questions in relation to Adams Ward:

1. What is the average length of stay on the Ward?
2. What is the through-put?
3. Adams Ward has 17 beds - is it at capacity all the time and, if not, how full is it?

The Chairman undertook to raise the Committee's questions with Barnet CCG and report back.

RESOLVED that subject to the two corrections noted above, the minutes of the previous meeting of the Health Overview and Scrutiny Committee held on 4 December 2017 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies were received from:

- Councillor Philip Cohen who was substituted by Councillor Anne Hutton

3. DECLARATION OF MEMBERS' INTERESTS (Agenda Item 3):

The following declarations were made at the meeting:

Councillor	Agenda Item(s)	Declaration
Alison Cornelius	11	Declared a non-pecuniary interest by virtue of knowing one of the Healthwatch Authorised Representatives, Mrs Margaret Peart.
Alison Cornelius	9	Declared a non-pecuniary interest in reference to page 3 of the Minutes of the Joint Health Overview and Scrutiny Committee held on 24th November 2017 by virtue of being a Trustee of Eleanor Palmer Trust which operates a Care Home.
Alison Moore	9	Declared a non-pecuniary interest by virtue of being the Chair of the East Central Early Years Locality Advisory Board.
Anne Hutton	9, 11	Declared a non-pecuniary interest in connection to Finchley Memorial Hospital which is located within her Ward.

4. REPORT OF THE MONITORING OFFICER (Agenda Item 4):

None.

5. PUBLIC QUESTION TIME (IF ANY) (Agenda Item 5):

None were received.

6. MEMBERS' ITEMS (IF ANY) (Agenda Item 6):

The Chairman introduced the Member's item in her name and noted that at the January Full Council meeting, the Leader had confirmed the extension of the Breastfeeding Support Service beyond the end date of the current contract with CLCH.

Upon invitation of the Chairman, Councillor Helena Hart, Chairman of the Health and Wellbeing Board, joined the meeting. Councillor Hart informed the Committee that in accordance with the Joint Health and Wellbeing Strategy 2015-2020, the Health and Wellbeing Board as a partnership is fully signed up to promoting successful breastfeeding particularly among younger and first time older mothers.

One of the ways in which this is currently supported is through a breastfeeding peer support service Contract with CLCH – the future of which is due for consideration by the Policy and Resources Committee on 13 February 2018. Councillor Hart noted that the Committee will be updated following the decision of the Policy and Resources Committee and the outcome of the ongoing discussions with CLCH.

RESOLVED that:

The Committee requested to receive a report at its next meeting on 24 May 2018 and instructed Officers to prepare a report detailing the provision of all

Breastfeeding Support Services in Barnet, the delivery locations and details of the contract extension with CLCH.
(**Action**: Forward Work Programme)

7. MINUTES OF THE NORTH CENTRAL SECTOR LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Agenda Item 7):

The Chairman introduced the item which set out the Minutes of the NCL JHOSC held on 24 November 2017. She noted that the next meeting will be held on 6 February 2018.

Members heard about the discussion which took place at the November meeting of the NCL JHOSC which highlighted the major social care challenges nationally as well as staffing shortages across London. The discussion also covered the pressure on Care Home beds in Barnet and that, due to the number of bed spaces available, other local authorities placed people from their borough into Barnet Care Homes.

In relation to long term workforce planning in the social care sector, it was noted that this topic would continue to be discussed at the next NCL JHOSC meeting on 6 February 2018.

RESOLVED that the Committee noted the Minutes of the North Central London Joint Health Overview and Scrutiny Committee held on 24 November 2017.

8. MINUTES OF THE BARNET HEALTH AND WELLBEING BOARD (Agenda Item 8):

The Chairman invited the following to the table:

- Councillor Helena Hart – Chairman of the Barnet Health and Wellbeing Board
- Dr Jeff Lake – Consultant in Public Health

Councillor Hart presented the minutes of the Board meeting held on 9 November 2017 as set out in the agenda.

She also provided a verbal update of the discussions held at the Health and Wellbeing Board meeting on 25 January 2018.

The Committee heard about the discussions held at numerous previous Health and Wellbeing Board meetings on the topic of Female Genital Mutilation (FGM). At the January meeting of the Health and Wellbeing Board, Councillor Hart drew the Board's attention to the International Zero Tolerance to FGM Day to be held on 6 February this year.

The Committee noted that this had been discussed on numerous occasions at Board meetings where the Chairman, on behalf of the Board, had expressed unequivocal opposition to FGM and highlighted the physical and mental harm caused as a result of it.

The Committee noted that training on FGM will continue to be rolled out across the CCG.

A Member noted that a statement will be released and made available on the Council website to promote International Zero Tolerance on FGM Day on 6 February 2018.

The Committee heard about the discussion held at the January Health and Wellbeing Board meeting which considered the annual Director of Public Health's report. This year's annual report focused on the Built Environment and Health.

A Member noted work should be considered to support young people with the provision of appropriate open spaces and housing.

Dr Lake spoke about the research on how the Built Environment can help to improve health and wellbeing, along with the work already being done to develop and enhance the Built Environment together with some recommendations for further action.

Councillor Hart briefed the Committee about the work already underway through the Borough's regeneration schemes and building programmes such as:

- The £50m funding that has already been committed towards improving roads and pavements.
- Referring to parks and open spaces, a significant investment in outdoor play facilities and Outdoor Gyms and Marked and Measured Routes in Parks - as well as the 'Our Parks' and Barnet Health Walks programmes.
- Working with traders on initiatives such as the healthier catering commitment which includes using colour-coded systems for all vending and catering products to educate customers to choose healthy food options.
- In respect of physical activity, Councillor Hart welcomed the achievements and increase to over 77% in the percentage of the 16+ population taking part in sport and physical activity. She envisaged even greater improvements once the new Fit and Active Barnet Campaign was launched in May.

Following a query on provision of information about healthy nutrition from a Member, Dr Lake noted that the Health and Wellbeing Board had discussed tackling obesity and its adverse effects on health.

Councillor Hart reiterated the importance of providing information to all residents and supporting them to make healthier lifestyle choices including healthy nutrition.

In relation to smoking cessation, Councillor Hart briefed the Committee about the discussion held at the January Board meeting concerning the safety of e-cigarettes. It was noted that CCG colleagues had requested that the wording of the Smoking Cessation Report be revised on the basis of the possible unknown health disadvantages as a result of e-cigarette usage. The Committee expressed their concern when informed of the ingredients of e-cigarette.

Dr Lake spoke about the importance of trying to reach a greater number of people by working closely with smaller providers across the borough. A Member noted that regulatory services will be contacted to inquire what actions can be taken to curb smoking outside cafes and restaurants.

RESOLVED that the Committee noted the Minutes of the Health and Wellbeing Board meeting held on 9 November 2017 and received a verbal update on the Minutes of the Board meeting on 25 January 2018.

9. SUSTAINABILITY AND TRANSFORMATION PLAN (STP) (Agenda Item 9):

The Chairman invited to the table:

- Mr Will Huxter – Director of Strategy North Central London CCGs

The Committee received a presentation from Mr Huxter which focused on four of the largest workstreams under the STP programme and its ambitions.

Mr Huxter informed the Committee that the five North Central London CCG's are working together under joint arrangements with a single Accountable Officer and Chief Finance Officer. The Committee also heard about the sustainability of services by providing integrated care which improved health and wellbeing outcomes for residents.

The Committee noted the importance of clinical input and leadership into each of the workstreams to develop each step of the STP. Mr Huxter briefed the Committee about the work being carried out around recruitment and workforce retention.

The Vice-Chairman asked for a breakdown analysis of the increase in operational hours of surgeries. He queried its impact on waiting times and whether the increase in surgery hours has meant that more patients are being seen.

In respect of Care Closer to Home Integrated Networks (CHINs), Mr Huxter noted that the benefit has been that patients can be seen more quickly than previously and further noted that data in respect of usage can be shared with the Chairman and Members. (Action)

In relation to CHINs, the Vice-Chairman queried the coverage of GP Practices under CHINs and requested an update as to the which surgeries were and were not covered under the so-far proposed arrangements. He also asked about further information on mental health and cancer. Mr Huxter undertook to provide this information on population size and Practices under CHINs as well as further information on mental health and cancer. (Action)

The Committee expressed their disappointment at the absence of information concerning the estates strategy in the report. Mr Huxter agreed that more work needs to be done in respect of estates and the provision of adequate housing for NHS staff in Barnet.

RESOLVED that the Committee noted the report.

10. SUICIDE PREVENTION IN BARNET (Agenda Item 10):

The Chairman invited to the table:

- Dr Jeff Lake – Consultant in Public Health

Dr Lake presented the report which sets out the progress made in delivering the annual 2017-2018 Action Plan.

Dr Lake noted that, following publication of the 'Inquiry into Local Suicide Prevention Plans in England' by the All Party Parliamentary Group on Suicide and Self-harm, all authorities must have in place:

- A suicide audit work to understand local suicide risk
- A suicide prevention plan in order to identify the initiatives required to address local suicide risk
- A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local action plan.

The Committee requested that, for future reports, all acronyms should be written in full in the first instance and only abbreviated subsequently. (Action)

A request was made in reference to the sample size on page 63 regarding the Thrive Programme as they will have statistics based on a larger sample. (Action)

It was agreed that a copy of the extract of the minutes under this item be circulated to Dr Jeff Lake for action.

RESOLVED that:

1. **The Committee noted the suggestions of the Health Select Committee Inquiry into Suicide Prevention, local arrangements for suicide prevention and progress in delivering the 2017/2018 suicide prevention action plan ahead of its being refreshed for 2018/2019.**

2. **The Committee receive an annual report on suicide prevention. (Action: Forward Work Programme)**

11. HEALTHWATCH BARNET UPDATE REPORT (Agenda Item 11):

The Chairman invited to the table:

- Ms Selina Rodrigues – Manager Healthwatch Barnet.

Ms Rodrigues presented the report and highlighted the example of good communication between General Practice and service users. She explained the importance of further engagement between Health Commissioners and patients.

The Vice-Chairman welcomed the report and noted that the residents' views should also be sought in respect of the development of CHINs.

A Member raised the need for further PPG engagement with GP Practices. Ms Rodrigues informed the Committee that Barnet CCG provide face-to-face support for the development of local PPGs working closely with Healthwatch.

She emphasised that the success of the PPGs is also dependent on active engagement of patients and commitment from Practice Managers and lead GPs.

Following a suggestion from a Member for information sharing between PPGs, Ms Rodrigues noted that further encouragement would be beneficial to ensure that PPGs share information, resources and lessons learnt.

In respect of Mealtimes Investigation at the Royal Free Hospital, Ms Rodrigues spoke about the support provided for patients. She also raised concerns about nutrition for patients with pre-existing conditions and regular provision of clean drinking water. These formed part of the recommendations to the Royal Free. She noted the assurance received by the senior dietitian. It was noted that, as the current catering contract is due to end, it is important for these issue to be embedded within the new contract.

The Committee welcomed the report and commended the work of Healthwatch Barnet and its volunteers.

RESOLVED that the Committee noted the report.

12. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME (Agenda Item 12):

The Committee noted the standing item on the agenda which lists the reports due to be reported the Committee on 2018.

It was noted that the Forward Work Programme will be updated to include:

- Suggested items by Barnet Healthwatch will be included on the Forward Work Programme – as noted under item 11 at this meeting.
- Update report on Breastfeeding Support Services, as noted under the Member's item 6 (a).
- Annual report on Suicide Prevention, as noted under item 10.

RESOLVED that the Committee noted the Forward Work Programme, as updated during this meeting.

13. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 13):

The Chairman thanked the Committee and Officers for their contributions to the discussions held at this meeting and during the municipal year. She also thanked the Governance Officers for all their help.

The Chairman expressed her gratitude to Councillor Old for his continued commitment as Vice-Chairman of the Health Overview and Scrutiny Committee as well as his enormous contribution to the work of the Joint Health Overview and Scrutiny Committee.

The Chairman also thanked Councillor Helena Hart for her invaluable contribution to all the HOSC meetings throughout many years.

The Vice-Chairman thanked the Chairman for her all her work and efforts as Chairman of the Health Overview and Scrutiny and Barnet representative and Committee Member on the Joint Health Overview and Scrutiny Committee.

The meeting finished at 9:21 pm

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 23RD MARCH, 2018** at 10.00 am in Committee Room 1, Islington Town Hall, Upper Street, London N1 2UD

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Pippa Connor (Vice-Chair), Martin Klute (Vice-Chair), Alison Cornelius, Abdul Abdullahi, Jean Kaseki, Samata Khatoon, Anne Marie Pearce and Charles Wright

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. APOLOGIES

Apologies were received from Councillor Graham Old.

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Connor declared that she was a member of the RCN and that her sister worked as a GP in Tottenham. Councillor Cornelius declared that she was a trustee of the Eleanor Palmer Trust, which operated a residential home in Barnet.

3. ANNOUNCEMENTS

The Chair noted that this would be the last JHOSC meeting for Councillors Abdullahi, Wright and Old as they would not be candidates in the forthcoming borough council elections. She thanked them for their service on the committee.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of items of urgent business.

5. MINUTES

Consideration was given to the minutes of the meetings held on 26th January and 6th February 2018.

RESOLVED –

(i) THAT the minutes of the meeting held on 26th January 2018 be approved and signed as a correct record;
(ii) THAT the minutes of the meeting held on 6th February 2018 be approved and signed as a correct record.

6. INTEGRATING HEALTH AND SOCIAL CARE

Consideration was given to a presentation from North London CCGs on integration of health and social care.

Dr Josephine Sauvage, Co-Chair of the Health and Care Cabinet, explained that the CCGs were aiming to integrate health and social care for the benefit of patients. However, the system was currently not aligned in this way, and money and resources were in the 'wrong places' for the ambitions and aims they had.

Dr Sauvage highlighted the importance the CCGs' wished to give to preventative services and to parity between the priority given to physical and mental health.

She drew members' attention to the recent successes that had been achieved, including earlier diagnosis of cancer patients.

The Committee was informed that the Joint Strategic Needs Assessment had included the demographic challenges the sub-region faced and had emphasised that there needed to be more thought on the wider determinants of health.

Members commented that they preferred the use of 'residents' to 'patients' as they felt this would emphasise the holistic approach that the CCGs aimed to take. They also queried how people could be best kept safe when dispersed into the community. They wanted to see Healthwatch and local residents involved in the boards that were considering proceeding with changes.

A member commented that hospital trusts were funded on the basis of their patient volume, and so this did not create an incentive to move health services out into the community. They asked whether a transfer of resources would be taking place to align with the priority for community-based services, and were informed that it would be gradual.

Members expressed concerns about the workforce and staff shortages. A member said that a greater ability for practice nurses to change their role and to move from practice to practice might help with the recruitment difficulties in the sector.

Members noted that local authorities were having to make social care cuts and public health budgets were also being reduced due to budgetary pressures on Councils. They expressed the fear that the heath service might be relying on local authority services for community-based care that were no longer available.

A member from Enfield expressed concerns about funding differentials between boroughs. She was informed that these had been agreed at the national level and was not something the NCL CCGs could alter themselves.

Members had concerns about lines of accountability and noted that the NCL sub-regional structures were not on a statutory basis and individual organisations had their own autonomy.

Members asked for an update on 'Care and Health Integrated Networks' (CHINs) for the next meeting.

Members had concerns about accountable care organisations and what could be seen as 'privatisation by the back door'. They were assured that the NCL CCGs had no plans to establish an accountable care organisation.

RESOLVED –

(i) THAT the presentation and comments above be noted;

(ii) THAT an update on integrating health and social care come to a future meeting of the Committee.

7. NORTH LONDON COUNCILS' COLLABORATION ON ADULT SOCIAL CARE

Consideration was given to a presentation from North London Councils.

Dawn Wakeling, Senior Responsible Officer for Adult Social Care for North London Councils, and Sanjay Mackintosh, the Programme Lead, addressed the Committee. They highlighted that they were focussing on nursing care, which was a large proportion of local authority social care expenditure. They were working with the CCGs on quality assurance in nursing care, and also holding events for providers.

The officers said they were keen to see staff development amongst the social care workforce. They wanted social care to be a desirable career and for a career path to be available to the workers providing it. Ms Wakeling said that the government was drawing up a Green Paper on the social care workforce and she would forward it to members via the clerk.

Officers highlighted the direction of government policy was one of shared responsibility for care costs between the state and the individual.

With regard to the social care workforce, members commented that they felt the social care workforce was disadvantaged by not having a professional body to represent it as a profession. Additionally, there were concerns from members about homecare workers not being paid for travel time between visits. Ms Wakeling said

that payment for travel time was a matter for each local authority and the contracts it entered into. She assured members that Barnet did pay staff for travel time between home care visit. She said she would try and find out information from other authorities as to whether it was the case there.

The Chair commented that there was a possibility of broadening the social care workforce by reaching out to BME communities where some people may not speak good English or use the usual social care employment portals but may have hidden talents.

RESOLVED –

THAT the presentation and the comments above be noted.

8. UPDATE ON ST ANN'S AND ST PANCRAS' HOSPITALS' REDEVELOPMENTS

Consideration was given to a presentation from St Ann's and St Pancras hospitals.

Andrew Wright, the Director of Strategic Development (Barnet, Enfield and Haringey Mental Health Trust), addressed the Committee. He informed members that Haringey had recently granted planning permission for their new mental health building, which would have state of the art facilities for patients.

Two-thirds of the site was surplus to requirements and there was therefore going to be residential development on this land. There had been concern from members about the low percentage of affordable housing on the site, and Mr Wright said that, in light of this, there were further discussions taking place about the potential of increasing the amount of affordable housing on the site.

Members were informed that the target date for the completion of the new mental health facilities on the St Ann's site would be the end of 2020.

Malcolm McFrederick, the Project Director (Camden & Islington Foundation Trust), addressed members on the St Pancras hospital plans. He said that they were planning on selling their site and moving the in-patient facilities to the Whittington site. They were looking to develop two new hubs – on Lowther Road and Greenland Road – and they were considering whether a third site would be required.

Mr McFrederick said that the Trust were going to go out for tender for a development partner. This could be on a long lease basis rather than for sale. The matter was also complicated by the fact the Department of Health had a historic interest in the site. Mr McFrederick explained that the site could possibly be sold to Moorfield's Eye Hospital as a replacement for their old site.

The Trust wanted to involve local communities in consultation on the future of the site. Mr McFrederick said that further information would come to both the Camden and Islington health scrutiny committees in June.

Members asked whether London Estates Devolution would apply to the schemes. They were informed that they were not at the stage where estates devolution would apply.

The Chair voiced concerns about the development board for St Pancras not meeting. Mr McFrederick said that the two development boards – one involving stakeholders and one involving providers – were being amalgamated. He assured the Chair that she would be invited to the next meeting.

With regard to the St Ann's site, members raised concern about the definition of 'affordable' being used when people referred to 'affordable housing'. They highlighted that the government definition of rents at 80% of the market rent level as 'affordable' would in fact not be affordable to many people in North-Central London.

Councillor Connor asked that increased bed space be incorporated into the new St Ann's development. She said that with usage of bed space close to 100%, there was a need to increase capacity. Officers said that this was not possible due to the lack of revenue funding for more beds. However, they assured members that there was scope to expand the unit in future.

Councillor Kaseki asked whether there would be training facilities on the new St Ann's site. He was informed that training did take place on the site and the Trust was keen that this continued.

RESOLVED –

THAT the presentation and the comments above be noted.

9. AMBULANCE SERVICES

Consideration was given to reports from the London Ambulance Service and East of England Ambulance Service.

Peter Rhodes, the Assistant Director of Operations at the London Ambulance Service, spoke to the statistics in the report. He said that the LAS was doing fairly well compared to other regions when measured against the national targets. Handover times were better in 2017-18 than in 2016-17. The handover processes were good at all North Central London hospitals, but delays happened when A & E departments were full.

Members asked about callers who phoned for an ambulance when they did not need one. Mr Rhodes said that this caused management challenges, however the 111 non-emergency number and the "hear and treat" programmes were able to resolve

some of these cases. There was also a question about frequent callers. Mr Rhodes said that these were often individuals with complex needs and needed intervention from other agencies, such as social services.

An attendee asked for borough-level data about response times. Mr Rhodes said they should be able to provide data in April about this.

Members asked about the placement of ambulances. Mr Rhodes said that the number and location of ambulances was under review.

Alan Whitehead from the East of England Ambulance Service was present to speak to members about his service. He said that his service was looking to employ more staff to alleviate staff shortages.

He asked members to note that Barnet Hospital was one of the hospitals that was the local hospital for some residents of his region. He said that the East of England Ambulance Service took an average of 20 patients per day there. There had been a decrease in 8% in the number of patients taken to Barnet compared with last year. He said that a circumstance in which there would be increased transport of patients to Barnet compared to the normal figure would be when Watford Hospital was put on a divert. However, this had not happened recently.

Members asked that an update on the situation with regard to the ambulance services be provided for members at a future meeting. The Chair added that it would be beneficial to hear from the ambulance services what they felt it would be useful to scrutinise, such as in regard to which data gave the most accurate picture of their service.

RESOLVED –

THAT the reports and the comments above be noted.

10. ADULT ELECTIVE ORTHOPAEDIC SERVICE REVIEW

Consideration was given to a presentation on Adult Elective Orthopaedic Services.

Members heard from David Stout and Rob Head on the proposed review. The North-Central London sub-region currently had 12 different sites which provided orthopaedic services; there was an aim to concentrate these services on fewer sites.

Officers assured the Committee that they were committed to open and transparent engagement. The review would be clinically led by Fares Haddad and there would be patient and public representation. They wanted to reduce variation in services – and to reduce the number of cancellations, infections and subsequent re-admissions which had to take place. They were also thinking of separating urgent and scheduled operations.

Members welcomed the commitment from the health officers. Councillor Klute asked officers to note that increased travel times in the event of the relocation of services were a concern for many patients and for relatives who wanted to visit them. Members also felt there was a danger of destabilising smaller hospitals and making them unviable if services were taken away from them.

The Committee asked that an update on the review be provided to it in November.

RESOLVED –

(i) THAT the presentation and comments above be noted;

(ii) THAT an update come to the Committee in November 2018.

11. IMPROVING HEALTH & WELLBEING AND REDUCING INEQUALITIES - SUPPORTING CLINICAL DECISION MAKING

Consideration was given to the presentation from the NCL CCGs.

Dr Jo Sauvage and Donal Markey spoke to the Committee about this item, which was an update to the information provided at the February meeting.

Dr Sauvage highlighted that the NCL CCGs wanted a transparent process which would improve clinical decision-making and ensure that patients throughout the sub-region were receiving the same service.

Changes to the guidance on clinical decision-making would be clinically-led and be based on updates from NICE (National Institute for Clinical Excellence) and the Royal Colleges. The CCGs would communicate with GPs and aim to engage them in the process. Patients would also be able to feed into the process.

Members noted that some GPs did not read some of the material they were sent and urged that methods other than the usual channels for communication be used. Mr Markey assured members that social media and other means of communication would also be used.

Members asked for clarity on what issues would be submitted to the JHOSC and what would not be. They also wanted to have sight of EIAs.

Members said that there was a need to distinguish between clinical and financial factors for taking particular courses of action. They wanted decisions on which procedure was of limited effectiveness to be taken on clinical grounds rather than on financial ones. Officers assured them that clinical priorities would be paramount.

The Enfield members voiced concern that Enfield CCG had taken action on this earlier than the other CCGs. They felt this was inconsistent.

Councillor Connor asked that a future meeting receive: a GP engagement plan update, information about financial risks, information on patient feedback, and there be JHOSC involvement in the scrutiny of the terms of reference.

Members asked about the timeline for the next iteration of the policy and were informed that it was likely to be available in July.

RESOLVED –

(i) THAT the presentation and comments above be noted

(ii) THAT an update come to the next meeting of the Committee.

12. WORK PROGRAMME

Consideration was given to a report on the work programme for the Committee.

Members agreed to postpone the 111 item from the July 2018 meeting to give time to discuss other items. They wanted to have an item on clinical decision-making and one on integrated care.

They also wished to have an update report on health developments from the local authority point of view.

RESOLVED –

THAT the work plan for 2018-19 be agreed, subject to the amendments above.

13. DATES OF FUTURE MEETINGS

It was noted the dates of future meetings of JHOSC would be:

- Friday, 20th July 2018 (Barnet)
- Friday, 5th October 2018 (Camden)
- Friday, 30th November 2018 (Enfield)
- Friday, 18th January 2019 (Haringey)
- Friday, 15th March 2019 (Islington)

14. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

The meeting ended at 1pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
Telephone No: **020 7974 4071**
E-Mail: **vinothan.sangarapillai@camden.gov.uk**

MINUTES END

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Decisions of the Health & Wellbeing Board

8 March 2018

AGENDA ITEM 8

Board Members:-

Chairman: *Cllr Helena Hart
Vice-Chairman: *Dr Debbie Frost

*Kay Matthews	Cllr Sachin Rajput	*Cllr Reuben Thompstone
*Dr Charlotte Benjamin	Ceri Jacob	*Dawn Wakeling
*Chris Munday	*Dr Clare Stephens	*Selina Rodrigues
*Dr Andrew Howe	*Dr Jeff Lake (substitute)	*Andrew Fraser

* denotes Member Present

1. MINUTES OF THE PREVIOUS MEETING (Agenda Item 1):

The Chairman, Councillor Helena Hart welcomed all attendees to the March meeting of the Health and Wellbeing Board. Speaking on behalf of the Board, the Chairman placed on record the gratitude and appreciation to Dr Andrew Howe for all his sterling work as Director of Public Health for the Council and the CCG and wished him every happiness and success in the future.

The Board was informed by the Chairman that all the actions from the previous minutes were taken including the requested amendments to the Smoking Cessation Strategy and to the Update on the Delivery of the Prevent Agenda in Barnet.

Ms Kay Matthews Chief Operating Officer for Barnet CCG, noted a correction on page 7 of the minutes to read: *Ms Matthews spoke about the work delivered and noted that the CCG as a statutory body will review the proposal at its Governing Body meeting and take the decision on next steps.*

It was **RESOLVED that subject to the correction referred to above, the previous minutes of the Health and Wellbeing Board be approved as a correct record.**

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from:

- Councillor Sachin Rajput
- Ms Ceri Jacob

3. DECLARATION OF MEMBERS' INTERESTS (Agenda Item 3):

Dr Debbie Frost made a joint non-pecuniary declaration on behalf of Barnet CCG Board members; Dr Clare Stephens, Dr Charlotte Benjamin and herself, in relation to Agenda Item 11, by virtue of being impacted through their respective GP practices.

Councillor Helena Hart declared a non-pecuniary interest in relation to Care Closer to Home - which is referred to under Item 11 and includes reforms to Secondary Care, by virtue of her son being a Consultant at the Royal Free Hospital which could be affected in the future by any such reforms.

4. REPORT OF THE MONITORING OFFICER (IF ANY) (Agenda Item 4):

None.

5. PUBLIC QUESTIONS AND COMMENTS (IF ANY) (Agenda Item 5):

None were received.

6. SCREENING UPDATE (Agenda Item 6):

The Chairman introduced the item which had previously been requested by the Board. She emphasised the importance the Board places on screening and the vital role it plays in early detection and prevention of disease.

The Board noted the importance of this message being disseminated to all sections of the Barnet community and the necessity to try and ensure far greater take up. To this end, the Chairman welcomed the work currently being done with the Communities Together Network to address take up – particularly in the diverse communities in Barnet.

The Chairman referred to her previously expressed concerns regarding the range, availability, accessibility and take up of cancer screening.

Bearing in mind the pivotal role that cancer screening plays in identifying the early signs of this devastating disease in otherwise healthy people and the opportunities thereby presented for suitably effective treatment, the Chairman expressed her concerns that approximately one third of eligible patients for breast and cervical screening and over a half of patients eligible for bowel screening are not being screened. The Chairman also noted that the true figures are not known as there is a real lack of clear reporting arrangements.

The Board welcomed Dr Jeff Lake, Public Health, Dr Shona Ash, Commissioning Manager Antenatal & New born Screening, NHSE.

The Chairman asked Ms Shona Ash, NHSE to outline the actions they are taking to improve take up and the dates those actions will be completed. She also asked Dr Jeff Lake to comment on the actions and set out when the reporting problems will be resolved.

The Chairman also asked Dr Lake to comment on childhood and new born screening and whether there were any recommendations as to how these might be taken further.

Ms Shona Ash delivered a presentation to the Board and spoke about the Antenatal & New born (ANNB) KPIs. Ms Ash referred to the processes put into place and noted that there are some challenges within certain groups in Barnet with regards to uptake. She spoke about the work being done to work with various groups in Barnet to improve uptake in screening.

The Strategic Director for Children and Young People, Mr Chris Munday referred to the information in the appendix to the report and noted that data refers to the NCL area.

It was requested that in the future where possible, data be included for Barnet specifically across all indicators so that comparisons can be made in relation to any improvements and changes in uptake figures. (**Action**)

Dr Lake referred to the previous discussions held by the Board which have emphasised the need for consistent reporting and addressing of low take up figures.

The Chairman invited Dr Catherine Heffernan, Principal Advisor for Commissioning Immunisations and Vaccination Services to the table. She noted that data tends to be very high at programme level rather than at borough level.

She emphasised that in comparison to other areas, London is good in terms of uptake and coverage but that performance at national level has not been as good. Dr Heffernan spoke about the work done to improve bowel screening uptake and noted the ambition to continue the upward direction of travel.

She informed the Board about the work and focus around cancer screening and the consultation on bowel scope screening.

In relation to the Breast Screening Programme, she noted that coverage has been good but improvements are needed. In respect of this programme, she noted the importance of ensuring that facilities are available not just in General Practice, but also in sexual health clinics and family planning clinics.

In respect of sending text reminders on screening, Dr Heffernan notified the Board about the hurdles which have been worked through including provisions of the Information Governance rules.

It was noted that this service is to be rolled out across London and that currently discussions are held regarding STPs and what can be done collectively.

Dr Clare Stephens, Barnet CCG noted currently a review is taking place around the information that is included in letters on cervical cancer screening. The Board requested that the timescale for the letter producing process be shared with the Director of Public Health and the Health and Wellbeing Board. (**Action**)

The Chairman emphasised the need to seek input from Healthwatch and the Health and Wellbeing Board in relation to the information contained in the letter. It was suggested that input be sought from Healthwatch and Community Barnet. (**Action**)

Ms Selina Rodrigues, Barnet Healthwatch welcomed the suggestion to have further discussions with Public Health and the CCG.

The Strategic Director for Adults, Health and Communities noted the main challenges around cancer programmes and the need to see what can be done differently at an operational level to improve reporting mechanisms.

In respect of the concerns expressed previously by the Board on numerous occasions, Ms Wakeling made a suggestion to include additional recommendations to receive the recovery plan in relation to adult cancer screening targets.

The Board agreed to include additional recommendations to read:

- *That the Board receives an item at its July meeting setting out the recovery plan in relation to adult cancer screening, with clear actions and a schedule to improve performance against adult screening target.*
- *That NHSE supply Public Health and Barnet CCG with details of availability of sexual health clinics across Barnet and London, with performance and uptake information on cervical cancer screening.*

It was therefore **RESOLVED that:**

1. **That the Health and Wellbeing Board noted the NHSE Report on screening programmes.**

2. **That the Health and Wellbeing Board sought assurance that a clear reporting cycle is established.**

3. **That the Health and Wellbeing Board sought assurance that a recovery plan is in place setting out clear actions and schedule to improve performance against screening uptake targets.**

4. **That the Board receives an item at its July meeting setting out the recovery plan in relation to adult cancer screening, with clear actions and a schedule to improve performance against adult screening target.**

5. **That NHSE supply Public Health and Barnet CCG with details of availability of sexual health clinics across Barnet and London, with performance and uptake information on cervical cancer screening.**

7. UPDATE REPORT ON PROGRESS OF BARNET CHILDREN'S SERVICES IMPROVEMENT ACTION PLAN (Agenda Item 7):

The Chairman welcomed the update report on the progress of the Barnet Children's Services Improvement Action Plan. Referring to the second monitoring letter, she noted that it stated that "the Local Authority is continuing to progress and consolidate recent improvements to services for children and young people seen during the first monitoring visit. Senior leaders and managers are appropriately focused to improve and embed good quality social work practice".

Whilst this was a positive message in the right direction, the Chairman noted that there still remains a lot of work to do and she was concerned that while OFSTED found that "Strategy discussions are timely – although the quality of these remains variable. While inspectors note improvements in police attendance at strategy meetings, the attendance of health professionals is still inconsistent".

She invited Mr Munday to comment on this and highlight some of the discussion points held at the previous Children, Education, Libraries and Safeguarding Committee meeting on 7th March.

Mr Munday presented the fourth Update report on the progress of Barnet Children's Services Improvement Action Plan. He noted the significant improvements made in various areas. The update on progress is divided into the seven improvement themes in the action plan.

He informed the Board about the monitoring visit which focussed on the 'front door' arrangements in the Multi-Agency Safeguarding Hub (MASH), the Duty & Assessment Teams and Intervention and Planning Teams.

In response to the query raised by the Chairman, Mr Munday noted that further work is needed to improve the quality of strategy discussions which remains variable as social workers are not consistently inviting health professionals to participate.

He updated the Board about the health discussions held in January which involved health and noted the importance of ensuring that staff realise the need to involve health in strategy discussions. He emphasised the need to reinforce with social workers the regulatory requirement that health workers are involved.

In addition, he noted the importance of participation by health workers and making use of technology solutions to enable debates to happen, such as Skype for Business. He noted the improvements made and noted that further improvement is needed.

It was **RESOLVED that:**

1. **That the Board noted the progress of the Barnet Children's Services Improvement Action Plan as set out in paragraphs 1.4 to 1.50.**

2. **That the Board noted details of Ofsted's monitoring visit set out in paragraphs 1.11 to 1.19 and the monitoring visit feedback letter received from Ofsted attached in Appendix 1.**

3. **That the Board noted the performance information provided in paragraphs 1.51 to 1.61 and Barnet Children's Services Improvement Plan Data Dashboard attached in Appendix 2.**

8. SEND STRATEGY AND JSNA (Agenda Item 8):

The Chairman introduced the report and noted that the Board is being asked to endorse this important Strategy, which aims to help children and young people with special educational needs – and disabilities achieve their full potential.

The Strategy sets clear goals for supporting children and families through integrated working, with health, education and the local authority working together. She very much welcomed the focus on integrated commissioning, inclusive education and the ambition for the best outcomes possible for children and young people with special needs.

The Chairman invited Mr Simon James, Assistant Director, SEND & Inclusion to join the meeting. She asked Mr James to comment on the lessons learnt from SEND inspection by the CQC and Ofsted that need local attention to improve outcomes for this particular group of children.

Mr James noted spoke about the preparation for the inspection and the importance of ensuring that robust governance and leadership is in place. He spoke about work done in other critical areas such as working with families and to ensure that a child's and their family's voice is at the centre of decision making.

Following a query from Mr Munday about the quality of the plans in place for improvement – Mr James spoke about the steps needed to improve participation and co-production with key partners, parents, families, children and young people in decision making. In relation to SEND reforms, Mr James noted that the statutory assessment system is now replaced by a 0-25 education, health and care plan. In relation to waiting times, it was noted that an update will be brought to the Board on whether waiting times have come down. (**Action**)

Following a query from the Board, Mr James noted that Educational Psychology provision are also deployed through schools noting the importance of the role that school plays.

Mr Munday thanked Mr James for his efforts and engagement with partners in this area of work.

Dr Debbie Frost emphasised the need to reduce waiting times and to explore a partnership approach to work closely together. Mr James informed the Board about the monthly partnership board meetings as the relevant forum for the discussions and to consider the systematic issues.

It was **RESOLVED that:**

1. **That the Health and Wellbeing Board endorsed the priorities outlined in the Special Educational Needs and Disabilities (SEND) Strategy 2017-2020 for Barnet.**

2. **That the Board endorsed the next steps outlined in the Special Educational Needs and Disabilities (SEND) Strategy 2017-2020 for Barnet.**

3. **That the Board endorsed the recommendations of the SEND JSNA and notes that the findings feed into the SEND Strategy.**

9. FIT AND ACTIVE BARNET (Agenda Item 9):

The Chairman introduced the Fit and Active Barnet Programme. She stated that due to the crucial part it plays in good physical and mental health and wellbeing, her view was that the programme should be called Fit, Active and Healthy Barnet. Levels of physical activity in the Borough have been worryingly low for many years now and so helping people to be more physically active has been a core priority both for the Joint Health and Wellbeing Strategy and across the whole Council.

This Report also sets out the good progress made to expand the opportunities available to residents. The Board at its previous meeting heard about some of the results of this with levels of physical activity improving and some 77% of over 16s now taking part in sport and physical activity.

She also stated that this report highlights that Barnet is the first Council in England to make public health outcomes key performance requirements of the leisure contract, an achievement of which, as the Chairman of the Health and Wellbeing Board and Lead Member for Public Health, she is extremely proud. She drew particular attention to the truly excellent new range of services from the leisure centres for residents detailed in section 2.2 – particularly

- the generous discounts and concessions for residents,
- free swimming for under 8s,
- the weight management schemes,
- the Cancer rehabilitation scheme,
- the Carers' Pass,
- the Community programme and
- the Activate Healthy Lifestyle Schools programme to name a few.

The Chairman invited Ms Cassie Bridger, Strategic Lead, Sport and Physical Activity to deliver the presentation and expand on the points raised about and the significant capital investment.

Ms Bridger delivered a presentation on the Fit and Active Barnet Programme and the new leisure service contract to promote health and wellbeing. She emphasised that the leisure service contract will achieve £1.5million of average annual payment to the council and includes innovations and operator investment. The income achieved will enable the construction of the two new leisure centres.

Following a comment from the Board, Ms Bridger noted that discussions will be held to consider roll out of the Golden Kilometre initiative for adults as well as children and young people.

Ms Bridger informed the Board that the collaboration with Middlesex University will include a cross-departmental team who will evaluate the effectiveness of GLL's programmes in supporting Barnet residents to get fitter and healthier.

The Chairman of the CELS Committee, Councillor Reuben Thompstone welcomed the report and queried when residents can apply for the 30% or 50% discounts. The Board noted that this is likely to become available from May this year.

The Board welcomed the report and requested to receive an update in 6 months and/ or 12 months depending on the availability of data. (**Action: Forward Work Programme**)

It was **RESOLVED that the Health and Wellbeing Board considered and discussed the progress made to encourage healthier lifestyles.**

10. A MULTI-AGENCY SAFEGUARDING HUB FOR ADULTS IN BARNET (Agenda Item 10):

The Chairman welcomed this report which is being reported to the Board at her request, following the decision of the Adults and Safeguarding Committee to progress the establishment of an Adults MASH in Barnet. This MASH is a key priority for the Barnet Safeguarding Adults Board and should be a priority for the Health and Wellbeing Board.

The Chairman invited the Board to discuss how to ensure that the health and care system in Barnet will work with the MASH and how the Board as a partnership can help the MASH be a success.

Ms Dawn Wakeling, Strategic Director for Adults, Health and Communities presented the report and noted that the MASH will go live as the Council moves its offices to Colindale. She noted that this will help the Council provide much better safeguarding services working with partners to tackle abuse and neglect.

In terms of different ways of providing services, the Board welcomed the report and expressed interest in the option to work as a virtual and a co-located team with a central coordinator linked to contacts in each organisation, facilitating the sharing of information.

It was **RESOLVED that:**

That the Health and Wellbeing Board commented on and endorsed the approach to developing the Adults MASH as set out within the report.

11. MINUTES OF THE CARE CLOSER TO HOME PROGRAMME BOARD AND JOINT COMMISSIONING EXECUTIVE GROUP (Agenda Item 11):

Ms Wakeling introduced the standing item on the agenda. The Board noted the details of the discussions and actions covered in the minutes of the Care Closer to Home Programme Board meetings as well as the Joint Commissioning Executive Group meeting.

It was **RESOLVED that:**

That the Health and Wellbeing Board approved the minutes of the Care Closer to Home Programme Board meetings of 16 November 2017 and 18 January 2018; and the Joint Commissioning Executive Group meeting of 5 December 2017.

12. FORWARD WORK PROGRAMME (Agenda Item 12):

It was **RESOLVED that the Board noted the items of business on the Forward Work Programme for 2018.**

13. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 13):

Councillor Helena Hart, Chairman of the Health and Wellbeing Board made the following closing statement:

As this is not only the last HWBB Meeting of the municipal year but also of this current Council with a new HWBB to be approved at the Annual Meeting of the Council perhaps I could be permitted to make a few closing personal remarks.

As most of you already know after a total of some 20 years on the Council and a great deal of heart searching I have finally decided to stand down – and in this case, it really is a question of spending more time with my family. There are many things I will miss but most of all the work we have managed to do together to improve the real quality of life in Barnet.

Virgil said that the greatest wealth is health but improving that health does take money and commitment and dedication. I think the work we have done as a Council, as a CCG, as Healthwatch and as individual members of this HWBB from its very inception bears testament to what can really be achieved if we all work as one. Thinking back over the last 16 years in , I remember as a newly re-elected Councillor in 2002 I had a Members Policy item to Council asking for us to institute a Healthy Catering and Eating Certification Scheme across the Borough. Well it only took about 10 years to institute our Healthy Catering Commitment Awards but we got there in the end and it has given

me the very greatest pleasure to be able to present certificates to so many different establishments over the last 5 years.

16 years ago, our only real focus on children's health was based on how many children were registered with an NHS dentist and how many decayed or missing or filled teeth they had – today our concentration on all aspects of Children's Mental and Physical Health and Wellbeing is embedded across the Council. 16 ears ago we seemed to deal solely with the effects of poor mental and physical health – and all too often just recording them. Today it is universally accepted that it is the role of every one of us to do everything in our power to educate and empower residents to avoid ill health.

When the then Leader of the Council Mike Freer appointed me as Barnet's very first Cabinet Member for Public Health in 2006, I had no Budget whatsoever and only goodwill for backup – hence my alternative title as Cabinet Member for nagging and spending other people's money. Nagging I have to say which came in very useful when negotiating for our nigh on £3 million uplift in our transferred Public Health budget.

In closing, may I thank each and every one of you for all your patience, help, support and sheer goodwill towards me both as Chairman of the Health & Wellbeing Board and in my previous role as Cabinet Member for Public Health.

We have achieved so much together. So I end with a final plea to keep on working together, keep on fighting and keep on believing that with a bit of give and take on both sides we really can make things better for all our residents in Barnet.

The Vice-Chairman of the Board, Dr Debbie Frost moved a motion of thanks. Dr Frost expressed her gratitude to the Chairman for all her work on behalf of the Board and particularly for her work towards the Shisha smoking Communications campaign and the Dementia Manifesto.

The meeting finished at 11.40 am

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AGENDA ITEM 9

Barnet Health Overview and Scrutiny Committee

24th May 2017

Title	**NHS Trust Quality Accounts 2017/18**
Report of	Head of Governance
Wards	All
Status	Public
Key	No
Urgent	No
Enclosures	Appendix 1 – Committee's Comments on 2016-17 Quality Accounts – May 2017 Appendix 2 – Committee's Comments on 2016-17 Quality Accounts – Mid Year Review – December 2017 Appendix 3 –North London Hospice Quality Account 2017/18 Appendix 4 – Community London Healthcare NHS Trust Quality Account 2017-18 Appendix 5 – Royal Free Hospital NHS Foundation Trust Quality Accounts 2017/18
Officer Contact Details	Anita Vukomanovic - Governance Team Leader 020 8359 7034 Anita.vukomanovic@barnet.gov.uk

Summary

This report presents the Quality Accounts from NHS Health Service providers 2017-2018. 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.

The relevant Trusts and the North London Hospice will be in attendance on the evening to present their report and to respond to questions from the Committee. The Committee will then provide their comments to the Trusts and Hospice, which they require to be included

in full within the final version of the Quality Account.

Recommendations

1. **That noting the requirement of the NHS Health Service provider to produce Quality Accounts 2017-2018, the Committee provides a statement which they require to be included in full within the final version of 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 (CQC), 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 Quality Accounts before they are 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 Committees 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 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 (Article 7) 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 – 15 May 2017 – The Committee provided their comments on each of the Trusts'/Hospice's Quality Accounts: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=8786&Ver=4

6.1.2 Health Overview and Scrutiny Committee, 4 December 2017 – The Committee undertook a mid-year review on the progress made by each Trust/Hospice on the comments provided against their Quality Accounts: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=9292&Ver=4

Appendix 1:

Minute Extract from the Meeting of the Barnet Health Overview and Scrutiny Committee on 15 May 2017

7. NHS TRUST QUALITY ACCOUNTS 2016-2017

North London Hospice

The Chairman invited to the table:

- Fran Deane – Director of Clinical Services, North London Hospice
- Amanda Fairhurst – Registered Manager, North London Hospice

The Committee scrutinised the Draft Quality Account from the North London Hospice for the year 2016-17 and wish to put on record the following comments:

- The Committee was pleased to find the North London Hospice had been rated "Good" by the Care Quality Commission (CQQ) following three separate inspections of their Finchley, Winchmore Hill and Haringey services. The Committee congratulated the Hospice on the rating. The Chairman also congratulated the Hospice on its 25th anniversary.
- The Committee commented that improvements had been made in terms of the layout of this year's Quality Accounts.
- The Committee noted plans to introduce a 'Hard to Reach Groups' programme to promote equal access to services for all potential users. The Hospice explained that although this was still being finalised, a group had now been established to work on the project and was planning meetings throughout the year. The Committee requested that information on the programme be brought back during the mid-year Quality Account's review.
- The Committee was happy with the quality of the Account and the inclusion of feedback from users. The Hospice explained it uses the feedback to keep track of how it is improving and to highlight areas where it can make further improvements. The Hospice explained that once the Dementia Strategy had been implemented, steps would be taken to investigate how the strategy was meeting the needs of the population. The Committee asked that data on the Dementia Strategy be included in the 2017/2018 Quality Account.
- The Chairman expressed how impressed she was that the Hospice had 980 volunteers across all its services.
- The Committee also praised the Hospice for their continuing work to reduce the number of patient falls, which this year is down from 36 to 27, whilst acknowledging the Hospice deals with very frail patients. The Hospice said there was ongoing work being carried out around falls and staff were trying to

maintain a balance between preventing falls and allowing individuals to remain as independent as possible.

- The Committee commended the Hospice on the 277 compliments received and said it was pleased to see some examples included in the report.
- The Committee also noted that the Hospice's goal of supporting people to die in their own homes, if this is their preferred choice, appeared to be a success having increased year on year.
- The Committee noted the introduction of an Outcome Star, currently named The "End of Life Star", and asked for more information about it. The Hospice explained that the Star is a collaborative piece of work with various organisations to achieve better training in hospices.
- The Committee congratulated the Hospice on having achieved zero cases of Clostridium difficile (C.diff) and other infections over the past four years.

However

- The Committee queried the figures surrounding bed usage and asked for clarification on whether the closed bed days had been excluded from the calculations. The Hospice confirmed closed bed days had been excluded and said it had been working hard throughout the year to improve the turnaround period, but it was often a balancing act.
- The Committee enquired whether issues related to plumbing, which had been the sole reason for the 39 closed bed days, had now been rectified. The Hospice recognised it was a continuing problem due to the nature of the services they provide.
- The Committee expressed concern about a large number of staff leaving the Hospice. The Hospice explained that these were mainly bank care assistants and nurses, but the substantive members were not leaving. The Hospice said they were working with the HR Director to meet challenges around retaining staff.
- The Committee noted that pressure ulcers were still a cause for concern with higher numbers of patients suffering from them compared with other hospices of a similar size. The Committee also asked for clarification around the definition of 'avoidable' and 'unavoidable' pressure ulcers and the implications for them and how this was being implemented into care. The Hospice said changes in recording had been implemented so that it could be seen that everything possible is being done to decrease the number of avoidable pressure ulcers . The Committee acknowledged that turning and moving patients in the last few days of their life may not be practical or kind.

In addition:

- The Committee queried how much it cost the Hospice to produce such a detailed report. The Hospice explained that the document is kept in PDF form only and so there are no printing costs incurred. The Hospice also explained

that this was a key document for them and was used throughout the year within the organisation as a learning tool and was also useful information for the Board of Trustees.

- The Committee raised some concerns that the Hospice could potentially be over stretching its resources. The Hospice explained that it always works in partnership where possible and is engaged in various work streams as well as working with the STP team.
- The Committee commented that there had been a significant increase in reported incidents of patient safety at the Hospice. The Hospice explained that it viewed this as a positive consequence of staff being more forthcoming in reporting all incidents.
- The Committee also noted the increase in medicine incidents. The Hospice said this again suggested an improvement in honest and open reporting and that none of the incidents had been classified as major.

The Chairman thanked the North London Hospice for attending.

Central London Community Healthcare NHS Trust (CLCH)

The Chairman invited to the table:

- Kate Wilkins – Assistant Lead for Quality at Central London Community Healthcare NHS Trust.

The Committee scrutinised the Draft Central London Community Healthcare NHS Trust's Quality Account 2016-17 and wish to put on record the following comments:

- The Committee noted the growth of the organisation and said it was a compliment to the Trust that they were able to take on extra work.
- The Committee enquired about the cost of producing this report and was happy to hear that costs were kept to a minimum because the report was published online only. The Committee were pleased that the Trust was using the report as a key document for learning and improvement.
- The Committee were also pleased to hear that the Trust had been successful in receiving funding for a new role for a pressure ulcers nurse. The Trust believed this will have a big impact on reducing the number of patients with pressure ulcers in the next year.
- The Committee asked how the data in the report was used in terms of training and up-skilling of staff. The Trust explained every investigation was used within training programmes and updates to staff were given via regular reports and newsletters. The Trust also explained that it was part of a national working group on pressure ulcers, but was not sure if information was passed onto voluntary organisations that it worked with, and so it would be looked into.

- The Committee enquired whether the procedure for end of life care at Barnet was the same as at Merton, as outlined in the report (Page 17 of the CLCH report). The Committee were impressed that this was the case, as this was an example of good practice.
- The Committee commented that the patient stories on dentistry provision were very good. The Committee were also glad to see that diabetes self-management was improving.

However:

- The Committee was concerned that the Trust expanding further into new areas could have an impact on maintaining a high quality of standard of care. The Trust explained that the inclusion of Merton and Harrow had been successful and reporting structures had fitted in well with these Boroughs. The Trust said going forward it would only be bidding for services that it was already experienced in and was not looking to expand further.
- The Committee noted the increase in the number of patients with pressure ulcers. The Trust explained that the situation in Merton and Harrow had led to challenges but it did not believe this was of major concern.
- The Committee commented that the figures showed a drop in December 2016 in the Dignity and Respect indicator as well as the Explaining Care indicator as perceived by patients (Pages 3 and 4 of their report) and asked for an explanation of the figures to be communicated to the Committee.
- The Committee noted there appeared to be issues surrounding the retention of staff at the Trust. The Committee was impressed that the recruitment of Filipino nurses had been so successful and was having a positive impact on the Trust. However, it was concerned that more work was need to recruit and retain UK nurses. The committee noted that the vacancy rates had fallen from 22% to 14% this year. The Committee also raised concerns around the cost of recruiting overseas nurses but was assured by the Trust that the cost was not significantly more than other recruitment.
- The Committee suggested that the Trust should conduct an ‘exit interview’ when a member of staff leaves in order to find out the reasons.
- The Committee noted the increase in the number of serious incidents being reported. The Committee was satisfied that this upward trend in reporting reflected greater transparency and reporting by staff.
- The Committee asked why the Trust had not taken part in the diabetes foot care Audit and requested an explanation for this be presented in the final report.
- The Committee commented that the equal opportunities statistics had not improved much since last year’s report. The Trust explained that a lot of work had been done on this and it believed this was an issue of staff perceptions. The Trust assured the Committee it would be looking into better ways of

publicising how successful the work on increasing equal opportunities had been.

- The Committee inquired about the deaths reported on Marjory Warren and Ruby Wards and why these had occurred. The Trust said that after being investigated, these deaths were not unexpected.

The Chairman thanked the CLCH for attending the meeting.

Cyberattack update:
The CLCH gave a quick update on how the recent cyberattacks had affected the Trust. The Trust said that it had been unaffected by the attack. CLCH also explained that it had a number of procedures and safeguards in place to protect itself from possible future attacks.

The Royal Free London NHS Foundation Trust

The Chairman invited to the table:

- Professor Steven Powis – Medical Director, The Royal Free London NHS Foundation Trust

The Committee scrutinised the Draft Royal Free London NHS Foundation Trust Quality Account 2016-17 and wish to put on record the following comments:

- The Committee was pleased that the Trust had been rated 'Good' in most areas by the CQC.
- The Committee complimented the Trust on their continuing progress on its Dementia Strategy in particular the introduction of a Passport for Carers.
- The Committee congratulated the Trust on the list of its key achievements over the year.
- The Committee noted the Trust's participation in national clinical audits which it found most informative. Whilst this is prestigious, it is recognised that there is considerable additional work for practitioners. However, the Committee was pleased that the results of the audit are being used to improve local practice.
- The Committee acknowledged the efforts made by the Trust to make the data clearer in this year's report and found the statistics suggested that the Trust was doing well when its performance is compared with the national average.
- The Committee commented that lower levels of diabetes were reported at Chase Farm than expected and queried the reasons behind this. The Trust said there had been an improvement in in-patient foot surveillance, in addition to projects on improved interventions in order to alert staff to dangerous changes in glucose levels. The Trust explained that at any one time up to 20% of patients at the Royal Free can be diabetic and it is a great challenge for the diabetic team to manage all of these.
- The Trust explained they were looking into an alerting system for pre-diabetics and this would be the focus for the next few years. The Committee requested that the Trust bring an update on this back to a future meeting.

However:

- The Committee noted that the number of reported incidents at the Trust had risen since last year. The Trust explained this was viewed as a positive sign that members of staff were reporting more incidents and the number of serious incidents resulting in harm had actually gone down.
- The Committee queried the accuracy of the figures on Sepsis. The Committee suggested these figures be investigated before the final version of the report is published. The Committee also queried whether a Sepsis intervention programme was currently in place in order to educate all staff about the signs and seriousness of Sepsis. The Committee were assured that all staff were trained to look for signs of Sepsis, especially at the triage stage of care.
- The Committee noted that the C.difficile key performance indicator on page 85 of the Royal Free report did not make sense, as it appeared that the Trust was performing better than the highest national performing trust. The Committee suggested these figures were also checked. The Chairman commented that she found last year's table easier to understand.
- The Committee commented that the C.diff figure was not clear, making it difficult to understand if the Trust was doing well when compared with its own previous year's figures as well as other hospitals. The Committee asked that the table be made clearer and the figures checked.
- The Committee felt that being ranked 23rd out of 25 hospitals for C.diff indicated this was an issue the Trust should look into further. The Trust explained that C.diff is measured in a number of ways and cannot be avoided in all cases, however the aim was to get the number as close to zero as possible. The Trust stated that they needed to do some work comparing its numbers of C.diff cases with other hospitals with similar complex cases.
- The Committee acknowledged that A&E had experienced a challenging winter which had been affected by social care provision issues, not necessarily caused by the five NCL Boroughs but often by Hertfordshire, which had led to difficulties with discharging patients. The Committee asked whether there appeared to be a trend whereby patients preferred to seek treatment from A&E rather than via other methods of accessing urgent care. The Trust said it was not able to comment on what was causing the trend but there had definitely been an increase in the number of patients attending A&E. The Trust suggested it could be due to the increasing and changing demographics in the population. The Trust explained it was working closely with colleagues in Primary Care and the CCG, as well as local councils, to try to co-ordinate responses across the system in order to ensure patients do not have to wait more than four hours when possible. The Trust also stated work was needed to encourage patients to go to the most appropriate place for care, but did not anticipate this being an easy issue to resolve.
- The Committee questioned the number of 'Never Events' and how these were being managed to prevent reoccurrence. The Trust explained these were mainly incidents in surgery and one was currently under review to establish

whether it met the criteria to be classified as a never event. The Committee did however acknowledge there had been a big reduction in these events over the year and encouraged the Trust to ensure these numbers remained as low as possible. The Committee were pleased to hear a surgical safety programme would be continuing and patient safety meetings were due to be held throughout the year.

- The Committee commented that no section had been included in regard to any compliments or complaints. The Committee suggested that a number of these are included in the final report.
- The Committee wished to put on record again their concern regarding the insufficient amount of parking at Barnet Hospital for both patients, visitors and staff. The Committee had mentioned this issue at last year's Quality Account meeting and were disappointed that the Trust had done nothing to improve matters since then. The Committee also expressed its concern that a quarter of the visitor/patient car park had been re-designated as staff parking and that a portacabin was also taking up 18 patient/visitor spaces.
- The Committee asked specifically about whether the hospital had received complaints in regard to the lack of parking. The Committee explained that at previous Health Overview and Scrutiny meetings suggestions had been made to extend the current car park on the east side of the hospital. The Trust said it would have to look into this. The Committee also suggested the Trust look into the possibility of installing a camera at the exit of the car park which would inform the driver whether they had paid for their parking or not. This would give the person the opportunity to return to the car park and pay for their parking rather than being fined.
- The Committee asked about whether there was a strategy for parking at the Royal Free Hospital, whilst acknowledging that the site was very restricted for space.

Update on Cyberattacks:
The Trust told the Committee that no viruses had infected the Royal Free computer system. Over the weekend, the Trust had closed down some of its systems that were not key as a precaution, but these were now all back up and running and in-patient services had remained unaffected. The Royal Free said that had also provided support to other Trusts that had been affected.
The Trust explained that they constantly reviewed and enforced cyber protection with a number of different anti-virus and encryption tools which were updated regularly. The Trust also ensured that staff were educated on the issue and sent out regular communications on the importance of cyber safety and security. The Trust also explained that it had contingency plans in place in the event of an attack.

RESOLVED – That the Committee requested that the above comments be included in the final version of the Trust's Quality Accounts.

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Appendix 2:

The Chairman introduced the report which provided a mid-year update on the progress made following the receipt of the Committee's comments on the Quality Accounts for the following organisations:

- North London Hospice
- Central London Community Hospital
- The Royal Free London NHS Foundation Trust

The Governance Officer advised the Committee and the representatives of the organisations listed above:

"The National Health Service (Quality Accounts) Regulations 2010 is the relevant piece of law that outlines the requirements for the management of Quality Accounts. It says that HOSCs are required to submit their comments on Quality Accounts for inclusion prior to the Account being published. The deadline for this is 30 June.

Ordinarily, Barnet's HOSC has always sought to send the Committee's comments to the organisations as early as possible. We understand that it is a complex and timely process to produce a Quality Account and that organisations also need to make allowances for their own internal deadlines. However, in May 2018, all Members of the Council will be up for re-election and, as such, they cannot be appointed to Committees until the first meeting of the Full Council. In Barnet's case, this is scheduled to be on Tuesday 22 May. We expect that Barnet HOSC will meet on Thursday 24 May to consider the Quality Accounts, which means that we can draft the comments the following day and ask to Members to review them over the Bank Holiday weekend. We can provide the comments to the Organisations at around lunchtime on Tuesday 29 May. This is later than we would normally submit comments for inclusion within the Accounts, although technically comments submitted up to 30 June are required to be included.

Please be advised therefore that we will be unable to provide you with comments at the usual earlier date.

This is something that will affect all HOSCs in London and so I wanted to take the opportunity to flag this in front of senior Health colleagues from all relevant organisations six months in advance, so that you have time to prepare.

I will contact each organisation outside the meeting about this information. However, I wanted to put this on record at this meeting for the purposes of good governance."

North London Hospice:

The Chairman invited the following to the table:

- Miranda Fairhurst - Assistant Director Quality
- Fran Deane - Director of Clinical Services

Ms. Deane referred to the Hospice's "Hard to Reach Groups" programme, which aims to promote equal access to services for all potential users. Ms. Deane noted

that this was a priority for improvement and that the Hospice had been receiving data within all three Boroughs that the Hospice serves.

Ms. Deane noted the when the Committee had reviewed the Hospice's Quality Account last year, they had been informed about the introduction of an "Outcome Star", currently named the "End of Life Star". Ms. Deane informed the Committee that this work had been slightly delayed as the Hospice was waiting for NHS Ethics approval but it was hoped to obtain approval in the new year.

Ms. Deane advised the Committee that a multi-professional group comprised of all hospice professions had been doing work to map their current provision against the Hospice UK Document on Hospice Enabled Dementia Care to inform its Dementia Strategy.

The Chairman asked what proportion of patients at the Hospice had Dementia at any one time. Ms. Deane informed the Committee that the Dementia rate was lower at the In-Patient Unit as the approach for Dementia patients tended to be about providing care at home as it was normally a more suitable environment. The Committee noted that about 7% - 8% of Hospice patients had Dementia at any one time.

The Chairman noted that last year the Committee had expressed concern about the large number of staff leaving the Hospice. Ms. Deane advised the Committee that some clinical staff were retiring and that the Hospice looked for ways to promote staff internally. Ms. Deane also informed the Committee that an Assistant Director for the Inpatient Unit had been recruited to post.

Responding to a question from the Chairman, Ms. Deane advised that when a member of staff left the Hospice, they would complete a face to face interview with HR.

The Chairman questioned what action the Hospice had taken on avoidable pressure ulcers. Ms. Deane informed the Committee that the Hospice identifies both inherited and acquired Stage 1 pressure ulcers, as well as Stage 2, 3 and 4, which allowed the Hospice to understand how ulcers have been obtained. Ms. Deane advised that the Hospice was also looking at sourcing alternative pressure-relieving mattresses following feedback from patients.

<u>Central London Community Healthcare:</u>

The Chairman invited to the table:

- Kate Wilkins - Assistant Lead for Quality

The Vice Chairman commented that the North Central London Joint Health Overview and Scrutiny Committee had become aware that one of the strands of the Sustainability and Transformation Plan (STP) is for health providers and organisations to work closer together on recruitment and retention strategies. The Vice Chairman noted that CLCH covered four STP areas and asked if that made recruitment and retention more complex for the Trust. Ms. Wilkins advised that recruitment is a huge problem across London and that CLCH is part of the Capital

Nurse Programme. Ms. Wilkins explained the role of the Capital Nurse Programme in attracting new nurses. The Committee noted that the Trust was able to offer rotation around different areas of nursing and then provide a job offer at the end. She offered to provide the Committee with further information on the Capital Nurse Programme.

A Member commented that some factors impacting on recruitment and retention would be out of the control of the Trust and asked if retention would be a cheaper option that the Trust would have more control over. Ms. Wilkins agreed.

A Member asked what the Trust's biggest challenge was in terms of retaining staff. Ms. Wilkins said that the organisation had vacancies. Boroughs such as Barnet only pay the outer London weighting rather than the higher inner London weighting, making it harder to recruit and retain staff. Ms. Wilkins undertook to provide the Committee with statistics on nurse retention.

The Chairman noted that Barnet, Enfield and Haringey Mental Health Trust went to Middlesex University to recruit and questioned if CLCH worked with universities. Ms. Wilkins advised that the Trust did.

The Chairman noted that last year the Committee suggested that face to face exit interviews be offered to all members of staff when they leave and that CLCH are now reporting that exit interviews are offered to outgoing staff either with their manager or with HR. The Chairman asked if the Committee could be provided with the percentage of staff that took up the option to either attend an interview or complete a questionnaire. Ms. Wilkins undertook to see if this information was available.

The Chairman noted that the Quality Account for last year had reported that the Trust had not taken part in the Diabetes Footcare Audit due to administrative reasons. She inquired if this had been dealt with. Ms. Wilkins advised the Committee that the Audit had not taken place last year due to a member of staff leaving. Ms. Wilkins reassured the Committee that the Audit would definitely take place this year.

<u>Royal Free London NHS Foundation Trust:</u>

The Chairman invited to the table:

- Professor Powis - Chief Medical Officer, Royal Free London Group

The Chairman congratulated Prof. Powis on his recent appointment as the Medical Director of NHS England and noted that he would take up the post in January 2018.

The Vice Chairman welcomed the work undertaken by the Trust on Cardiotocography (CTG) and said that he would be keen to see further information on this in the Trust's next Quality Account.

A Member questioned how the Trust was performing in relation to four hour waits at A&E. Prof. Powis reported that Barnet Hospital had been performing very well over

the last four weeks and was recently tracking around 85% to 90%. Prof. Powis praised the work of the new Executive Team at Barnet and the new work being done by Social Care colleagues to discharge patients. The Committee were pleased to note that Barnet Hospital's performance had improved upon last year's figures. Prof. Powis informed the Committee that recently the Royal Free Hospital had not performed as well and had seen statistics in the lower 80s percentage wise. The Committee noted that the Royal Free Hospital had had significant building work in the last couple of months which was likely to have affected this result to some extent.

A Member noted the Trust's priorities for 2017/18 included the recruitment of 30 patient and family experience partners and questioned the role of a "partner" Prof. Powis undertook to provide further information on this.

A Member asked what more could be done to prevent patients going to A&E unnecessarily. Prof. Powis noted that GPs are also under a huge amount of pressure and if patients could not access their GP then they would go to A&E. Prof. Powis stressed the importance of educating people about different pathways, such as using the 111 Service.

The Chairman noted that the Committee had received a report on the use of "Streams" at their last meeting and congratulated the Royal Free on their excellent work in that area.

The Chairman noted that the Trust had stated that they needed to do work to compare the numbers of C.Diff. cases with other hospitals with similar complex cases and inquired if this work had been done yet. Prof. Powis advised that work was ongoing.

Responding to a question from the Chairman, Prof. Powis noted that as of the end of October 2018, there had been 47 cases of C.Diff. across the Trust against a target of 39 cases. Prof. Powis undertook to provide the Committee with the C.Diff. root cause analysis.

Responding to a question from a Member on the priority for 2017/18 of "To systematically analyse the experience of bereaved families and friends", Prof. Powis undertook to provide further detail of the web-based survey which is going to be launched.

The Chairman noted that the Committee had received an encouraging update on the parking situation at Barnet Hospital from Dr. Steve Shaw at their last meeting. The Chairman advised that the Portacabins were due to be removed which would free up additional space for parking.

The Chairman informed the Committee that there was a plot of land on site which she believed could accommodate 80 – 100 parking spaces and that also there was a section of waste land and some grass verges that she believed could accommodate additional parking. She informed the Committee that she was still receiving complaints and that the matter would not improve unless serious attention was given by the Management to provide additional parking spaces on site.

RESOLVED that the Committee noted the three reports and requested the information as set out above.

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NORTH LONDON HOSPICE
QUALITY ACCOUNT
2017-18
DRAFT FINAL

Contents

Executive Summary

Patient Story

I decided to refer myself to North London Hospice back in 2016. I happened to pick up a leaflet about the Hospices and its services in my local North London Hospice charity shop and decided to give them a call. At the time I was undergoing chemotherapy treatment and found myself really struggling with the side effects. I wasn't functioning well physically or emotionally and I felt I needed some extra support. I was then invited to the Hospice for a clinical assessment and the nurse who saw me suggested I should try a course of reiki to ease the pain I was feeling and to help me relax.

Since then I have also had four sessions of psychological support to help me deal with my illness mentally. Being told you have an incurable illness is a mammoth thing to deal with. I felt very alone and unsupported and having North London Hospice has been an immense help, allowing me to process the ordeal I am going thorough.

The Health and Wellbeing Centre offers a variety of supportive groups. I have taken part in one-to-one sessions with an art therapist. It has really helped me to cope and process my feelings and emotions. Most recently, I joined the photography group, which is run by a professional photographer. It's great fun. There are five patients and some carers in the group and we meet on a monthly basis. We learn and share tips on taking good photos and sometimes meet up to go to photography exhibitions.

I can't give up. I know my illness isn't going to go away and I'm not going to get better but that doesn't mean I have to stop living and doing all the things I enjoy doing. I urge everyone to write a bucket list. I have 81 things listed on mine and I have so far completed 28 of them, I intend to keep going and cross off as many of them as I can. I'm so thankful to North London Hospice for all their support. Hospice's aren't just there to care for people during their final few days they are there to make an unbearable bearable and enable people to live despite having an incurable illness.

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

It is with great pleasure that I introduce you to North London Hospice's (NLH) 2017 - 2018 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 saw the re-naming of our Outpatient and Therapy Service to that of the Health and Wellbeing Centre. The feedback from user's of the service were instrumental in the re-naming of the service as it was important that the name resonate with them and those who will use our services. The work of the services was showcased at our Health and Wellbeing Centre launch in March 2018.

One of our Priorities for Improvement this year was to adopt a "co-production" model to use when developing the new services in the Health and Wellbeing Centre. This means involving people who have used our services in deciding what new services to offer and how to develop them. Throughout the year a variety of new services and groups have been set up, all with the aim of enabling health and wellbeing. This includes groups for people with long term conditions other than cancer, offering services to patients earlier in their illness and support for carers.

I am pleased to see the progress that has been made with our Priorities for Improvements this year. It demonstrates our commitment to the ongoing development and delivery of quality services.

Next year's Priorities for Improvements have been presented to the Feedback Group for their comments and suggestions. The projects being: the implementation of a one page patient profile, the productive ward in the inpatient unit, a new falls group for our community patients and the continuation of our Hard to Reach Group and the work they are doing to improve access to our services.

In October we held our first North London Hospice staff showcase conference as part of the celebration of the 25 year anniversary of our inpatient unit. Seven departments presented on a wide variety of topics sharing practice to enable a greater understanding and learning across the organisation. It was a successful conference, positively evaluated by attendees. Plans are underway for another conference next year.

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 2018

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. The full year's Quality Account (QA), along with the previous year's QAs, will be found on the internet (NHS Choices and NLH website) and copies will be readily available to read in the reception areas at the Finchley and Winchmore Hill sites. Paper copies will be also 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. Out-of-Hours Telephone Advice Service
3. Health & Wellbeing Service (H&W) Formally Outpatients and Therapies (due to the re-naming of service at the end of the year, both names are used in the Quality Account)
4. Inpatient Unit (IPU)
5. Palliative Care Support Service (PCSS) - NLH's Hospice at Home service
6. Patients and Family Support Service (including Bereavement Service)
7. Triage Service

For a full description of our services please see Appendix One

Part 2: PRIORITIES FOR IMPROVEMENT 2017-18

The following priorities for improvement for 2017-2018 were identified by the clinical teams and were endorsed by the Quality, Safety and Risk Committee, Board of Trustees, local commissioners and Health and Overview Scrutiny Committees.

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

Priority One: Patient Experience:

Scoping Hard to Reach Groups to address potential inequalities in service provision

What we planned to do:

- To identify current reach, potential reach and mechanisms for widening access and to identify barriers to access and specific needs of groups. This was in response to the report by the Care Quality Commission "A Different Ending: Addressing inequalities in end of life care" (2016).
- To find out what local Clinical Commissioning Groups (CCGs), Boroughs and Hospice UK identified as gaps in the provision of specialist palliative care by Hard to Reach Groups (HTR) in order to improve their access to services.
- To find out how much HTR groups were currently accessing our services and where the gaps in referrals were and finally use this information to prioritise one HTR group and begin to identify recommendations for the hospice to widen access

Progress against the plan

The initial task was to undertake an external overview to identify who is Hard to Reach at End of Life in our boroughs. This exercise took the form of internet research as well as reading publications, and telephone conversations with local authority/CCG employees. From the information gained, we then undertook a series of internal surveys to gain qualitative and quantitative data to create an initial picture of who we are reaching and possibly who we are not reaching.

In addition links were made with external agencies such as the Westminster Drugs Project and the Substance Misuse Service in Barnet and Harrow, as well as linking with our three Healthwatch Leads.

Despite it being difficult to get accurate information about local priorities as well as which groups are currently accessing our services and to what degree, it has been possible to identify groups to focus on. The groups identified are: working with Substance Misuse and Homelessness, people with learning disabilities and most prevalent cultural groups in our boroughs.

Going forward:
This is a two year project. Please see 2018-19 Priority for Improvement for details of ongoing work.

Priority Two: Patient Experience:

Co-production of services in Outpatient & Therapies (OP&T) – now Health & Wellbeing

What we planned to do:
To develop a model where all new service developments within the service are co-produced by all relevant stakeholders to ensure the right intervention at the right time is delivered by the right people.

This came from the identification in a previous Priority for Improvement that identified a need to develop a model of care 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 current and potential patients and carers as well as staff and volunteers from other local provider services.

Goals:
To introduce:

- 3 new interventions for those with long term conditions
- 2 new interventions for carers
- 2 new interventions for those with cancer by March 2018
- A resource folder

Progress against the plan
The co-production model for service development within the Health and Wellbeing Service (previously Outpatient and Therapies) is now thoroughly embedded and has become part of how the service works.

All the goals were met. We have new services for those with long term conditions, cancer and carers including:
Relaxation group
Breast cancer support group
Managing fatigue sessions
Men's group
Carers skills course,
Relaxation for Carers
Support group for carers
Teens support group
Catching the Light photography group

A Resource folder with information about co-production and examples of how the model has been used in practice is available for staff.

Alongside these outcomes there have been other initiatives developed using this model such as working with Noah's Ark (a Children's Hospice, in Barnet) to support the transition of young people to adult hospice services.

Links have been made with several external teams such as the Heart Failure Team and the community neurology teams and we are hoping to work with the Head and Neck cancer teams, using a co-production model to plan and develop collaborative services for these areas.

The stakeholders, particularly the users of the services have found the inclusion in developing services for them and around them an empowering experience which has had other positive effects for them in other aspects of their lives. It has also shown that investment in this model encourages 'buy in' from the stakeholders and the services co-created are successful.

Going forward
Further development of services is planned using the co-productive model.
The development of a resource folder has been key to supporting the development and change of the service. This model will be shared with the NLH management group to support other internal service developments.

Priority Three: Patient Safety:
Falls Management and Prevention Project on the Inpatient Unit

What we planned to do:

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

Progress against the plan

- The existing falls and moving and handling paperwork were revised and polices modified accordingly. An audit of relevant paperwork completed before and after the project showed improvements in all key areas. Of particular note is the 75% improvement in number of patients with a falls care plan and the 50% improvement in completion of first assessments.
- Daily review of Karnofsky and Phase of Illness tools were used as the prompt to review patient risk of fall through a new assessment. The audit showed improvement in timely reviews. Changes in the Karnofsky and Phase of Illness were prompts for this to happen.

- Staff surveys carried out before and after the project showed that 100% of staff had more confidence in their knowledge of assessing falls risks and subsequent strategies to attempt to reduce the risk.
- It had been anticipated that specific training would be provided, however in practice the decision was made that the mandatory moving and handling training was revised to include a section on the new falls paperwork. The revised training commenced in July 2017, in addition the physiotherapist has been undertaking one to one training with staff on the unit as required.
- Alarms have been purchased to use for patients at risk of falls as they alert staff to when a patient is on their feet, and a low bed is to be purchased when funding has been secured

Going forward

- To re-audit audit in September 2018 to ensure standard of paperwork completion remains high
- To write an e-learning module for the NLH staff on Falls Management by August 2018

Priority Four: Clinical Effectiveness:

Establishing a Multi Professional Journal Club for hospice clinicians

What we planned to do:

To set up a multi-professional journal club to support continuing professional development for clinical staff and promote multi-professional working, with aims being to:

- Keep staff abreast of new literature, clinical evidence and research
- Enable staff to learn / improve their ability to critically analyse and appraise research
- Improve clinical care & patient outcomes by promoting professional practice that is evidence based

Progress against the plan

The Journal Club was launched in July 2017 following planning by the steering group, and seven sessions were subsequently held. Attendance varied from 4 – 12 people, with an average of six members of staff per session. Articles were presented by staff from the following departments: medicine, physiotherapy, Health & Wellbeing Centre, Patient & Family Support Services and the Inpatient Unit.

The Journal Club provided an arena for continuing professional development in a multi-professional setting for those staff that attended. It enabled a cross-section of staff to meet, who would not necessarily do so in the ordinary working week, and provided stimulating discussion on a variety of topics, from neuro-muscular stimulation to care for Lesbian Gay Bisexual and Transgender people. Staff considered and critiqued articles on topics that would not necessarily be foremost to their practice, thereby broadening their knowledge and outlook. The Journal Club also enabled members to become more aware of the importance of critiquing articles and the skills required to do this.

Analysis of the evaluation sheets attendees were asked to complete after each session found that:

85% felt multi-professional working had improved
78% felt more up to date with new literature
71% felt better able to critically analyse an article
89% felt the session they attended would result in improved patient care

Going forward

The setting up of a multi-professional journal club has been a positive initiative and valued by those who have attended.
The intention is to continue the Journal Club, whilst looking at how it might be adapted to enable more staff to attend. A survey has been undertaken to determine why some people did not attend. Results will be discussed at a Journal Club Steering meeting with a view to change the date / time / location of the meeting if a better proposal is put forward.

PRIORITIES FOR IMPROVEMENT 2018-19

The following Priority for Improvement Projects for 2018-19 have been identified by the clinical teams and endorsed by the Quality, Safety and Risk Committee.

All projects were discussed at the Hospice Feedback Group, their comments incorporated into the plans and users' future involvement in the projects discussed.

The priorities for improvement projects are detailed under the three required domains of Patient Experience, Patient Safety and Clinical Effectiveness:

Patient Experience - Project 1:

To address inequalities in service provision through improving access targeting Hard (Need) to Reach Groups previously identified the 2017 - 2018 Priority for Improvement (Year One).

How this was identified:

Following the scoping undertaken in 2017 - 2018, it was agreed that focus for Year 2 will be on:

- People with learning disabilities,
- Homelessness people (with substance misuse in particular)
- Improving our working with the significant cultural groups across the three boroughs we service - Barnet, Enfield and Haringey.

Relationships with specialist providers formed in Year One informed us that there is greater need for a coordinated approach to these groups at end of life.

In addition, the NLH literature and website will be up-dated to ensure it is inclusive of all groups who may need to access our services.

What we plan to do:

- To work via the Steering Group to address the areas outlined above. This will include service user involvement and a member from our Communications Teams.
- To develop a flexible model to improve engagement and support of Hard (Need) to Reach Groups identified.
- To build on work commenced at the end of Year One with the Westminster Drugs Project (providing substance misuse services in Barnet) of providing mutual training and awareness sessions, from which we can question existing practice. We will bring stakeholders together from all three boroughs to share learning and develop a consistent approach. We will aim to identify champions/link workers in each borough from the Community Teams and Health and Wellbeing Service.
- Our Compassionate Neighbours development will target the top one or two cultural groups in each borough. The intention will be to recruit Compassionate Neighbours from

these communities as well as provide Community Members with a good fit with a Compassionate Neighbour volunteer. Information and learning from this networking will be brought back to the Steering Group where consideration can be given for further work; for example following the model described above, of mutual training between NLH and organisations supporting/representing those communities as well as consideration of the best pathways of support. (See page xx for more information on Compassionate Neighbours).

What the outcomes will be:

- We undertake to show evidence of:
  - changes made to image/literature/website
  - mutual training, ideas and implementation of some different pathways of practice
  - identification of champions/link workers
  - knowledge about cultural groups and their specific needs around end of life
  - specific case examples that could demonstrate the impact of the development

Patient Experience - Project 2:

Introduction of a "One Page Patient Profile"

NLH wants to introduce the use of a One Page Patient Profile across its services.

A one-page profile is a simple, concise way of communicating information about an individual patient. It includes what is important to them, what they like and how they want to be supported - on a single sheet of paper. They are completed by the patients themselves or if they are unable to do this, by people who know them well. The information obtained is used when planning patient care and prevents patients being asked repetitive questions. It helps staff to see the patient as the person he / she is.

How this was identified:
2017 – 2018 has seen the establishment of a Dementia Steering Group. The concept of a One Page Patient Profile was part of a presentation by the group at the NLH Staff Showcase Conference. It was agreed that this would be a good initiative to introduce to enhance our patient-centered approach. This is particularly relevant for those patients who are not able to tell us what is important to them either because they have dementia or any other problem affecting their communication ability. Also a member of our Feedback Group brought up the concept of having a visual aid in the patient's bedrooms on IPU of how patients were before they became ill to help staff delivering patient centered care.

What we plan to do:
The Dementia Steering Group will take the lead on producing a One Page Patient Profile which will be initially presented to the Feedback Group for comment. Once the format and wording is agreed, the intention is to implement it across all our services (Community, Inpatient unit, Health and Wellbeing Services).

What the outcome will be:

The outcome will be that all patients will have the opportunity to have a One Page Patient Profile unless they express they do not want one. Staff will be able to use this information to improve the individualised patient-care given.

Patient Safety - Project 3:

Establishing a Falls Group for Community Patients

This is a group that is both educational and practical.

The aims of the Falls Group are to:

- Improve patient awareness of why falls happen
- Give strategies to reduce the risks
- Give strategies of what to do if they do fall
- Give strategies to help / improve their balance

How this was identified:
This Priority for Improvement was proposed by members of the Feedback Group. The group had been up-dated on the progress of the 2017 – 2018 Falls Project on the inpatient unit and wished to see a falls project for community patients.

What we plan to do:
To set up a multi-disciplinary steering group to run a Falls Group for our Health and Wellbeing patients, community patients and any inpatient unit patients admitted for symptom control who will be discharged home.

We plan to:

- Establish the multi-disciplinary steering group
- Distribute a questionnaire to Feedback group members to ascertain their views and baseline knowledge of above aims.
- Review similar groups set up other hospices and local community groups and then plan their model based on information gained.
- Pilot the falls group and evaluate it.

What the outcomes will be:

A questionnaire will be given to patients before and after they attend the groups to ascertain if the aims have been achieved.

The outcomes will be for patients to:

- Have increased awareness of why falls happen and know what they can do to reduce them in their home environment.
- Have better knowledge of what to do if they do fall.

Clinical Effectiveness - Project 4:

The Implementation of the Productive Ward in the Inpatient Unit (IPU).

The Productive Ward has been developed by the NHS Institute for Innovation and Improvement. It comprises of a series of 15 modules that are introduced on the ward to improve ways of working that leads to "Releasing Time to Care". This in essence means making changes in the ward setting to enable nurses to spend more time with their patients.

How this was identified:
This was identified after hearing encouraging feedback from other hospices who have implemented the Productive Ward and from reading literature describing positive outcomes following its implementation. As the IPU have a new management team in place, the time is ideal to review practice and ensure maximum time is spent with patients.

What we plan to do:
To set up a steering group made up of IPU staff of all grades of nurses, health care assistants and a ward administrator.
The group will develop an action plan to introduce the three core modules over the first year as a minimum.

What the outcome will be:
The outcome will be that the 3 core modules will be implemented by March 2019

- "The well-organised ward",
- "Patient Status at a Glance" and
- "Knowing How we are doing"

This is a two year project, further outcomes will be identified in year two.

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 2017-18, 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 2017-18 represents 27 per cent of the total operational income generated by NLH for the reporting period.

Participation in clinical audits

During 2017-18, 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 2017-18 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2017-18, 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 2017-18 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. In 2017-18 the following local clinical audits were carried out and NLH undertook the following actions to improve the quality of healthcare provided.

1. **SAFE USE OF BEDRAILS**

   An audit was undertaken in the inpatient unit to determine how many patients had a bed rail risk assessment carried out. The audit concluded that 100% of patients had the risk assessment completed and that 91% were completed on the day of admission. However, only 54% of the risk assessments were fully completed. Review identified this was because the assessment form was over complicated. A simplified version was produced, piloted and is now routinely in use. A re-audit has been planned for summer 2018.

2. **TIME TO FIRST CONTACT POST TRIAGE (OUTPATIENTS & THERAPIES)**
   100% compliance with the timescale required by current in-house policy was observed. However, it was noted during the audit that the policy did not define when the required timeframe is measured from i.e. from when the patient is released from Triage or from when the OP&T team receives the paper referrals. The Out Patient & Therapies Operational Policy has now been updated to clarify this requirement as being from receipt of referral by OP&T.

3. **MANAGEMENT OF PRESSURE ULCERS**
   This audit was undertaken using the Hospice UK Pressure Ulcer Audit tool. The audit results were adequate and overall validated the known concerns (previously identified through pressure ulcer Root Cause Analysis investigations undertaken). The key areas for improvement were addressed through the ongoing Pressure Ulcer Management Action Plan and included improved communication with patient regarding pressure ulcer prevention and the photographing of pressure ulcers with consent. A re-audit is planned for June 2018.

4. **PREVENTION OF FALLS**
   The results of the first audit highlighted known issues of concern with regard to the appropriateness and use of current falls risk assessment forms and the linking to individualised care planning. All the required outcomes have been actioned under the Fall Prevention Priority for Improvement Project 2017 – 2018. A re-audit was undertaken at the end of the project and found improvements in all areas of paperwork. Of particular note was the 75% improvement in care planning. A re-audit is planned for September 2018.

5. **AUDITS OF DEMENTIA FRIENDLY ENVIRONMENTS AT WINCHMORE HILL and FINCHLEY**
   This audit was developed by the Kings Fund to determine how "dementia – friendly" the care environment is.
   It was undertaken in Winchmore Hill (Health and Wellbeing centre). The results were good and only a few changes were recommended for consideration. Some changes are cost prohibitive such as flooring. However, there are other areas that are being considered such as signage and alternative artwork.
   The audit was also repeated on the Finchley site having last been undertaken in June 2016. Similarly, the findings were good. An action plan was developed to ensure all the minor recommendations were acted upon (mainly concerning equipment and signage to be easily accessible if a patient with dementia / cognitive impairment is admitted to the unit). We plan to have achieved the required actions by 1st August 2018. Both audits will be repeated during the autumn of 2018.

6. **ANTIMICROBIAL STEWARDSHIP**
   Overall levels of compliance were encouraging, but further consideration was required about the requirement (in National guidance) that the use of antibiotics be reviewed within 48-72 hours of commencement. Therefore, following the audit the 'Start Smart'

national guidelines were circulated to all NLH doctors and the Royal Free Antibiotic prescribing guidelines have been adopted for use by NLH.

7. **IPU DISCHARGE PROCESSES**
   This audit against standards set within an in-house policy evidenced much good practice, but raised some questions about the need to improve documentation in terms of whether/when Continuing Healthcare (CHC) Fast Track funding was awarded and when GP discharge letters have been written and sent. Amendments have been made to the electronic patient database. Review of Discharge planning practice is part of the Inpatient Units objectives for 2018.

8. **MANAGEMENT OF SAFEGUARDING INCIDENTS**
   This was a review of the processes around the management of safeguarding incidents logged over a 12 month period. Much good practice was noted, although there was some deviation from the standards laid down in the NLH Safeguarding Adults Policy. Initial discussions with a relevant Manager, referral to the relevant Borough and analysis meetings did not always take place within the internally set time frames. In addition, some incidents remained open over an extended period.
   As a result, a Safeguarding Key Worker for each incident has been introduced to ensure regular reviews take place and incidents are closed in a timely manner. This area of practice was re-audited after 6 months and demonstrated that safeguarding incidents are now being managed and closed in a timelier manner and that the Safeguarding Key Worker role is becoming embedded in working practice.

9. **HAND HYGIENE AUDITS**
   These audits have been undertaken for all 3 Community Teams, Health and Wellbeing team and IPU. Levels of compliance in the Community teams ranged from 78 – 89% (down from 86-91% last year), for Health and Wellbeing 85% (down from 91% last year) and for IPU was 94% (up from 88% last year).
   These audits are undertaken by means of a self-assessment tool and in the Community and Health and Wellbeing Teams are completed by a relatively small number of staff (ranging between 5 and 24 per audit). Consequently percent compliance scores can be misleading as a small change (such as a single member of staff not filling the form in correctly or acknowledging a lapse in an element of best practice) can have a significant impact on overall percent compliance.
   The action plan for all areas is to use the Link Nurses to re-enforce good practice amongst staff.

10. **INFECTION CONTROL AUDITS**
    This audit has been undertaken for IPU, Winchmore Hill and George Marsh Centre premises, with levels of compliance of 95%, 95% and 100% respectively. Action plans are being developed to address the elements of non-compliance for IPU and Winchmore Hill.

11. **MEDICINES MANAGEMENT AUDITS**

Controlled Drugs, Accountable Officer and Medicines Management audits have been undertaken. All three audits have been devised by Hospice UK to meet the requirements of all relevant legislation and are undertaken annually. Levels of compliance have not changed significantly since last year's audits, with a small increase in compliance with regard to prescribing of Controlled Drugs. An action plan to further improve compliance is now being progressed by the Accountable Officer working with the recently recruited specialist pharmacist.

12. **AUDIT OF 5 PRIORITIES OF CARE**

This audit was undertaken to assess the documentation used for patient care on the Inpatient Unit during the last days of life, known as '5P's paperwork'. This is the documentation introduced in accordance with the new Priorities for Care which succeeded the Liverpool Care Pathway (LCP) in 2015.

The results indicated that the 5P's documentation had not been fully completed for all the patients reviewed. Reference to nutrition & hydration was least well documented and looking for evidence of the various aspects of 5Ps care was complicated by the fact that a mixture of electronic and paper records are used and sometimes information is repeated in both format of notes.

Review of the documentation process is a strategic objective for IPU in 2018.

13. **USE OF IPOS IN OUTPATIENTS**

The Integrated Palliative Care Outcome Scale (IPOS) invites patients to list their main symptoms and concerns and is a key tool when seeking to measure, demonstrate and improve patient care. Patients attending an Out Patient Clinic should be asked to complete an IPOS form prior to their first and every subsequent visit. This audit was undertaken to assess how reliably these forms are being completed and how well the information they contain is being used to influence subsequent care planning for each patient.

This audit is in the process of being analysed but initial results show that the service is good at ensuring completion of the IPOS every visit and the discussion of IPOS is part of every conversation with the patient, however it does not always influence the care plan.

Research

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2017-18, 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.

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2017-18 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 2017-18 as of the 31st March 2018.

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. NLH was found to be compliant in all of the areas assessed and each site was rated "Good" in all domains.

DATA QUALITY

NLH did not submit records during 2017-18 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 2017 - 18 and received a satisfactory score of 98%.

For 2017 - 18 NLH has not yet received confirmation that our assessment has been reviewed by the Health and Social Care Information Centre (HSCIC).
The review of our submission by the NHS usually takes a few weeks and we may receive confirmation of this before the Quality Account is published

A statement about GDPR:

The General Data Protection Regulations are due to become law on the 25 May 2018, replacing the Data Protection Regulations. North London Hospice is working towards ensuring that they have procedures in place to ensure that they are compliant with the new regulations.

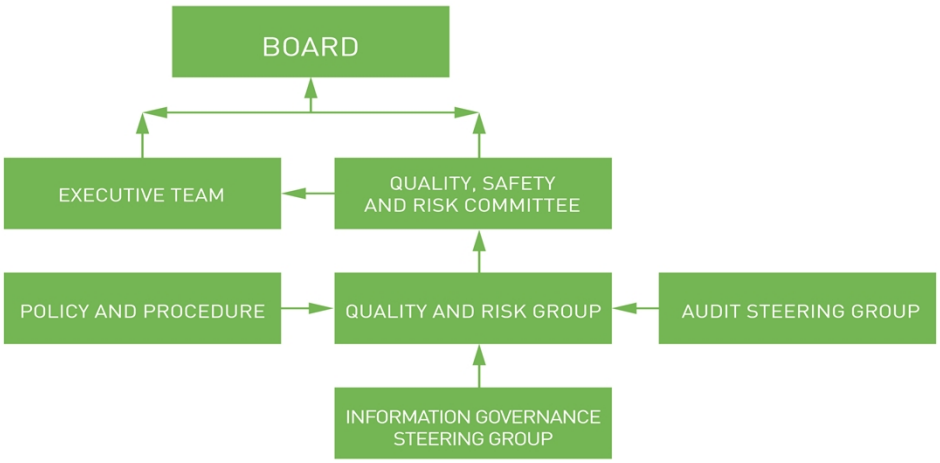
NLH was not subject to the payments by results clinical coding audit during 2017-18 by the Audit Commission. This is not applicable to independent hospices

For a details regarding Information Governance please see Appendix Two

PART 3: QUALITY OVERVIEW

QUALITY SYSTEMS

NLH has quality at the heart of everything it does as depicted in the diagram of reporting and quality assurance arrangements below:



For a full description of our groups that oversee and review quality please see Appendix Three

KEY SERVICE DEVELOPMENTS OF 2017-18:

Corneal donation project
This year we have worked with Moorfields Eye Hospital NHS Foundation Trust to explore corneal donation. The team from Moorfields came to the Hospice to provide a training and education session for staff on Corneal donation including the process of donation, the factors that would prevent an individual from donating and the role that the Hospice could play in raising the profile of donation with our patients. A study had been undertaken in another Hospice that had identified that there had been 'no harm' to patients where they had raised corneal donation with patients on admission to the inpatient unit.

A small working party was established to consider corneal donation and agreed that it was an area that we should be promoting with our patients. Corneal donation gives patients the opportunity to give something back and leave a legacy, it is enabling those who had registered as organ donors to fulfil their wishes.

The pilot was launched in November 2017. Changes were made to the initial patient assessment to facilitate conversations with patients, information on corneal donation was provided by Moorfields and a guide for staff on the process until death was produced. Staff have also had the opportunity to observe the corneal retrieval process in order to be able to speak with firsthand knowledge to patients and families regarding the process.

Between November and February 2018, corneal donation has been approached with 93 of the 106 patients admitted to the inpatient unit. 4 patients have been referred to Moorfields, resulting in 2 donations. One patient was ultimately contraindicated for donation and one referral was deferred due to a change in the decision to donate following contact with the next of kin. The two patients who donated could have helped save or even restore sight in up to ten people.

Following feedback from staff the guidance for staff will be updated and corneal donation will be covered in the inpatient unit Doctors and Nurses induction to ensure consistency approaching the subject with patients and their relatives.

Dementia

At the beginning of the year the dementia steering group was established with clear objectives for the forthcoming year based on Hospice Enabled Dementia Care (Hospice UK 2015):

- To develop, educate and support staff in dementia care
- To scope and recommend models of care for the organisation
- To build collaborative relationships within our community

Achievements to date:

- Presentation at the staff conference in October 2017 to promote awareness of dementia care and the steering group.
- Audits of the Dementia Friendly Environment were undertaken at Winchmore Hill and Finchley sites
- Current models of hospice care were explored and examples of good practice added to the virtual "dementia library" to consider adopting should grants become available
- A wealth of good practice was collected over the year and added to the virtual "dementia library" (in the shared folder).
- Links were made with all 3 Admiral Nurses and joined the 3 local Dementia Action Alliances
- The Hospice UK Dementia Community of Practice Group was attended.

Information gained and links made have enabled NLH Dementia Steering group to start to map and understand local care provision for dementia. A plan for 2018-2019 year has been written based on knowledge gained and gaps identified.

Increased Pharmacy Provision
This year the Hospice has invested in additional Pharmacy provision for the inpatient unit through the appointment of a part time pharmacist. This dedicated specialist palliative care pharmacist oversees drug regulations especially with regard to controlled drugs, makes suggestions on possible changes to our formulary (including cost savings). The pharmacist reviews the medication every patient is taking on admission to the inpatient unit to ensure patients are provided with the correct medication. Attending the consultants ward rounds and the multi-disciplinary team meetings enables them to give both specialist and general advice on medication to support symptom management and patient care.

Faith Communities
Spiritual Care and Volunteering Engagement have been working together to develop and deliver a short course aimed at ensuring members of each community feels enabled and empowered to support people who are living with illness, dying or are around people who are dying. This grew into NLH challenging local Church of England and Catholic churches to take up the Lenten challenge - "rather than give something up for Easter why not take something up and become a Compassionate Neighbour?" We have had a great response and are planning to repeat this with other faith communities throughout the year at relevant times.

Hospice Biographers
This is a new organisation that recruits volunteers to digitally record patients' life stories, and gives the patient a choice of format in which to receive it, as well as nominating people who can receive it. Having heard about the training in Emotional Resilience provided by NLH they approached us to tailor the course for them and deliver it to all of their volunteers. This is an income generating initiative that also promotes the training and the NLH model of volunteer support to all hospices participating in this project.

Compassionate Neighbours
Whilst not an NLH innovation, as part of the roll out of the model adopted by St Joseph's Hospice, we are being innovative in the way in which we are delivering. Aiming to enable people who have become isolated to reconnect with the community around them, we are encouraging neighbours to not only visit people in their own homes, but also to co-produce activities as an opportunity for social interaction. We are working in partnership with other local community organisations to help make this happen.

Renaming of Outpatients & Therapies to Health and Wellbeing (through the Feedback Group)
With the investment over the last couple of years into the Outpatient and Therapy Team the service has been able to develop and evolve. However, it became clear that it lacked its own identity and that stakeholders were unclear what the service offered. As the new team settled and developed a broader range of interventions that were more appropriate for people earlier in their disease trajectory, a new name for the building and consequently the service was required.
In order to ensure that the name reflected what the stakeholders saw the building and service as, the renaming was put to the Feedback Group for discussion and ultimate naming.

The Health and Wellbeing Centre was officially launched in March 2018.

Health and Wellbeing Centre Highlights 2017 – 2018
The Outpatient and Therapies service has undergone a transformation during the last year culminating in the renaming of the building and service to the Health and Wellbeing Centre.

The multi professional team has now embedded a number of new initiatives and extended interventions not just for patients but also for carers.

Interventions come under the headings of
- Symptom Management,
- Rehabilitation and Self-management,
- Emotional Wellbeing,
- General Wellbeing and
- Community Engagement

Using the co-production model has enabled us to have a broad range of activities that our patients and carers have identified as their concerns.

The highlights for this year are:
- The development of Carer support and interventions:
  - Five week course for carers caring at the end of life.
  - monthly support group
  - relaxation course
  - Complementary therapy
  - Psychosocial support
- 'Catching the Light' photography group. In May we held an exhibition of landscape photographs by one of our patients which we invited internal and external people to. Using a co-production model at this event we started to develop a photography group. The group has two elements – the 'creating' and the 'being'. It is a space to learn, share and enjoy photography as well as a place to support each other through illness, decision making and treatment. This group has an online platform where they share their photographs with the group, they have been to exhibitions and regularly meet to take photographs
- Death Café – during Dying Matters week 2017 we launched our first Death Café at the hospice. Based on the Swiss Café Mortel movement, Death Cafés were created by Jon Underwood in 2011 and offer an open and confidential space with tea and cake, to share our thoughts, concerns, hopes and experiences of death. It is a discussion group rather than bereavement support. These are run bimonthly
- Teens Support group – this group is very much in its infancy but had been developed and met monthly for the last three months offering psychosocial support alongside peer support to young people living with a family member diagnosed with a life limiting illness
- Community engagement
  Visiting musicians, folk dancers and theatre group performances throughout the year
  Two workshops in conjunction with the National Portrait Gallery – 'What's in a Portrait?'
  16 talks to local community groups about North London Hospice showcasing the Health and Wellbeing Centre
- Dramatherapy Student placement – a yearlong placement which has enabled us to develop further our creative psychotherapy services including 'Life Matters men's group'

an 8 session confidential creative group offering space to explore things that matter and meeting others facing similar challenges
- The Launch of the Health and Wellbeing Centre and the Health and Wellbeing Service in March 2018 promoted the service and hospice. Current and prospective users attended as well as local health, social care and local leaders.

Home from Home
At North London Hospice we realise the importance of mealtimes to both patients and their families. Our Catering Manager visits each patient on admission, she introduces her team and explains what we offer patients and also what is available for visitors. Patients enjoy eating their meals joined by their spouse /partner. It adds a feeling of normality into a situation which can feel very alien.

We are constantly striving to make our environment feel warm, friendly and comfortable for all who access our services. During the last year we have updated our family room so it now has a much more homely rather than institutional feel. It is now a calm, quiet space where family members can sit and reflect.

Within our Living Room we try to provide distractions for patients and visitors - we have a piano available for anyone who wishes to play and we have recently introduced a jigsaw table. We mark celebrations/ festivals and screen showings of major sporting tournaments. Our "Come and Connect" programme continues to create a vibrant atmosphere of IPU and community patients and families coming together for lunch and volunteer supported activities. Again this helps patients stay connected to the outside world.

Outcome Star Development – Working Title 'Preparation Star'
NLH initiated the development of an 'End of Life Star' to be used in palliative/End of Life care and invited in other collaborators (for example St Joseph's Hospice, Macmillan Cancer Support, Jewish Care and the London Association of Directors of Adult [Social] Services) to help fund the development.

The progress of development of the Outcome Star was delayed in 2017. The draft Star, called 'Preparation Star' was produced by the summer 2017 and staff from collaborators, including NLH, were trained to test it out. A question was raised about ethical approval for this development, for organisations, like NLH, who are part funded by NHS. Seeking this approval has delayed the development. It is now in place, though we were ultimately advised it had not been necessary but was considered best practice. However, approval will give greater legitimacy to the final product and make it more likely to be used in NHS settings. NLH staff are due for refresher training in April 2018. The final version should be available nationally by the spring of 2019. (See Appendix Four for further details on Outcomes Stars)

Feedback Group
The user Feedback Group set up in 2016 has continued to meet regularly. The group's scope has extended this year to include inpatients and their families as well as users who have been discharged from our care and bereaved family members. Themes discussed have been catering provision, feedback from the user survey 2016, suggestions for and presentation of potential new priority for improvement projects 18-19, the hospice's new strategic plan and have included face to face discussions with NLH's CEO, Directors, clinicians and managers. Some changes made following suggestions:
- Smoothies added to inpatient unit menu

- Soup for patients pureed not sieved
- Provision for carers to be included in new falls group development
- Feedback Group attendee offered to be part of Need to Reach project with his experience of the local Mauritian community

The revised Steering Group continues to involve two users and next year hope to explore how best to involve community team users.

Community Teams: Rapid Response
Each community team identify a Clinical Nurse Specialist (CNS) daily to act as a rapid response (RR) nurse who has the capacity to respond to urgent need, this may be a new urgent referral or a patient already known to the service who has unexpectedly deteriorated. The RR nurse can visit the patient the same day to assess them, develop a treatment plan and coordinate their care working with the patient's general practitioner and district nursing service to support the patient and their family / friends. The aim of the rapid response nurse is to promote patient comfort and prevent unwanted / unnecessary admissions to acute hospitals. Each team have a health care assistant (HCA) who is able to offer practical help should the patient require it and has the capacity to spend time with the patient supporting them and their family.

Integrated Community Palliative Care Team
The Palliative Care Support Service (PCSS) have integrated a HCA into each borough team who work supporting the CNSs in caring for patients at home, the HCA can help with practical issues for example providing personal care until statutory services commence, as well as, supporting relatives when patients are dying. In addition, commencing in April 2018 the Enfield and Haringey teams have recruited a Palliative Care Nurse (Band 6). The aim of this post is to be able to support patients in a more practical way and supporting the work of the district nurses and the rapid response service aiming to help patients to remain in their preferred place of care and promote their comfort.

The end stage renal failure project
The project has now completed and recommendations have been made for developing the implementation of advanced care planning for patients undergoing renal dialysis, who are not responding to treatment. We have offered collaborative working and are in discussions about how this will work in the future.

PARTNERSHIP WORKING

NLH are working together with:

Sustainability and transformation Plan (STP)
NLH is actively involved with North London Partners in Health and Care, being members of the North Central London (NCL) STP Last Phase of Life Steering Group progressing the business case which is one of four projects under the NCL STP Urgent and Emergency Care Programme.

The business case is looking to:

- increase investment in community based specialist palliative care services throughout NCL, with a focus on the provision of care in Care Homes.
- develop a Single Point of Access for Last Phase of Life.
- redesign commissioning arrangements for Last Phase of Life services across NCL.
- support Acute Trusts to equalise investment in acute palliative care services.

This has included Steering Group meetings, service planning meetings and regular teleconferences between providers.'

Sharing Skills & Knowledge
Working together with Westminster Drugs Project to identify each agencies gaps in knowledge about one another's' service area and looking at how we can fill these. Intending to use this as a model for ways of working in the future. This not only increases the skill and knowledge of frontline workers, but also introduces NLH to client groups that may otherwise not have accessed our services.

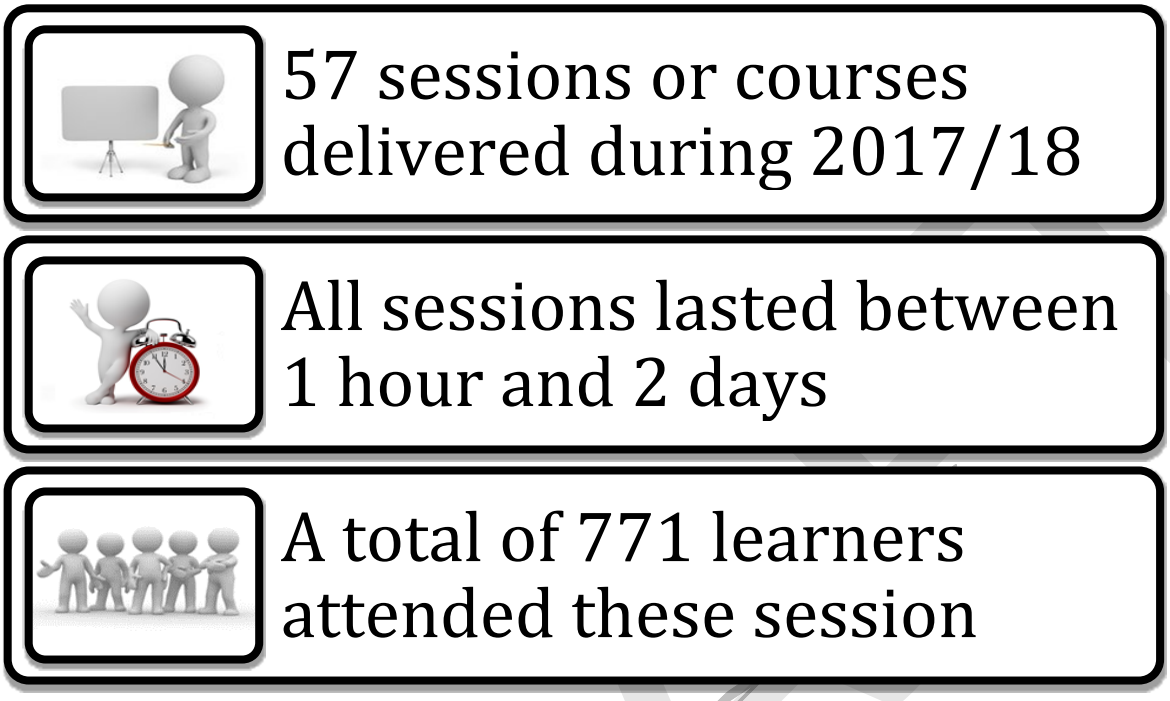
Specialist Palliative Care Community Teams
Each of the three Community Teams have continued to develop their working relationships and practices with District Nurses, Community Matrons, Heart Failure Team, Respiratory Teams, Dementia services and with the Neurological / Frailty Multi-Disciplinary Teams.

Noah's Ark (Children's' Hospice). The Health and Wellbeing service has been working in collaboration with Noah's Ark looking at what their young people (and their parents) who are transitioning to adulthood may require to support this transition and move into adult hospice services

Quality Team
The Assistant Director's Quality have been supporting the Royal Collage of Nursing's work with Royal College of Physicians and NHS Benchmarking to develop the National Audit of End of Life Care in hospitals and are also part of the Hospice UK advisory group for the National Benchmarking of Hospice inpatient unit safety metrics programme.

EDUCATION AND TRAINING

Achievements and Developments



- Two new courses, the Level 5 Award in Palliative Care Awareness and the Level 2 Award in Emotional Resilience were developed this year. These new accredited courses have been created in partnership with Barnet and Southgate College and OCN London. These awards are nationally recognised qualifications and can be used towards Continuing Professional Development (CPD) evidence across all levels in the Health and Social Care setting. The already successful QCF Level 2 Award in End of Life Care continues to be well subscribed and has received excellent feedback from the external moderator with Barnet and Southgate college:

  Level 2 Award in End of Life Care Feedback - Good Practice – *"All portfolios sampled today have clear assessment planning and supportive feedback which confirms what has been achieved. The quality of the evidence submitted was to a high standard and it is clear assessors expect learners to take a pride in the presentation and standard of their work". "Please continue with the excellent work".*

- North London Hospice (NLH) is a Gold Standards Framework (GSF) Regional Centre, offering the Gold Standards Framework Care Home Programme (GSFCH). The Education Team were actively involved in the successful completion of the cohort programme by three care homes. These care homes are now working towards accreditation. The aims of the GSFCH programme are to improve:

  The quality of care for all residents in the home
  The coordination and collaboration with others
  Outcomes, by reducing hospital admissions and deaths
  The programme equips homes to apply for GSF accreditation.

- NLH provides an induction programme for new staff and volunteers in addition to the annual mandatory training. The induction training has been revised and now includes a "*Patient Journey*" session in the form of a case study. This session is facilitated by internal clinical and non-clinical staff. A case study team has been formed to prepare and discuss the delivery of each of these sessions.

- The Education Team supported the development of three posters presented by NLH at Hospice UK conference November, 2017.
  Poster titles:
- "*Educating the Next Generation*"
- "*Developments in Pressure Ulcer Management and prevention*"
- *"Inpatient Unit Education Programme"*

- This year saw the first NLH Staff Showcase Conference as part of the 25 year anniversary of Inpatient care. Seven departments presented topics using a variety of methods from Case Studies, Practical Demonstrations, from popular Game Shows to PowerPoint presentations. This conference demonstrated the knowledge and expertise within NLH and is informing the planning of an external conference in 2019.

- New Head of Education role

  This role was successfully filled in October 2018. The key functions of this role are to:
  1. Manage and lead the development of excellent education programmes that are financially viable and relevant to the work of NLH.
  2. Establish relationships with external stakeholders in order to secure external education contracts to achieve a budgeted income.

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.

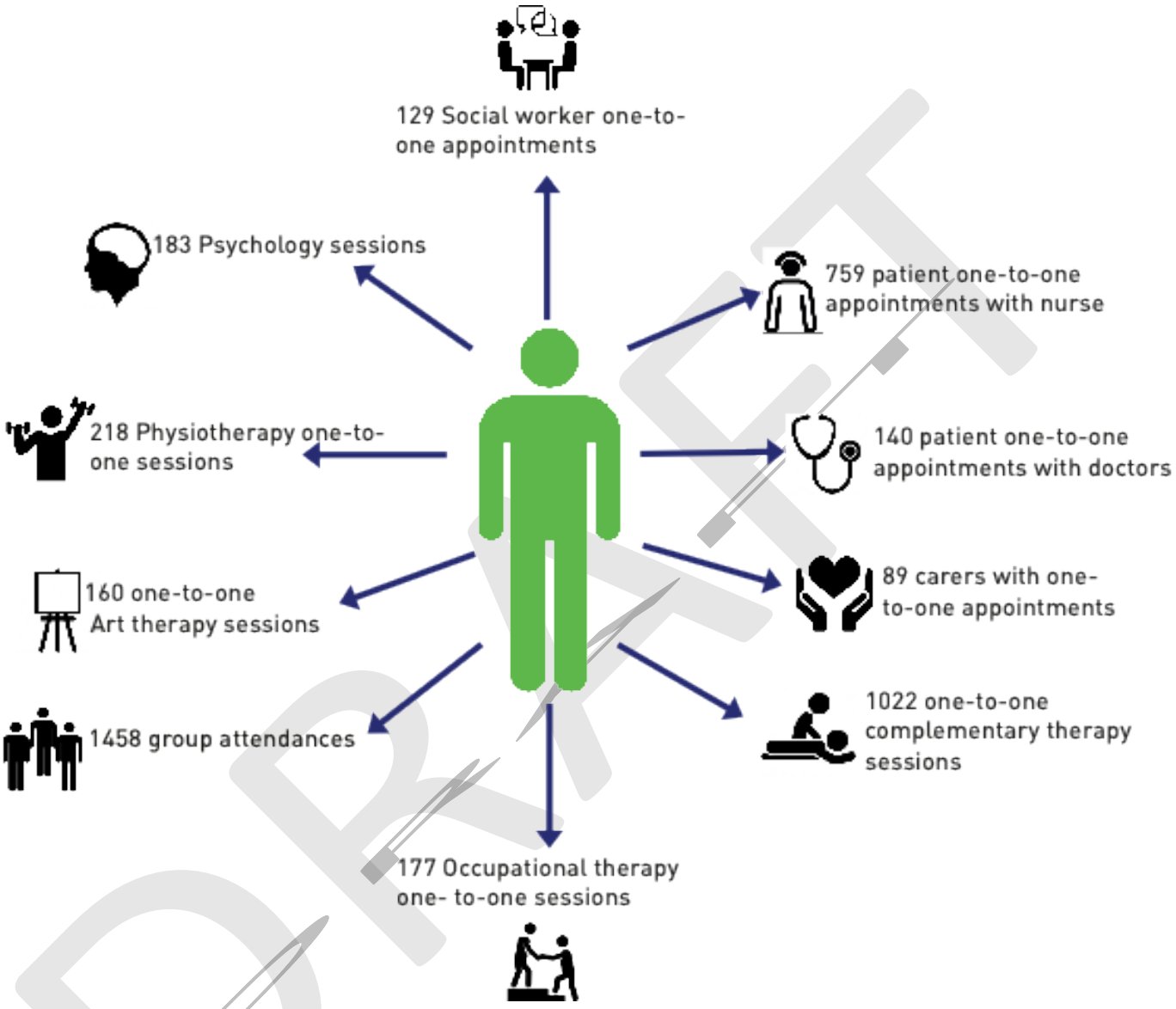
In Patient Unit (IPU)

This year has seen a decline in admissions to the inpatient unit, however there has been an increase in bed occupancy from 75% in 2016-17 to 78% this year.

The percentage of cancer versus non cancer diagnosis has remained consistent (85%), despite NLH referral criteria being inclusive of all life-limiting conditions. This year has seen an increase in patients being discharged from the IPU. The average length of stay has increased this year from 13.5 to 16.5 days; we have seen 18 patients with stays of over 40 days prior to their death, and 8 patients with 40+ day stays prior to their discharge from the unit. This reflects the complexity of patients' needs.

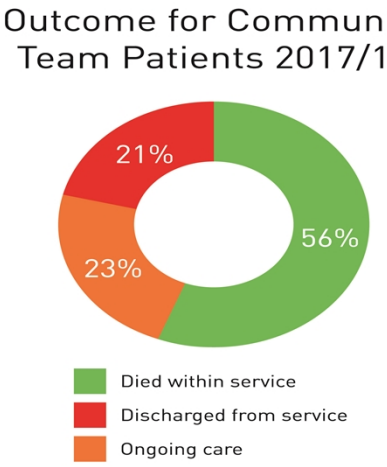
There were more days this year than last where beds were closed (78 days this year, 39 days last year). This was due to specific issues with three rooms this year that have meant prolonged closures of rooms. In addition we have experienced issues with housekeeping provision. Members of the facilities team now attend our daily IPU bed allocation meeting to ensure facility issues are highlighted and dealt with promptly to limit the impact of closed bed days.

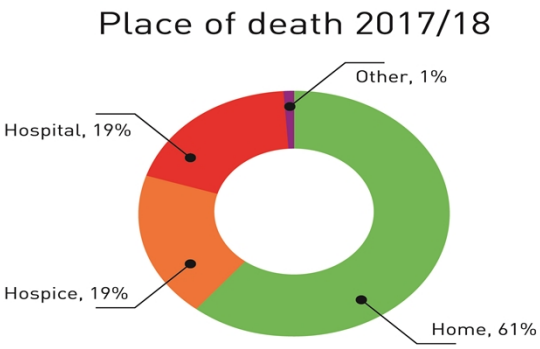
Health & Wellbeing Service



This year, in line with the reorganisation of services in the Health and Wellbeing Service the statistics have been collected to reflect the one service. There has been an increase in group activities and in new areas of work specifically with carers and peer support.

Community Teams



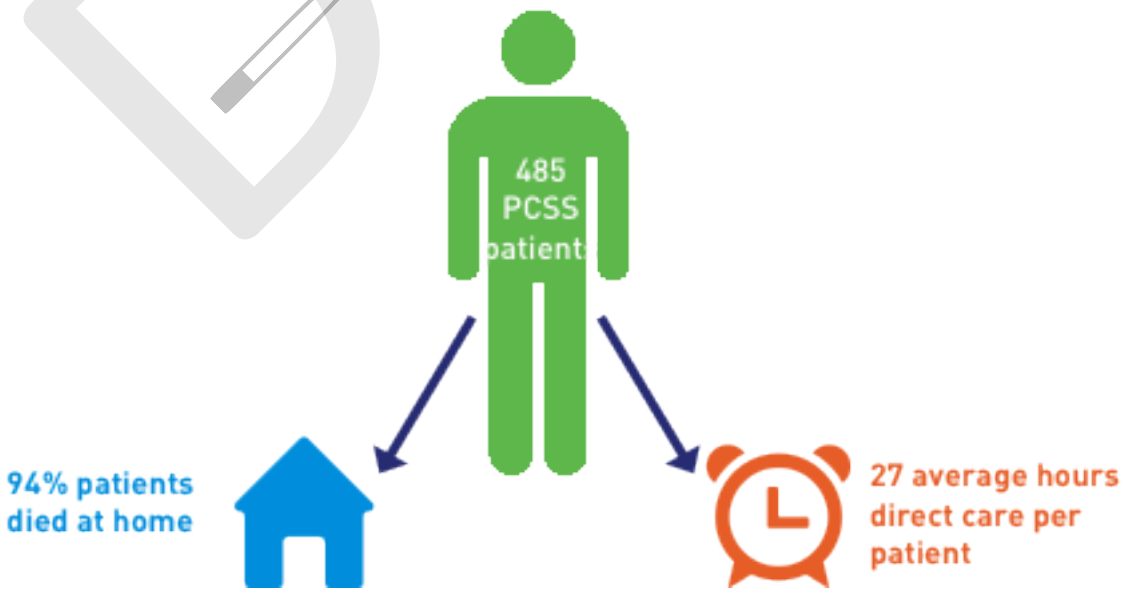


The Community teams have supported 2145 patients in their homes this year which is comparable to the activity last year.

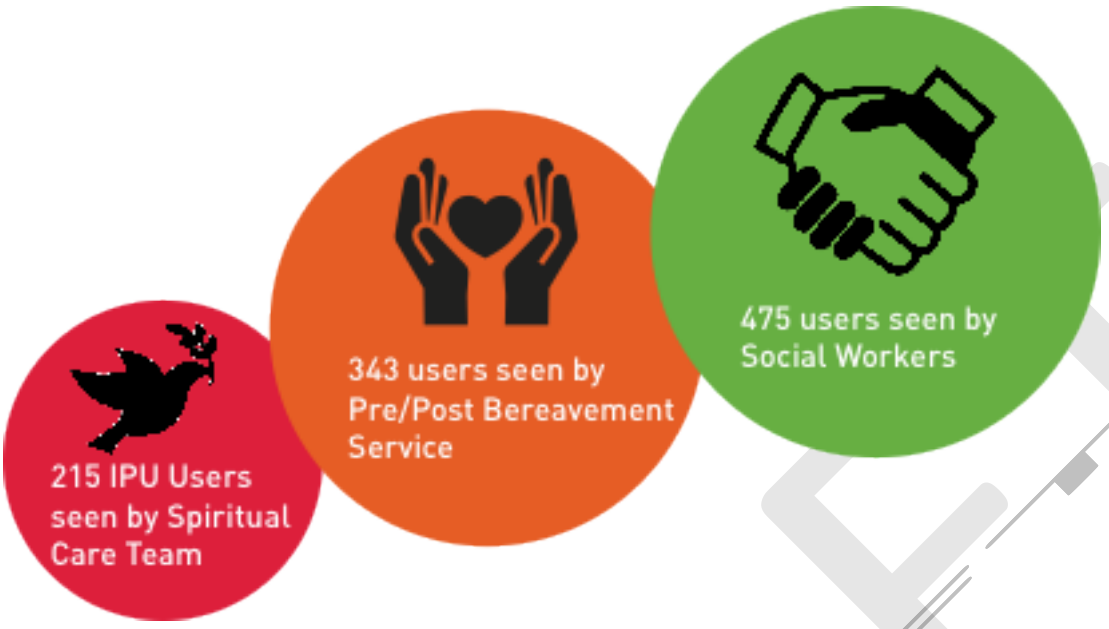
Of these community patients, 21% were discharged when they no longer required specialist support, 56% were supported by the service until their death, with 23% remaining on the caseload.

Of the 1201 patients who died whilst under the care of the community team, 61% patients were supported to die in their own homes (including care homes), an increase from 56% last year. Hospital deaths have reduced from 21% last year to 19%.

Palliative Care Support Service (PCSS)



Patient and Family Support Services



This year has seen an additional investment within social work with the introduction of a part time social worker into the Health and Wellbeing Service. The activity for social work shows an increase from the 462 users seen in 2016-17. There has been a reduction in the number of users seen for Pre/Post Bereavement this year, this is due to gaps in service provision due to Bereavement Personnel and changes in Social Work Management. The slight reduction in Spiritual Care support on IPU is due to re- aligning the role of the Spiritual Care Manager. The original intention of this role was to provide expert Spiritual Care Support (in addition to training and oversight of the chaplaincy team) across all services in the organisation. The post holder became increasingly involved in the IPU only. During 2017/18 the strategy was to provide more support in the community [please put in figures if they are available]

SERVICE USER EXPERIENCE

NLH values all feedback from people who have used our services and gain in it a variety of ways: Comments cards, thank you cards, patient/family stories and surveys, concerns and complaints.

Feedback is reviewed at service level with team members and also through NLH governance groups. All feedback is collated and analysed for themes and identify any improvements or changes required as we endeavour to meet the needs of our patients and their families.

2017 User Surveys

The annual service-specific surveys in 2017 have been collected by both paper and using a tablet device.

Paper surveys were sent from May-October 2017 to:

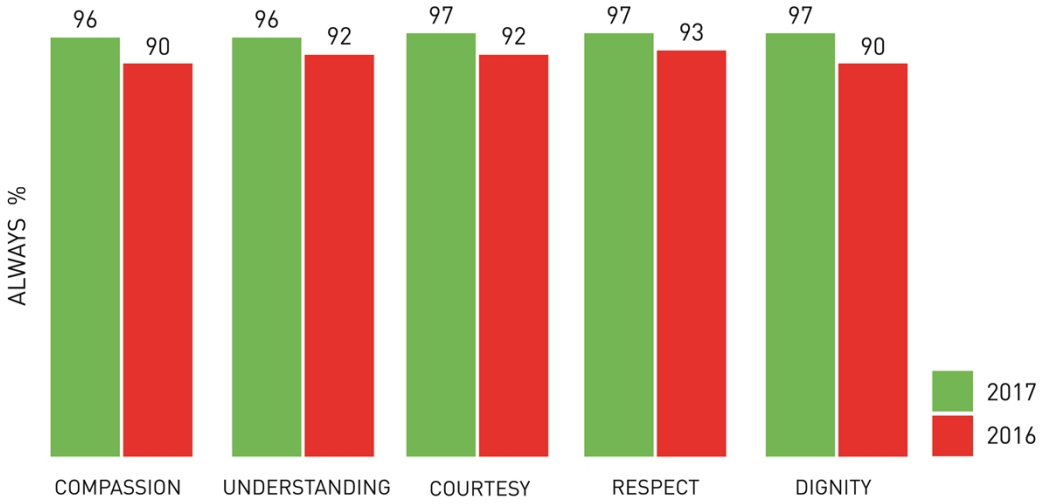
- Community patients and relatives
- Inpatient unit relatives
- Health and Wellbeing Service patients

A total of 786 surveys were sent out, 282 returned (36%).

33 Tablet surveys were completed by Inpatient Unit patients during the year.The aim of the tablet surveys is to be able to provide real-time feedback so any issues can be dealt with immediately.

Key Performance Indicators

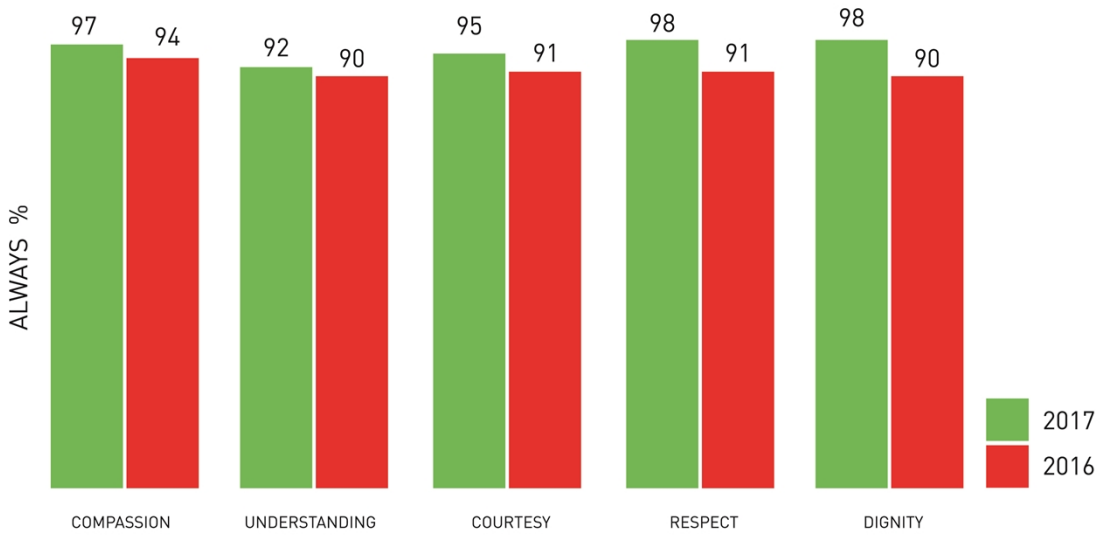
Key Performance Indicator 1
Patients: Do you feel staff always treat you with:



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

We are pleased to see an increase in all areas from our patients.

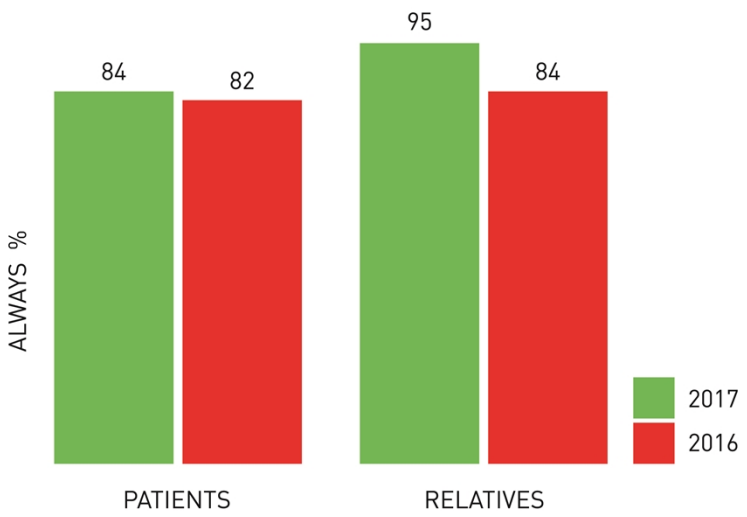
Patients: Do you feel staff always treat you with:



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

An improvement in all areas from relatives.

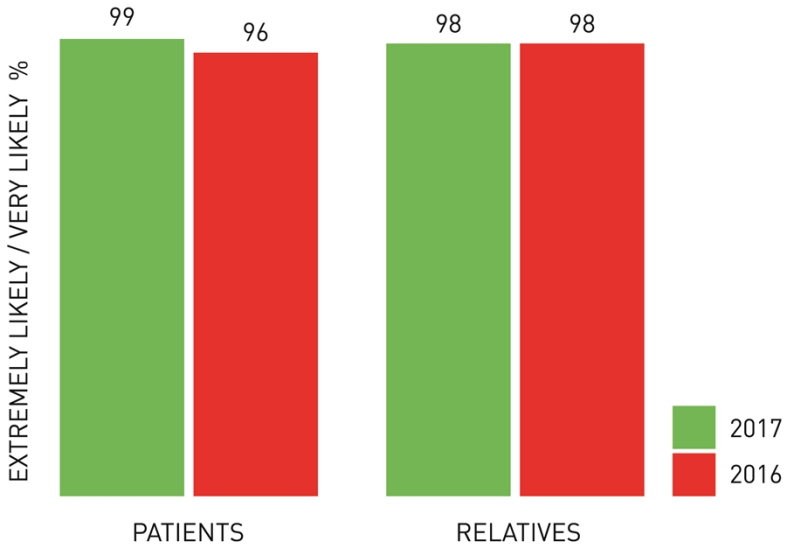
Key Performance Indicator 2
Are you/was the patient involved as much as you want/he/she wanted to be in decisions about care and treatment



For patients, one person from the Community Team answered 'Never', the remaining responses are 'Not Sure'.

For relatives, the Barnet and Enfield Community Teams' results have remained similar. A good improvement from the Inpatient Unit, Haringey Community Team and Palliative Care Support Service.

Key Performance Indicator 3
Would you recommend the service to friends and family



This year 100% of Inpatient Unit patients said they would be extremely likely to recommend the service. For the Community Teams, 1 respondent replied 'Unlikely' and 1 person replied 'Extremely Unlikely'.

COMPLAINTS

Quality Performance Indicator	2015-2016	2016-2017	2017-2018
Number of Complaints (NLH target less than 30)	21	10	15

Quality Performance Indicator	2015-16	2016-17	2017-18
Investigations completed, complaint upheld/partially	11	9	11
Investigations completed, complaint not upheld	5	1	1
Investigations unable to proceed as complainant not able to give full information	4	0	0
In progress			3

Analysis:
Of the 15 complaints received, 8 were regarding patient care. Three of these involved IPU, 3 community, one Health and Wellbeing and one was concerning our facilities at the Finchley site. This correlates with 0.03% of patients and families supported by NLH made a complaint.

Of these eight complaints five were upheld, one was partly upheld and two are currently being investigated. Four of them related to education staff/volunteer communication, and five to clinical care or practice.

The following are some of the actions taken following completed investigations this year:

- IPU staff informed of need to document all conversations regarding care of the deceased
- Community team now meet every morning to understand that day's capacity to respond to non-planned home visits

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

Concerns:
This year we received 19 concerns from our users. 14 related to clinical care.

Compliments:
This year a total of 215 written compliments were received and recorded on NLH's Compliments Log

Community Team Barnet:
"On behalf of mum, my brothers and I would like to pass on our gratitude for all your help and support through such a difficult time. Mum really enjoyed talking to you and appreciated the care you gave. Can't thank you enough for being there for her and us."

Community Team Enfield:
"On behalf of all the family we would like to say a very big "THANK YOU" for all that you did for dad over the past year. The care he had from everyone was exceptional but you were particularly kind and supportive, especially to xxxx and we are very grateful for the way you eased the journey for all of us."

Community Team Haringey:
"Just a small note to say thank you for all the help and support you gave to my mum and me in the last few months. I imagine that your job can be a really hard one but you keep going and we admire you for that. Please keep up the good work."

Inpatient Unit:
"I would like to thank you for the excellent care and friendship that you showed towards my dear friend during his last 3 weeks and whilst her was in your care. At all times he felt safe whilst he was with you and he was always treated with dignity and respect. Furthermore his wife was always made to feel welcome and involved. I know he could not have had a better place to spend his final days and my heartfelt thanks for all the brilliant work that you carry out on a day to day basis."

PCSS:
"Thank you so much for all your invaluable help with my lovely mum. Your support was appreciated by us on the sad day. You went beyond your call of duty."

Health and Wellbeing Service:
"This centre is the most marvelous place offering great help and information in the most difficult of times. The welcome is always warm and friendly, the lunches are amazing, the exercise classes very helpful & informative by experienced professionals. As for the carers, you look after us so well, the massages by xxxx are extraordinary & help so much with my stress & anxiety. The carers skills group is wonderful - to be able to share grief & fear openly helps so much. Thank you for everything. NLH is our lifeline right now."

Supportive Care:
"We wish to thank you most sincerely for your care, concern and support. Your gentle sympathy and practical kindness will be remembered with great affection and gratitude."

PATIENT SAFETY

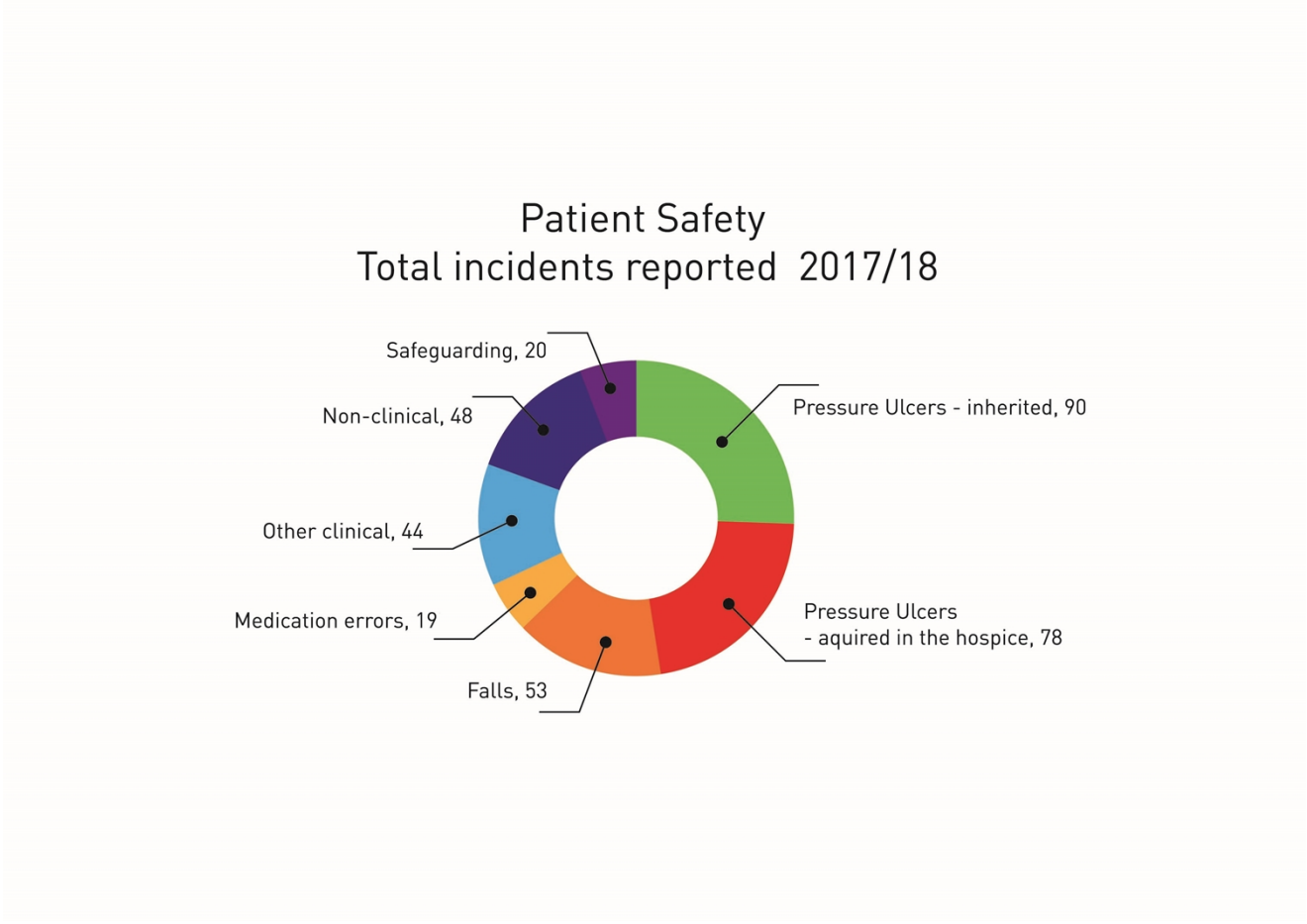
Incidents

	2015-16	2016-17	2017-18
Total number of Incidents	216	371	352

Analysis

The total number of incidents reported this year is very similar to last year. Last year we commented on the increase in incidents from 2015-16 and attributed it to the introduction of a risk management database which improved reporting. We have had one Duty of Candour incident related to a patient fall.

This year we updated our Sentinel (electronic reporting system) making several minor changes to ensure it is user friendly and helps us to meet our reporting requirements.
We have refined our systems to ensure reporting, monitoring and analysing of incidents takes place in a blame free culture, so incidents can be learnt from and wherever possible, prevent re-occurrence.



Pressure ulcers, whether inherited (patient was admitted to the IPU with them) or acquired (developed whilst on the IPU) continue to make up almost half of all reported incidents. We have robust reporting arrangements and are confident that all pressure ulcers are reported and reviewed in a comprehensive manner. This enables practice to be improved by learning from all aspects of it.

This year we have continued to ensure we are doing everything we can to prevent pressure ulcers developing. A full Root Cause Analysis was undertaken for all Grade 3 and Grade 4 pressure ulcers, as well as for Ungradeable pressure ulcers and Deep Tissue Injuries. In all cases the ulcers were found to be unavoidable, in that everything was done to prevent them developing. All pressure ulcers of any grade, acquired in the hospice were unavoidable (compared to 6 last year that were found to be avoidable).

We continue to work through our Pressure Ulcer Management Action Plan. Having listened to our patients, who reported they found our current pressure relieving mattresses uncomfortable, we have replaced all mattress with an alternative brand.

Inpatient (IPU) 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. This year, Hospice UK were only collecting data on falls and medication incidents.

Falls

	2015 - 2016	2016 - 2017	2017-18
Number of Patient related slips, trips and falls	36	27	50
Falls per 1,000 occupied bed days	7.83	5.74	9.86
Hospice UK Benchmarking Falls per 1000 occupied bed days (for Hospices of the size of NLH)	10.6	10.8	10.4

Comment: This year our numbers of patient falls has increased. We have reviewed our practice and made changes as part of the Priority for Improvement (see section 2) and can report that for the last six months of the year, our numbers are more in line with the average number of falls for a hospice of this size. In particular we closely monitor patients who fall more than once. A Root Cause Analysis was undertaken for a patient who fell three times and small changes to practice were made as a consequence of the investigation.

Medicine Incidents

	2015 - 2016	2016 - 2017	2017-18
Number of medicine incidents	22	28	17
Medicine incidents per 1000 occupied bed days	4.8	5.74	3.35
Hospice UK Benchmarking Medicine incidents per 1000 occupied bed days	6.4	10.4	11.5

Comment: We are significantly below the number of average medicine related incidents and can partly attribute this to our rigorous prescription chart checking system.

Infection Prevention and Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2015-16	NUMBER 2016-17	NUMBER 2017-18
Patients who contracted Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia whilst on the IPU (NLH target 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 203 (156.8 WTE) permanent staff and 45 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.

	2015-16	2016-17	2017-18
Staff joined	50	74	34
Staff left	52	59	64

Of the leavers indicated above, 32 were bank staff whose contracts were terminated since they had not recently completed any shifts.

Difficulty in recruiting Band 5 and Band 7 nurses has persisted, despite continuing efforts to address the issue. Three current employees are undertaking appropriate advancement apprenticeships. Potential recruitment and retention incentives continue to be sought and pursued where appropriate. An annual leave sale/purchase scheme was launched during the year, as well as a discounted cinema arrangement, and staff benefit from goods free-sampling opportunities arranged through 'Gems at Work' and 'Work Perk'. Long service is recognised by presentation of appropriate certificates during suitable staff functions, including an inaugural Staff Conference held in October. Approval has been given to apply one-off financial incentives to attract applicants to roles of special scarcity and to reward staff for successful introduction of candidates where appropriate. 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; it served a valuable role during the year in the consultation

process associated with outsourcing a service function under TUPE arrangements.

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=88	Volunteers N=131	All hospices	Staff N=88	Volunteers N=131	All hospices
Strongly disagree	12	3	4	5	1	3
Disagree	9	4	6	11	2	6
Neither agree nor disagree	5	10	8	14	19	22
Agree	29	30	32	53	53	46
Strongly agree	45	53	50	17	25	23

The survey was completed by 44% of our staff and 17% of volunteers. Participation was marginally lower than the average for all hospices using the survey, and lower than that the previous year. The Executive Team noted a slight increase in dissatisfaction in these areas. The data were presented to the Board of Trustees, where it was felt participation needed to increase to give a more definitive reflection of opinion amongst both staff and volunteers and it was agreed a more proactive approach would be taken in future to broaden participation. 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 would be rigorously investigated and dealt with (although none have been received).

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

NLH Board of Trustees Quality Account Comment

Over the last 5 years, as a Board of Trustees, we have been impressed by the progress made in a number of key areas that directly impact the experience of patients, their friends and families at some of the most poignant and difficult times in their lives.

In this my last year as Chair of the North London Hospice, I am delighted to once again commend the achievements under the Priorities for Improvement, as well as the overall Quality measures described in the Quality Account. 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.

The Board has been especially impressed by the transformation of a fairly traditional model of Out Patient services into a more responsive service, focussing on Health and Wellbeing. Significantly, this change was shaped using a co-production model involving patients, carers, volunteers and staff. At an inspirational launch held on the 15th of March, those of us who attended heard first hand from patients and family members about the tangible benefits of the new model in terms of their positive experiences. The complexity of the task of identifying Hard to Reach groups has further highlighted the value and importance of joint work with other organisations already assisting people in what may be regarded as groups who do not regularly access Hospice services. Much of this work is ongoing, is reflected in the Priorities for 2018/19, and supports our aim of extending the reach of Hospice services. In terms of patient safety, a greater understanding of the factors that contribute to slips, trips and falls have increased patient safety on the In Patient Unit, helping staff, patients and carers contribute to a safer environment. The multi-disciplinary journal club has fostered greater shared understanding across professions and different parts of the service.

For 2018/19, the Priorities for Improvement build on the positive outcomes on the In Patient Unit in relation to falls, extending the learning into community settings. The Productive Ward programme aims to improve efficiency and safety on the ward in order to release time to care, is especially welcomed. In addition, an initiative derived from good practice in Dementia Care will introduce a one page Patient Profile for everyone, compiled with the patient and their friends and families. Acknowledging the complexity of the work in relation to Hard /Need to Reach groups, further work is to be undertaken on this initiative in the year ahead.

The Board welcomes the improvements illustrated in this year's Quality Account and fully supports the Priorities for Improvement identified for 2018/19, understanding that they build on much of the excellent work already being undertaken.

Over successive years, it has been very encouraging to see the benefits that new initiatives have brought to the safety and positive experience of patients, as well as those caring for them.

John Bryce
Chair
North London Hospice Board of Trustees

STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

Barnet Clinical Commissioning Group

Barnet Health and Overview Scrutiny Committee

Healthwatch Barnet response to North London Hospice Quality Account for 2017-18

Enfield Clinical Commissioning Group

Healthwatch Enfield

Haringey Clinical Commissioning Group

Healthwatch Haringey

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.Health and Wellbeing - H&W (formerly Outpatients and Therapy)

The Health and Wellbeing Service are a multi professional team whose underlying principle aims are to enable and empower those that are living with the effects of a life limiting condition to manage their symptoms and be in control of their condition, to gain information to help make the decisions they need to make, to function independently and to live as well as is possible, working towards achieving what matters most to them.

The service offers a range of interventions on an individual and group basis as well as

opportunities for social interaction and peer support to both the patient and the carer. The services are available from the time of diagnosis and we work closely with the other teams in the hospice.

The multi professional team includes a Palliative Care Consultant, Specialist nurses, physiotherapy, occupational therapy, complementary therapy, psychological therapies, spiritual care and social work.

4. Inpatient unit (IPU)

NLH has 18 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons such a symptom control, those experiencing complex psycho social issues or for 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. Patient and Family Support Service (including Bereavement Service)

Support focuses on the individual and their relationships pre and post bereavement, with a range of service which may include practical and psychological/psychospiritual support as well as providing information, guidance and education.
As part of a multi-disciplinary approach, following assessment, a plan of support may range from the provision of the specific benefits of experiencing a more informal relationship with a volunteer, now including Compassionate Neighbours, or where the level of complexity of emotional and relational need requires the skills of more highly trained practitioner. Registered nurses, doctors and allied professionals and some hospice trained volunteers should be able to gain a view about general psychological wellbeing and provide appropriate supportive interventions, advice and assist in problem-solving. The Patient and Family Support team are able to offer a further level of support. The department is also responsible for developing services for Carers, including young carers and kinship carers, as well as responding to the needs of children and young people. We work closely with the Health and Wellbeing Service to develop group work, which help create opportunities for peer support and informal networks developing beyond the hospice.

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 advice to referrers and patients with any potentially life limiting illness. In Haringey, NLH is 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

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)

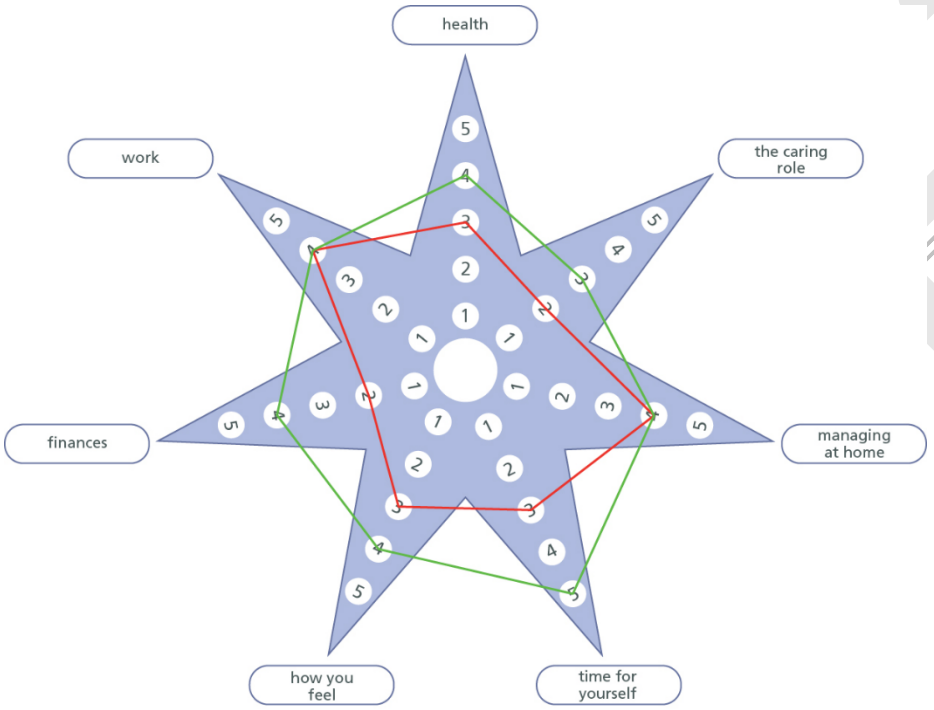
ASG is responsible for providing assurance of all audit activity through reports to Q&R and QSR. ASG presents its Audit Plan and Audit Reports and recommendations to Q&R for approval and monitoring. The audit plan is ratified by QSR on an annual basis. ASG will also ensure that any risks identified during 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 – THE OUTCOME STAR

Outcomes Stars™ are evidence-based tools for both measuring outcomes and supporting change. Each version is an assessment, support planning, and review and outcomes tool in one, measuring change however that is defined for the particular client 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.



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Authors: Sara Burns, Joy MacKeith and Amaragita Pearse
www.outcomesstar.org.uk

ACCESSING FURTHER COPIES

Copies of this Quality Account may be downloaded from 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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Director of Clinical Services

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CLCH DRAFT QUALITY ACCOUNT 2017-18

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2017-18.

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 sixth year that we have done so.

What does the CLCH Quality Account include?

In January 2017 we launched our Quality Strategy *Simply the Best, Every Time*: *A strategy for the delivery of outstanding care 2017-2020.* The strategy can be found in full at https://www.clch.nhs.uk/application/files/6015/1066/8582/quality_strategy_2017-20.pdf

The strategy describes our six quality campaigns. These are Positive patient experience; Preventing harm; Smart effective care; Modelling the way; Here, happy, healthy and heard and Value added care. Key outcomes, along with their associated measures of success are listed for each campaign. Over the course of the three years, the measures of success become increasingly demanding. Performance against the measures of success will be continuously monitored and reported via the Quality Committee and Trust Board as well as via the shared governance model.

The strategy also explains how our Quality Account priorities will be aligned with these campaigns and outlines how the Trust will need to invest in resources to implement them.

In accordance with the strategy, we have collected information about our performance against the six quality campaigns and we have used this information to look at how well we have performed over the past year and to identify where we could improve over the next year.

The strategy introduced the concept of shared governance. This is a partnership which ensures that front line staff, as well as patients and members of the public, are involved in the delivery of care. Following its introduction, shared governance is being successfully rolled out across CLCH.

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 community health services for two million people across ten London boroughs and in Hertfordshire.

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.

In October 2017 CLCH acquired adult community services in Wandsworth as well as community nursing; these included complex case management of a GP Team, a primary care therapy team; intermediate care services; phlebotomy services and specialist nursing including; continence; respiratory, heart failure, tissue viability and diabetes.

Further Information about CLCH, including about the services we provide and the areas that we provide them in, is provided on our website at the following link https://www.clch.nhs.uk/about-us

Our vision is *Great care closer to home* and our mission is *Working together to give children a better start and adults greater independence.* Further and more detailed information about our vision, mission and values can be found in our annual report.
https://www.clch.nhs.uk/application/files/7515/1680/4204/clch_Annual-Report_2016-17_final.pdf

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the Quality Account for the year ending March 2018; it has been a busy time for CLCH where we welcomed new services to the Trust this year, including Wandsworth Adult Community Services, Wandsworth and Richmond Sexual Health Services and Children's services in Wandsworth and Richmond. I was delighted to hear in April this year that we are one of 4 finalists for the Patient Safety Award category of Organisation of the year for our work on the Quality Strategy, Simply the Best, Every Time.

We also prepared for our CQC inspection which took place in September 2017. We welcomed the opportunity to highlight the work our clinical services deliver. During the visit CLCH hosted a team of 28 CQC inspectors and specialist advisors, who assessed four of our services: Children's; Adults; Inpatient and End of life care. The team visited 17 sites, in six boroughs, where they talked to over 150 staff, carers, patients and service users about their experience of CLCH and observed the care that CLCH provides. They also reviewed our documentation and patient notes, evaluated our systems and processes and assessed the environment in which we provide care. A focus group was also held with some of our Black, Asian and Minority Ethnic staff. We were pleased to receive an overall *Good* rating for the trust.

This year we have rolled out a number of projects and initiatives to improve quality and these are outlined in the account. Of particular note has been the work we have progressed with our Shared Governance quality councils of which we now have 13 across the Trust. You can read more about these in the Quality Account. I would like to extend my thanks to our users, members of the public and staff who played a significant role in making these such a success.

I am pleased to say that this year we awarded Quality Development Unit status to our first two teams: Podiatry in Harrow and the Respiratory Team in Hertfordshire. Once a team has achieved excellent results in their self-assessments, quality indicators and quality inspection team visits, they can apply to the Quality Panel to become a Quality Development Unit. The panel comprises members of the Trust Board, Chief Nurse, Director of Nursing, external stakeholders (including a patient representative) and peers. Units that achieve this status receive support to invest in the service and become a resource for other teams looking to improve.

I would like to thank all our staff for their continued commitment to providing excellent care. I would particularly like to recognise our staff in both adult and children's services who worked to support the community following the terrible events at Grenfell Tower last year and also our nurse practitioners who provided care to those affected on the morning of the Parsons Green tube bombing.

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

Signed

Andrew Ridley
Chief Executive Officer
*mandatory statement for CEO

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

The Trust Quality Committee has continued to review progress against our Quality Strategy *Simply the Best, Every Time* and associated priorities. Our aim is simple: to ensure CLCH provides outstanding care. As well as receiving monthly updates and a quality dashboard, the committee has reviewed a more in-depth quarterly report on progress. The committee has continued to invite staff, service users and carers to give quality presentations each month and committee members have regularly visited a range of clinical areas in order to see and hear for themselves how the Trust is delivering services.

I am pleased to note that during the year that there has been:

- a reduction in the incidence of pressure ulcers,
- a reduction in falls that caused harm,
- an increase in the number of patients who reported that they were treated with dignity and respect.

We continued to concentrate on the reduction of pressure ulcers in bedded units and whilst we have had a number of pressure ulcers this year, I was pleased to read in our CQC report that inspectors felt we had put in place a range of measures to help prevent pressure ulcers and that they recognised the good work of our pressure ulcer working group.

Like Andrew, our Chief Executive, I have been pleased to see the success of our Shared Governance Quality Councils. Shared governance is a dynamic partnership involving staff, managers and patients that promotes collaboration, shared decision- making and accountability for improving quality of care, safety, and enhancing work life. We will continue as a committee to do everything we can to champion this approach.

In 2018-19 the Quality Committee will continue to monitor progress against the objectives set out this year in the Quality Strategy and to support our staff in achieving these objectives. I would like to take this opportunity to thank all members of the Committee for their hard work in putting quality at the heart of everything we do.

Carol Cole

Chair of Quality Committee

PART 2 – PRIORITIES FOR IMPROVEMENT 2018-19

Our quality priorities for 2018 – 2019 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 six quality campaigns and their associated measures of success, were selected to reflect both national priorities, such as the Five Year Forward View and Leading Change, Adding Value, and also local priorities, such as achieving the Trust's objective of moving from an overall CQC rating of `Good' to `Outstanding'. Further and more detailed information about the development of, and the rationale behind, our quality priorities can be found in our Quality Strategy.

The Trust's Quality Committee agreed a dashboard to monitor progress against each of these priorities. Progress against our priorities is reported to the committee on a quarterly basis as part of our comprehensive quality report and is also reported to the Board via a performance report. The quality campaigns, their key outcomes and associated measures of success for 2018-19 are as follows:

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

Key Outcomes	Measures of success 2018-19
Service developments and plans of care co-designed with patients and service users	92% or above of proportion of patients whose care was explained in an understandable way 90% of proportion of patients who were involved in planning their care The use of co-design will be evaluated across the organisation Evaluation from patient feedback of their involvement in the Quality Councils
Patient stories and diaries used across pathways to identify touch points	Evaluation of Always Events and their impact on patient experience Quality Councils to start leading on the development of Always Events with local implementation Thematic analysis of previous year's stories with shared learning Continued use of patient stories by all services and shared at Divisional and Trust forums Evaluation of patient diaries and the impact on patient experience
Patient feedback used to inform staff training	Patient feedback will be integral to the review and development of education and training Evaluate how patient feedback has influenced training and education Evaluate the use of patient stories as part of learning from serious incident reviews
Divisional quality council objectives	Two objectives with outcome measures

CAMPAIGN TWO: PREVENTING HARM

Key Outcomes	Measures of success 2018-19
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 Incidence of PU and falls will continue to fall (5%) Red flag evaluation will take place Reporting of incidents increases whilst levels of harm reduce 0% PU in bedded areas 100% RCA completed on time
Safety culture and activities signed up to in ALL services	Safety culture and activities signed up to in all services
Variations in practice identified and acted upon	Quality Action Teams to develop areas to exemplars Develop a learning repository to enable teams and services to share issues identified from incidents 2017-18 and evaluate the use of the repository and its effectiveness 2018-19.
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Outcomes	Measures of success 2018-19
Clinical staff use the most up to date clinical practices	Central alerting system (CAS) alerts. KPI target for timely alert closure ≥90% NICE 80% 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	78% staff able to contribute to improvements at work (staff survey) Central resource dedicated to improvement analytics
CLCH will be a leader in innovative community practice	Each Division to identify within business planning process an innovation for 2018/19 Research activity increased by 5%
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN FOUR: MODELLING THE WAY

Key Outcomes	Measures of success 2018-19
New roles and career pathways are in place which supports the needs of patients/service users	Vacancy rates across the Trust to be reduced to 10% or less. Staff turnover (voluntary) to be reduced to 10% (or less). The continued implementation of Apprenticeship roles The evaluation of the Nurse Associate pilots in Adults and Children services The evaluation of the Capital Nurse Foundation rotation programme pilots The evaluation of the staffing models in all clinical services Staff survey results Evaluation of 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	Implement and evaluate a model of professional practice for clinical staff across the Trust
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
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN FIVE: HERE, HAPPY AND HEALTHY

Key Outcomes	Measures of success 2018-19
Staff are fully engaged and involved in the model of shared governance	Four to five Quality Councils are established per division and well attended. Shared governance forums are effective at resolving issues and concerns
Staff turnover (voluntary) below 10% by 2020 Staff vacancies below 10% by 2020	Staff turnover (voluntary) to be 10% or less. Staff vacancy rate below 10%
Staff surveys are undertaken which demonstrate improving levels of staff engagement	0.5+ on staff engagement index compared to the average for other community Trusts nationally
Wellbeing strategy to support staff health and well-being and reduce staff absence	A 3% reduction in the number of staff who report feeling unwell as a result of work related stress in the 2018 Staff Survey Sickness absence remains below target of 3.5%
The Trust is committed to and makes demonstrable reductions to agency spend	Agency spend is proportionally reduced as sickness, turnover and vacancy rates reduce The number of staff recruited to staff bank increases by 15%
Divisional quality council objectives	Two objectives with outcome measures.

CAMPAIGN SIX: VALUE ADDED CARE

Key Outcomes	Measures of success 2018-19
The user experience across CLCH, primary care, specialist services and social care is as seamless as possible	Implementation of actions that resulted from the divisions' assessments of the patient/user experience.
Clinical staff use the latest technology to improve care delivery	Each Division to identify within business planning process an innovation for 2018/19 Each division has used improvement tools to improve 1% of services
Front line staff lead new lean ways of working	Each Division to identify within business planning process an innovation for 2018/19 Each division has used improvement tools to improve 1% of services
Divisional quality council objectives	Two objectives with outcome measures.

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

Prior to the January 2017 launch of our *Quality Strategy 2017-2020* we consulted widely on the strategy and all our stakeholders for comments on our quality campaigns; the proposed key outcomes and the associated measures of success. We also described how the quality priorities in the *Quality Strategy* would be the same as for the *Quality Account.*

The consultation on our quality priorities this year took place between 11th January and the 4th May 2018. We again wrote to all our external stakeholders requesting their comments on the quality campaigns and proposed measures of success for 2018-19. Information was also provided for staff via internal communications and our *Spotlight on Quality.* Our external website also allowed people to comment on our quality priorities.

Responses to the proposed quality campaigns have generally been positive although some responses thought that the proposed number of outcomes was too high. Some responders suggested that the outcomes were not realistic in the light of workforce and funding issues that the Trust faced.

Some of the specific issues raised in response to the consultation were as follows:

Patient experience: The use of patient stories was considered a good way of involving patients and carers in the work of the Trust.

The need for a glossary to explain the acronyms. This has been addressed and glossaries have been incorporated into the account.

The way that CLCH communicates with volunteers: This issue is being looked at in more detail at the Quality Stakeholder Reference Group (QSRG)

Membership of the Trust: In response to a question how members of the public could become members, details of how to become a member were sent to the requestee. The issue of encouraging non staff to become members of the Trust will also be discussed at the QSRG.

The podiatry service: This response did not provide comments in respect of the quality priorities but raised queries about booking a podiatry appointment. A response was provided to the responder by a senior manager from the service.

STATEMENTS OF ASSURANCE FROM THE BOARD

REVIEW OF SERVICES

During 2017-18 CLCH provided and/ or sub contracted 82 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 2017-18 represents 100% of the total income generated from the provision of NHS services by CLCH for 2017-18.

PARTICIPATION IN CLINICAL AUDITS

The Trust has 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.

Clinical outcome reviews.

During 2017-18 There were no clinical outcome reviews (formerly known as national confidential enquires) which covered services provided by CLCH therefore CLCH did not participate in any clinical outcome reviews.

National clinical audits

For the same period CLCH registered in all five (i.e. a 100%) of the national clinical audits that the Trust was eligible to participate in. These audits, for which data collection was completed in 2017-18, are listed in the table below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

The reports of five national clinical audits were reviewed by CLCH. The actions that CLCH intends taking in response to the audit are incorporated into the table below.

Please note that the table below will be further updated when the results from the audits have been received.

National Clinical Audit	Participation	Submitted cases or reason for non-participation	Outcomes and actions
National chronic Obstructive pulmonary disease (COPD) audit programme	Yes	126 cases were submitted which was 97.6 % of the 129 cases required The services taking part were: West Herts respiratory service; Barnet respiratory service, Merton respiratory service, Harrow respiratory service.	*Awaiting results due late March/early April*
SSNAP (Sentinel stroke national audit programme) (Previously known as the National Stroke Audit)	Yes	69 cases were submitted which was 88.4 % of the 78 cases required. The services/team taking part were the Stroke early support discharge (ESD) team, Merton ESD team, Merton community neuro rehabilitation team.	*Awaiting results due late March/early April*
National audit of intermediate care 2017.	Yes	12911 cases were submitted which was 47% of the 27470 cases required. The services/team taking part were Alexander rehabilitation unit at Princess Louise nursing Home; Athlone rehabilitation unit; Edgware Community Hospital (Barnet CCG patients); Finchley Memorial Hospital (Margery Warren Ward, Barnet CCG patients); Ruby Ward, Edgware Community Hospital (Harrow CCG patients) Barnet intermediate care services.	Evidence from the audit indicated that intermediate care works with more than 91% of service users. The audit demonstrated that the service either maintained or improved their level of independence. **Action**: The audit will run again in 2018, and will focus on maximising independence, and reducing use of hospitals, and care homes.
National Audit of Hip Fracture Services	Yes	Barnet intermediate care services Data collection still in progress	*Waiting for results due late March/April*
National Diabetes Foot Care Audit (NDFA)	Yes	Services participating: Community diabetes podiatry service (Westminster), Community diabetes podiatry service (Kensington and Chelsea)Data collection is still in progress	*Waiting for results due late March/April*

Local audits

The reports of 24 clinical audits were reviewed by CLCH in 2017-18. The actions that the Trust intends to take, as a response to the audits, to improve the quality of healthcare provided are incorporated into the table below.

Title	Division	Service	Outcomes and actions
1. Clinical audit of cognitive assessment of patients admitted to Rehabilitation wards	North	Jade and Ruby inpatient wards	This audit aimed at ensuring compliance of cognitive assessment as per NICE guidelines for dementia care and falls assessment. **Findings included:** Assessment for cognitive screening was completed for 70% of patients within 24 hours 100% of patient had screen completed with a standardised screening tool. Of the patients screened 60% were shown to have some form of cognitive impairment. 50% of patients were screened further using another objective measurement or functional assessment. 60% of patients had the results of cognitive assessment discussed with their family. 100% of patient had results of cognitive assessment shared with the relevant multi-disciplinary team and GP. **Actions identified included:** OT team to prioritise assessing patients within 24 hours of admission to ward to achieve 100% compliance. 100% of patient's assessment found to have cognitive impairment to have further screen or functional assessment completed within 5 days of initial assessment. All results of cognitive impairment to be discuss with carers/family within 5 days of assessment.
2. Dysphagia diet audit checklist	North	Jade, Ruby and Marjory Warren wards	To reduce the risk of aspiration and choking incidents, this audit aimed at ensuring all modified diet textures were appropriate for patients with swallowing difficulties measured against the National Patient Safety Agency - Dysphagia diet food texture descriptors. **Findings included:** Texture C thick puree, texture D pre-mashed and texture E fork mashable diet passed except for the following: Texture C thick puree diet, Texture D pre-mashed diet, Texture E fork-mashable diet. **Actions identified included:** Kitchen staff to be trained to remove all pre-packaged texture C, D and E meals from packaging and served on a plate to ensure no loose fluid. Any meals with garnish are not to be ordered for texture C thick puree i.e. salmon in dill. Weetabix (milk fully absorbed and smooth consistency) is to be used for texture C thick puree breakfasts (not porridge).

Title	Division	Service	Outcomes and actions
3. The effectiveness of acupuncture versus low level omega laser in the treatment of plantar fasciitis service	North	Harrow Nursing Intermediate care and podiatry	This evaluation aimed to understand which form of treatment (namely acupuncture or low level omega laser) was more effective in relieving the pain experienced by patients that suffer from plantar fasciitis. **Findings included:** Patients who received acupuncture showed that their pain was reduced by 22% after first treatment and 34% after second treatment. Patients who received laser treatment had their pain reduced by 7% after first treatment and 24% after first treatment. Patients who received acupuncture treatment were satisfied with their treatment; increased their confidence in the treatment received as a result they felt encouraged to continue with their treatment. Acupuncture treatment provides fast and consistent pain relief to plantar fasciitis pain when compared to laser treatment. **Actions identified included**: More sessions to be provided in the acupuncture clinic. Another study to compare the two forms of treatment, included the pain score after the third treatment, bigger size sample to be collected.
4. Accident and emergency school nursing response - Service evaluation / Clinical audit for Hounslow school nursing service 2017	CHD	Safeguarding Children [Hounslow] jointly with the London Borough of Hounslow,	The audit aimed at ensuring clinicians and their skill mix teams were accurately recording a child's allergies and sensitivities status onto the Trust's clinical system and that record keeping compliance has increased **Findings included:** The audit achieved 95% compliance for the teams that took part which is significant **Actions identified included**: By mid- December the professional Lead for children's nursing will have met/or discussed with all team leads the required entry on the clinical system and the associated crib sheet. An action plan will be agreed with team leads where concerns were raised.

Title	Division	Service	Outcomes and actions
5. Allergies and sensitivities mini audit	CHD	Children's nursing	The audit reviewed whether current advice on specialist formula prescription is in line with local CLCH primary care specialist infant formulae prescribing guidance (SIFP guidance). **Findings included:** GP/Specialist Doctors (particularly in the private sector) appear to be the majority of professionals who initiate prescriptions for specialist infant formula in primary care Amino acid formula (AAF) appears to be over prescribed; It would appear that specialist infant formula, initially prescribed in primary care, continued to be prescribed even when it was not appropriate - inappropriate prescribing results in unnecessary spend of NHS money and could affect patients' clinical outcomes **Actions identified included:** CLCH paediatric dietitian team to continue to promote the local SIFP guidance to GPs, Specialist NHS and private doctors and dietitians; CLCH paediatric dietitians team to continue to review patients prescribed a specialist infant formula.
6. Baby friendly initiative (BFI) standards	CHD		*Information awaited*
7. X ray requesting and interpreting audit.	North	St Charles UCC	*Information awaited*
8. Clinical record keeping	South	Community dental services	The aim of this audit was to investigate all information recorded by community dental services (CDS) at new patient examinations as against national guidelines. **Findings included:** The average percentage of records with information recorded in each category indicated: Basic 49 (range 4-100%); other 39 (range 0-100%); conditional 27 (range 2-79%), and aspirational 16 (range 0-38%). **Actions identified included:** An accepted standard template, with slight variation for adults and children, to be drafted for use with immediate effect by all CDS staff, to improve information recording and standardise records. Spot checks to be made throughout the year that the agreed template is being used. Audit to be repeated in the next audit cycle 2018/19.
9. Antimicrobial prescribing	South	Community dental services	This audit assessed the current antibiotic prescription recording in the 10 sites in CLCH dental services measured against Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, NICE guidance (NG15), Aug 2015

Title	Division	Service	Outcomes and actions
			Findings included: 61 antimicrobial prescriptions were issued from 10 sites over a 3-month period, which is an average of 2.03 prescriptions per site per month, indicating a low level of antimicrobial prescribing is taking place. Justification for prescription was recorded in the Prescription Log in 90% of cases and a treatment plan post antimicrobial was recorded in the prescription log in 97% cases, indicating antimicrobial prescribing is being done appropriately. **Actions identified included:** Written prescription logs to be completed fully, legibly or with entries Y/N/NA only. Electronic R4 prescription template to be developed and used for all prescriptions so that all details are in the Patient R4 electronic notes. Staff awareness of antimicrobial resistance to be reinforced, to prevent improper use of such drugs. Patient awareness of antimicrobial resistance to be increased,
10. Use of fluoride in adults with learning disabilities (Inner CLCH community dental service)	South	Community Dental Services	*Information awaited*
11. Safe and secure handling of medicines audit for 2015 – 2016.	Medical Directorate / Trust-wide	Medicines Management	*Information awaited*
12. Patient group directions	Medical Directorate / Trust-wide	Medicines Management	*Information awaited*
13. Use of antimicrobial prescribing at bedded services	Medical directorate / Trust-wide	Medicines Management	The audit aimed to ascertain whether antimicrobial prescribing and associated documentation in CLCH bedded areas was in line with CLCH antimicrobial prescribing guidelines **Findings included** 9 standards were addressed: 3 standards achieved 100% compliance. 6 standards achieved a compliance range of 13 % to 99% representing and improvement from previous audits. **Actions identified included:** Provide information relating to antimicrobial prescribing for doctors. Prescribers on bedded sites to notify ward

Title	Division	Service	Outcomes and actions
			pharmacist each time an antimicrobial is prescribed. CLCH bedded services doctors to have regular meetings, pharmacists to attend. Monitor patients' blood results to ensure appropriate action is taken.
14. Safe management and use of controlled drugs - Bedded areas	Medical directorate / Trust-wide	Medicines Management	This audit aimed 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. **Findings included:** 2 of the bedded services were fully compliant, 2 of the services improved their compliance since the last audit. In 2 of the services there was a slight worsening of compliance. **Actions identified included:** An action plan to address the specific issues completed for each bedded service with all actions to be completed by 31st March 2017.
15. Safe management and use of controlled drugs in community services	Medical directorate / Trust-wide	Medicines Management	The audit was aimed at identifying and ensuring the Trust's 41 sites were compliant with the CLCH medicines management policy relating to the safe and secure handling of controlled drugs (CD) as well as national guidance. **Findings included:** Overall services comply with most aspects of the CD Policy. **Actions identified included:** CLCH CD standard operating procedure (SOP) template to be updated incorporate more details on management of CDs on site e.g. CD keys, delivery of CDs.
16. Aseptic non-touch technique (ANTT) audit	Medical Directorate / Trust-wide	Infection Prevention	This audit measured the practice of staff that undertake invasive procedures against ANTT Department of Health and NICE guidance. **Findings included:** Of 49 staff observed in practice, 43 demonstrated 100% compliance. Of staff who did not demonstrate full compliance (6 of 49) the compliance scores ranged between 82 – 96%. **Actions identified included:** Increase number of ANTT audits undertaken to increase available data.
17. Dental audits	Medical Directorate / Trust-wide	Infection Prevention	This audit evaluated 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 included**: 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%).

Title	Division	Service	Outcomes and actions
			The remaining ten services scored green (90 – 97.9%). **Actions identified included:** Annual and six monthly infection prevention 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.
18. Hand hygiene audits (Bedded services)	Medical Directorate / Trust-wide	Infection Prevention	This audit measured compliance with the hand hygiene policy. **Findings included:** Compliance = 94.6% against the Trust Board KPI of 97%. The validation compliance result ranged between 86.7% - 100%. **Actions identified included:** To address compliance concerns (including scores below 97%) with a collaborative local action plan; A review of the hand hygiene audit tool to include recording barriers to hand hygiene.
19. Hand hygiene audits (Community services)	Medical Directorate / Trust-wide	Infection Prevention	The aim of this audit was too assess hand hygiene compliance with the hand hygiene policy. **Findings included :** 97% if staff were compliant with 'bare below the elbow', 22% of clinical staff reported that they had covered cuts and abrasions on their hands with a plaster. **Actions identified included:** Continued support to clinical teams through visibility, continued clinical support visits, attending meetings; organizing a hand hygiene road show to drive home the importance of effective hand hygiene.
20. Urinary catheter care documentation audit	Medical Directorate / North / Trust-wide	Infection Prevention / Continence	This audit evaluated whether all adult patients with a urinary catheter in situ at the time of audit were assessed and monitored regarding the need for a catheter; and whether all catheter care was documented accurately in accordance with the urinary catheter policy. It also aimed at ensuring compliance with NICE quality statement and NICE Guidelines 2012 regarding the urinary catheter pathway; the use of CLCH's urinary catheter assessment and monitoring form. **Findings included:** 63% of the assessment forms were completed; 42%) gave urinary retention as the reason for catheterization. 11% accounted for incontinence. Urethral catheterization accounted for 74% and suprapubic for 26%. 67% of patients had been catheterized for longer than one year. 4% of with a catheter in situ had a urinary infection at the time of the audit compared to 2.4% in 2015. **Actions identified included:** Training in completion of catheter care documentations to be included as part of the catheterization training/study day.
21. Clinical records keeping re-audit 2017	Medical Directorate / Trust-	Clinical Effectivene	The aim of this re- audit was to obtain assurance that the services that had not previously met the 90% compliance in the annual audit had achieved compliance in line with the Trust's clinical record keeping

Title	Division	Service	Outcomes and actions
	wide	ss Team	standards. **Findings included:** The re-audit show indicated overall ≥90% compliance. **Actions identified (*information awaited)*** The clinical records steering group will be meeting to discuss the report and put forward recommendations.
22. Clinical records keeping audit 2017	Medical Directorat e / Trust-wide	Clinical Effectivene ss Team	The aim of the audit was to monitor Trust record keeping standards **Findings included:** The compliance level achieved by the Trust was 83% demonstrating a 'significant assurance rating. **Actions identified included:** A 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 of the next re-audit.
23. Community nursing NICE guidance CG179 pressure ulcer	Quality/tr ust-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 included:** 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 (and carers if applicable), whilst 16 (8%) stated this was not applicable. This shows good compliance with regard to these standards, although not the required 251 (100%). **Actions identified included:** *Information awaited.*
24. 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. **Finding included:** Employees reporting improvement 82.04% (target 80%), improvement reported: 28.29% (target 40%). **Actions identified included:** Increase training on chronic pain management and provide advice on managing ergonomic risk factors in work settings.

Acronyms and explanations of terms

AAC	Assistive Communication Service within the Children Health's Division
AAF	Amino Acid Formula (infant feeding formula)
BERG Balance Score	The BERG Balance Scale is a clinical test of a person's static and dynamic balance abilities
Braden Scale	The Braden Scale uses a special scoring system to evaluate a patient's risk of developing a pressure ulcer
CG	Clinical Guideline
CHD	Children Health's Division
CMaps	Conversation Maps (diabetes structured education programme)
COPD	Chronic obstructive pulmonary disease
CRK Audit	Clinical Records Keeping Audit
Doppler	A safety check carried out before compression bandages or hosiery are prescribed for patients with venous leg ulcers
eHF	extensively hydrolysed formula (infant feeding formula)
EQ-5D-5L	A standardised measure of health status that provides measures of health for clinical and economic appraisal
MDT	Multi-disciplinary Team
MFRA	Multifactorial Falls Risk Assessment
MUST	Malnutrition Universal Screening Tool
NCNR	CLCH Network Community and Rehabilitation
NICE	The National Institute for Health and Care Excellence
OT	Occupational Therapy
PRN	'pro re nata' - medicines that are taken "as needed"
SIFP	Specialist Infant Formulae Prescribing guidance
SOP	Standard Operating Procedure
TOMs	Therapy Outcome Measures
WHO	World Health Organisation

PARTICIPATION IN RESEARCH

CLCH has introduced a new three year Research Strategy (2018-2020). The strategy outlines how CLCH will enhance patient experience through building research capability and capacity.
The strategy also makes a pledge that `all staff and patients in CLCH will have the opportunity to participate in research.' To support this aim CLCH will, in May 2018, take part in the National Institute for Health Research's (NIHR) *I Am Research* campaign. This campaign aims to build
awareness of health and care research and celebrates how research has shaped, and continues to shape, the NHS and patient outcomes. Much of the activity will take place at our community sites and the campaign will give us s an opportunity to engage closely with our patients and also give staff a boost and a thank you.

Examples of current studies that CLCH is involved in include:

Sexual health services:

- PreP Impact study: this is the clinical trial of a drug. It aims to assess the impact on the occurrence of sexually transmitted infections and HIV diagnosis. This may lead to clinical and cost effective access to the drug in the future.

- A randomised control trial called SAFETXT is a randomised controlled trial of an intervention delivered by mobile phone messaging. It aims to reduce sexually transmitted infections by increasing sexual health precaution behaviours in young people (16-24) and is due to be completed by June 2018.

Parkinson's service:

- Pain study**:** this study looked at the type and frequency of pain experienced by people with Parkinson disease

- Familial Parkinson's study**:** a study using genetics to understand Parkinson's disease. This may lead CLCH future involvement into research for new treatments

During 2017-18, there were over 25 clinical staff participating in 17 clinical research studies in 5 specialities that had been approved by a research ethics committee. CLCH is a host site for approximately one half 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.

The number of patients receiving relevant health services provided by CLCH during 2017-18 that were recruited during that period to participate in research approved by a research ethics committee was 165

COMMISSIONING FOR QUALITY AND INNOVATION (CQIN) PAYMENT FRAMEWORK

A proportion of CLCH's income during 2017-18 was conditional on achieving quality improvement and innovation goals directed by NHS England and built in to the contracts held with our NHS Commissioners. These included NHS Central London CCG (as co-ordinating commissioner on behalf of NHS West London, NHS Hammersmith and Fulham, NHS Hounslow, NHS Brent, NHS Ealing, NHS Hounslow and NHS Camden CCGs as Associates), NHS Barnet (as co-ordinating commissioner on behalf of NHS Enfield, NHS Haringey and NHS Camden CCGs as Associates), NHS Harrow and NHS Herts Valleys. Achieving the agreed CQIN goals represents an additional 2.5% of the contract values of these contracts. Our achievements against the CQIN goals for 2017-18 are detailed in the following tables.

(Please note that the figures in the tables 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 CQINs and hence final achievement could vary).

CWHHE

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£241,844.28	£241,844.28
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£241,844.28	£241,844.28
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£72,553.28	£32,648.45
Health & Wellbeing	Improvement of staff health and wellbeing	£72,553.28	£36,276.64
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£145,106.57	£145,106.57
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£145,106.57	£145,106.57
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£145,106.57	£145,106.57
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£145,106.57	£145,106.57

BARNET CCG

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£157,005.96	£157,005.96
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£157,005.96	£157,005.96
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£47,101.79	£0
Health & Wellbeing	Improvement of staff health and wellbeing	£47,101.79	£23550.89
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£94,203.58	£94,203.58
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£94,203.58	£94,203.58
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£94,203.58	£94,203.58
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£94,203.58	£94,203.58

HARROW CCG

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£40,469.81	£40,469.81
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£40,469.81	£40,469.81
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£12,140.94	£12,140.94
Health & Wellbeing	Improvement of staff health and wellbeing	£12,140.94	£12,140.94
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£24,281.89	£24,281.89
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£24,281.89	£24,281.89
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£24,281.89	£24,281.89
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£24,281.89	£24,281.89

HERTS VALLEY CCG

CQIN Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£1,678.93	£1,678.93
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£1,678.93	£1,678.93
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£503.68	£0
Health & Wellbeing	Improvement of staff health and wellbeing	£503.68	£251.84
Supporting proactive and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	£1,007.36	£1,007.36
Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£1,007.36	£1,007.36
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£1,007.36	£1,007.36
Personalised care and support planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	£1,007.36	£1,007.36

LOCAL INCENTIVE SCHEMES (LIS)

Merton CCG: Merton CCG contract does not have a CQIN with CLCH but instead had an incentive scheme, related to the reduction of emergency hospital admissions and the achievement of patient outcome measures. This scheme was worth 2% of the contract value, which would represent £539,772.00 over and above the contract value.

LIS Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
Reduction in the annual rate of potential years of life lost for those patients known to Merton Community Services	None set	£0	£0
Patient Experience 1	To achieve 92% of responders rating Merton Community Services either good or excellent	£53,977.00	£16,193.00
Patient involvement with care decisions	To achieve 87% of responders stating that they were involved as much as they required in their care and support management.	£53,977.00	£16,193.00
Patient Reported Outcome Measures (PROMs)	To achieve an improvement in the number of patients with PROMs recorded prior to and post service intervention	£53,977.00	£16,193.00
Non-Elective Admissions Avoidance	To achieve an annual reduction in non-elective admissions for those patients known to Merton Community Services	£269,886.00	£80,965.00
Patient self-management	Improvement in the percentage of patients reporting that they are confident in their ability to manage their own health following a service intervention	£53,977.00	£16,193.00
Patient Experience 2	Improvement in the percentage of patients reporting that their team delivering their care operated in a co-ordinated manner to deliver the best possible care and support	£53,977.00	£16,193.00

WANDSWORTH

Wandsworth contract does not have a CQIN with CLCH but instead had an incentive scheme.

Year One of the scheme focuses on service processes to deliver a more a fuller understanding of the patient cohorts and workforce levels required to support the delivery of services to this cohort.

The LIS equates to 10% of the contract value.

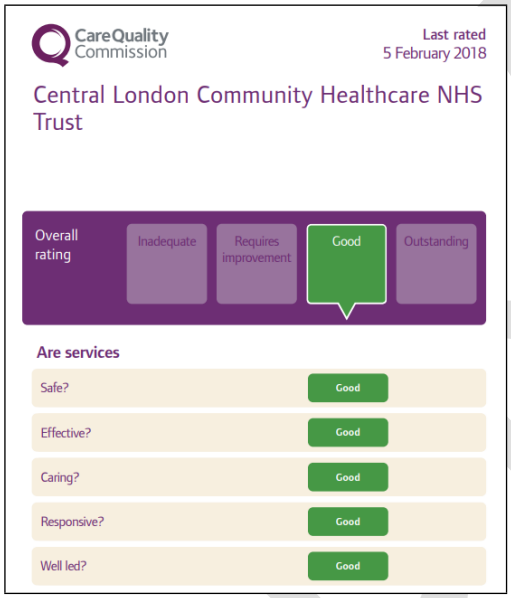
LIS Title	Goal	Plan for 17/18	Forecast Achievement for 17/18
IV Antibiotics	The development of IV antibiotics protocol that will support case management of CAHS patients in the community	£155,300.00	£116,475.00
CAHS Caseloads	Review of existing CAHS caseload including baselining and banding of patients according to low, medium and high acuity	£155,300.00	£116,475.00
CAHS Staffing	Review of CAHS staffing establishment including training needs analysis, opportunities for workforce planning and development; planning for future demand and supply in light of demographic changes and delivery of the SWL Sustainability and Transformation Plan	£155,300.00	£116,475.00
Clinical Data Migration	Migration of Community Clinical data sets from RIO to EMIS	£310,600.00	£310,600.00

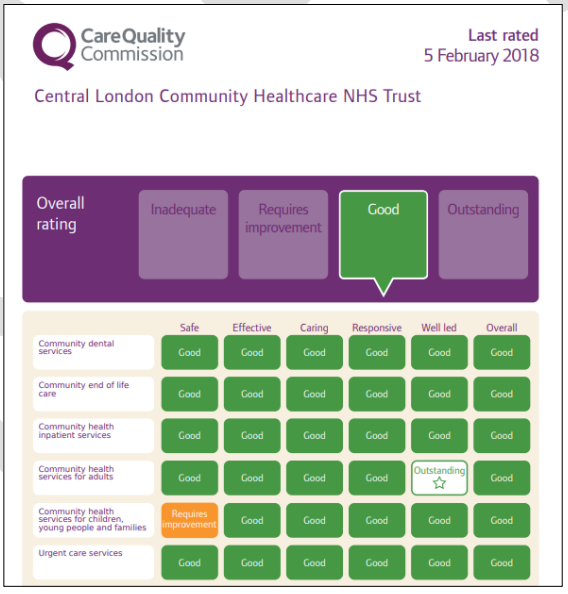
Care Quality Commission (CQC)

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 any enforcement action against Central London Community Healthcare NHS Trust during 2017-18

CLCH has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2018.

In September 2017, the CQC inspected four of the Trust's core services. These were Community health services for adults; Community health services for children and young people; Community health inpatient services; and End of life care. Additionally they undertook a well-led assessment in October 2017. In January 2018 their report rated the Trust as 'Good' overall, with several improved ratings in individual core services. The grids below reflect the inspection report ratings.





The Trust received improved ratings in the 'Safe', 'Effective' and 'Well-Led' domains for Community End of Life Care domain from 'Requires Improvement' to 'Good', and an improved rating of 'Good' overall for the core service (previously 'Requires Improvement'). The Trust also received a rating of 'Outstanding' for the 'Well-Led' domain in the Community health services for adults' core service (previously 'Good').

The Trust was not issued with any actions which it must take to improve, nor was it issued with any requirement notices. The CQC did highlight actions that the Trust should do to improve and in response, CLCH created plans to achieve them.

As can be seen from the above grid, CLCH was given a rating of 'Requires Improvement' for the *Safe* domain in community health services for children and young people. This rating was awarded mainly due to staff caseloads. The Trust has recruitment and retention plans in place to address this. Recruitment and retention is described in more detail in the section regarding progress against the Trust's quality priorities.

The CQC did not set the Trust any 'must do' action in order to improve children's services; they did however suggest some actions that the Trust implement to improve. We continue to work with our commissioners of children's services to provide care within the commissioned model

The Trust's compliance team continues to actively work towards improving the Trust's rating from 'Good' to 'Outstanding'. This includes all teams assessing themselves against CQC standards and benchmarking against providers that have been rated as outstanding.

Secondary use services

CLCH submitted records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. We reported that 93.1% of records included the patients' NHS number and 90.2% their general medical practice.

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 93.1% of records included the patient's NHS number and 90.2% included their General Medical Practice number.

Information governance toolkit

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

Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2017-18

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 accurate and up to date, 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 fully committed to improving the quality of the data in use across all of its services.

The following is a summary of the actions that CLCH has taken to improve its data quality during the 2017 - 2018 year:

- The data quality policy has been reviewed and approved to set the expectations of the organisation as a whole and of staff.

- A data quality plan overseen by the Trust Data Quality Forum has been developed with clinical and operational input and includes the identification of prioritised data quality matters to address.

- Data quality reports are provided on a key number of data quality matters to address and reported through to all divisional and trust level so action may be taken.

The Data Quality Forum (DQF) has oversight of this area of work led by the Chief Information officer. It has a very strong operational input with divisional Business Managers and is supported by the relevant functions responsible for clinical systems and reporting. In the context of data quality, this group has the following specific aims to improve data quality in 2018-19

- To actively support the implementation of the Data Quality Strategy by assisting in the operational implementation of the data quality plan.
- To identify, and regularly review, a representative set of data quality metrics which appropriately reflect the level of data quality within the Trust with a view to establishing improvement activity and corrective actions.
- To support the development of an internal audit programme for data quality issues and to regularly review the results of those audits with a view to establishing improvement activity and corrective actions.
- To agree and promote a series of data standards within the Trust.
- To act as an advocate/champion for the importance of data quality issues.

CLCH will be taking the following actions in 2018-19 to improve data quality.

- Appointing a trust lead for data quality and information
- Working with teams to improve the quality of their data collection and reporting

The Capita Business intelligence performance analytics (BIPA) function is an active contributor to both understanding and exposing areas where data quality may be improved to aid an understanding of performance and effective delivery of care. CLCH will complete the development of our data warehouse in 2018/19 that will automate reporting including for data quality so that any issues identified can be fixed.

LEARNING FROM DEATHS 2017 – 2018

Learning from deaths of people in our care can help us NHS organization's improve the quality of the care we provide to patients and their families, and identify where we could have done more.
In October we published a 'Learning from Death Policy' based on The National Quality Board at NHS Improvement's 'National Guidance on Learning from Deaths'. Implementing this policy, which was written with the acute sector in mind, within the context of a community Trust has required some thought and is subject to on-going refinement.

CLCH openly publishes the numbers of deaths within the inpatient units of the trust, (there are 5 in-patient units and an inpatient hospice) and any deaths in these units are all reviewed using an accredited review tool, the CLCH Mortality Review Form, based on an accredited case review methodology.
Since January 2018 the trust has widened the eligibility criteria for patient's deaths that require reviews as shown below;

- All deaths in inpatient beds
- All known deaths from adult community services within 30 days of date of discharge
- All deaths of homeless health caseload within 30 days of discharge.

(Children and patients with learning disability are subject to different review procedures).

From January 2018 divisional leaders have been working with teams to implement the new processes that set out how to record all deaths within the scope described above. This still requires further work to embed and to date the numbers coming through the reporting system Datix are not significantly different from the inpatient bed mortality data. The medical director has re-communicated the importance of this change in approach and is working with operational teams to make the reporting robust but streamlined, including setting up weekly mortality meetings at Clinical Business Unit level. This annual report describes the number of deaths in the inpatient cohort and how those deaths have been reviewed and the learning that was captured set out in Table 1 below.

Table 1 -*Note; the final data for March 2018 is not yet available.*

	Prescribed information	Form of statement
27.1	The number of in- patients who have died during the reporting period, including a quarterly breakdown of the annual figure	30 in the first quarter 32 in the second quarter 38 in the third quarter 27 in the fourth quarter Includes expected hospice deaths
27.1.1	The number of other deaths within the community where this approach was used to generate learning	2 1-The death of a homeless man in Central London 2- Patient found dead at home as a result of suicide.
27.2	The number of deaths included in item 27 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	Across 2017-18, 127 deaths have been recorded and 6 investigations have been carried out in relation to the 127 deaths included in item 27.1 0 in the first quarter; 2 in the second quarter; 2 in the third quarter; 2 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0%

	Prescribed information	Form of statement
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	Case 1 - Whilst there was a completed DNAR form in the records there was no evidence of the discussion with the family in the body of the medical record. CPR was commenced, although stopped very quickly this was inappropriate given the DNAR decision. Case 2-No action points noted Case 3 no actions noted Case 4 - Some of the assessment forms were not signed and dated. The 1st DNAR was complete but did not have evidence of discussion with patient family documented in the clinical record. Boxes were checked on the clerking form to indicate the DNAR form had been completed. Case 5- a user of the homeless heath team the patient was receiving care within local hostels and community clinics – there were no issues identified for learning. Case 6 Unclear mental health history in records. Good evidence of utilisation of all the skills within community teams, proactive support within difficult circumstances
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	Lead Clinician for the ward asked to feed back to local team in case 1. Case 4 led to discussion regarding acuity levels for rehab- incorporated into a wider review of Trust rehab functions and admission criteria. Case 5 has a high profile and there was some pressure to review as an SI. The case review process was more applicable and did not lead to an SI investigation
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Insufficient scope in actions identified to undertake this. The widening of the scope of the reviews from January 2018 should affect this

	Prescribed information	Form of statement
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	0
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	0

Incident reporting – NHS 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 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.

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

Information awaited – data has not yet been published by NRLS.

PART 3: OTHER INFORMATION

QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2017-18

Progress against our quality campaigns is described in detail in the dashboard and performance report below. These outline the Trust quality performance both for quarter four and the full year.

Our Quality KPIs

Quality Campaign	Key Performance Indicator	Target	Performance		Previous Year 2016-17	Performance improved or maintained
			Mar-18	Year end		
A Positive Patient Experience Changing behaviours and care to enhance the experience of our patients and service users	Proportion of patients who were treated with respect and dignity	95.0 %	98.6 %	97.4 %	94.5%	Yes
	Friends and family test - percentage of people that would recommend the service	95.0 %	94.1 %	92.1 %	91.3%	Yes
	Proportion of patients whose care was explained in an understandable way	90.0 %	94.3 %	92.9 %	90.1%	Yes
	Proportion of patients who were involved in planning their care	85.0 %	92.3 %	84.5 %	81.8%	Yes
	Proportion of patients rating their overall experience as good or excellent	92.0 %	91.4 %	92.2 %	91.8%	Yes
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	100.0 %	99.3 %	99%	Yes
	Proportion of complaints responded to within 25 days	95.0 %	100.0 %	100.0 %	100%	Yes
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %	100.0 %	100%	Yes
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %	100.0 %	100%	Yes
Preventing Harm Incidents & Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	96.0 %	97.6 %	97.2 %	95%	Yes
	5% reduction in falls causing harm (on 2016/17 baseline)	4	8	81	-	New measure
	5% reduction in pressure ulcers grade 3 / 4 (on 2016/17 baseline)	12	11	105	144	Yes
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	0	5	4	No
	Proportion of external SIs with reports completed within deadline	100.0 %	100.0 %	98.6 %	99.4%	No
Preventing Harm Prevalence (NHS Safety Thermometer)	Proportion of patients with harm free care	98.0 %	93.2 %	93.7 %	93.6 %	Yes
	Proportion of patients who did not have any NEW harms	98.5 %	98.2 %	98.3 %	98.6%	No
	Proportion of patients who did not have a NEW (CLCH acquired) pressure ulcer	98.5 %	99.1 %	99.0 %	95%	Yes
	Proportion of patients who did not have a fall	98.5 %	99.4 %	99.2 %	99.3%	Same

Smart, Effective Care Ensuring patients and service users receive the best evidence based care, every time **Effective Services**	Proportion of patients who did not have a catheter associated urinary tract infection	99.0 %	99.4 %	99.5 %	99.4 %	Yes
	Proportion of patients who did not have a venous thromboembolism	100.0 %	99.8 %	99.8 %	99.8 %	Yes
	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.8 %	0.3 %	0.4 %	Yes
	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90.0 %	100.0 %	100.0 %	99.1%	Yes
	Percentage of hand hygiene episodes observed across CLCH services (excluding bedded areas) that are compliant with policy	97.0 %	100.0 %	100.0 %	99.3 %	Yes
	Percentage of local clinical audits, service evaluations and quality improvement projects undertaken by services.	40.0 %	65.9 %	71.7 %	65.9 %	Yes
	Percentage of services completing NICE Baseline Assessment Form within agreed timeframe	75.0 %	100.0 %	65.0 %	100.0 %	No
Modelling the Way Providing world class models of care, education and professional practice	Statutory and mandatory training compliance	95.00 %	89.82 %	89.82 %	91.95%	No
Here, Happy, Healthy & Heard Recruiting and retaining outstanding clinical workforce	Staff Vacancy rate (Clinical)	12.00 %	12.14 %	12.14 %	15.53%	Yes
	Staff Turnover rate (Clinical)	12.00 %	16.67 %	16.67 %	12.91%	No
	Staff engagement index score	3.88 %	3.89 %	3.89 %	3.86%	Yes
	Sickness absence rate - 12 month rolling (Clinical)	3.50 %	3.65 %	3.65 %	3.69%	Yes
	New Bank staff recruited		170	309.00	256	Yes
	Percentage of staff who have an appraisal	90.00 %	86.48 %	86.48 %	87.79%	No
Value Added Care	Staff to have been trained to basic level in improvement skills including Lean	6%	6.0 %	6.0 %		New
	Services have used improvement tools	5%	4.8 %	4.9 %		New

OUR PRIORITIES
POSITIVE PATIENT EXPERIENCE

Key Outcomes	Measures of success 2017 - 18	Update
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	The Trust continues to achieve above 90% compliance relating to the PREM question 'was your care explained to you in an understandable way?' The *Always Event Project* has been aimed at addressing this issue and ensuring that patients are fully aware of their care plans and feel involved in the decision-making process.
	Achievement of 85% of proportion of patients who were involved in planning their care	This has been achieved in quarter 4. The Patient Experience Team have successfully rolled out the first *Always Event* across all community nursing teams and all of the teams are now using the new script, training material and leaflets designed to involve patients in their care. The next Always Event projects have now been launched across both End of Life Care and the Learning Disability services with meetings taking place in February and March 2018 respectively. The Always Event for End of Life care will be related to bereavement and the specific objective is currently being discussed. The Learning Disability project will be delivered in partnership with the Carers Network and will be the first of its kind as there is yet to be a joint Always Event project successfully delivered by any other NHS provider.
	The use of co-design will be embedded throughout the organisation	The Patient Experience Team has successfully delivered patient led engagement and co-design events to discuss and help shape the proposed Continence Service transformational change. This has included the successful recruitment of patients to test current and new continence products options. The Patient Experience Team has also led a co-design project to improve patient experience with front of house staff. This is a continuation of the previous walk-in centre project and has been highlighted as an area for improvement through additional analysis of patient feedback and complaints. As a result of the co-design work, bespoke training sessions for front of house staff have been developed and delivered. The sessions took place in January and March 2018 and

		attended by over 25 staff in total. The feedback was overwhelmingly positive with attendees noting 'the training was delivered at a good pace' and was 'full of useful examples of how to improve the patient experience for each of our patients'. The patient experience team are looking at opportunities to deliver further training throughout 18/19. The Patient Experience Team has led on the delivery of engagement roadshows taking colleagues and clinicians out to patient groups/events to talk about the change in the Patient Transport Criteria. The change to the eligibility criteria has also been shared with partners such as Healthwatch, Commissioners and GPs to ensure that all of our key stakeholders have been made aware of them before they are implemented in May 2018. The Patient Experience team have successfully delivered the '*Gold Standard of Care' Project* alongside the bedded rehabilitation transformation project. This has involved gathering patient feedback on Alex rehabilitation unit in order to better understand our patient's expectations during their time on the ward. The patient feedback and outcomes were shared alongside a patient story at the 'Rehabilitation Transformation Programme Workshop, Our Future Model' event on the 22nd March. The Patient Experience team helped facilitate two Podiatry engagement events in Merton, on 5th and 8th March. These events were to help inform patients of the change in eligibility criteria for low risk patients. They also provided an opportunity to signpost patients to other organisations who can provide support for low risk patients who are to be discharged from the service. These events were run in collaboration with NHS South West London Alliance. As part of the Patient and Public Engagement Strategy update, the Patient Experience team are aiming to host two engagement events. The first will be held at Southfields Library in Wandsworth on 9th May and the second will be held at Edgware Community Hospital on 21st May. This will be an opportunity for our patients to be involved and engaged in our strategy.

	Patients will be members of the Quality Councils in each division	As of January 2018, there are currently 13 Quality Councils in place. Patient representatives are on 9 of the 13 Quality Councils with more representatives identified to add to the 4 new councils. Patient engagement continues to be high and well received and in a patient representative feedback session held on 19th March 2018, patients provided positive feedback about their ability to engage and help improve quality.
Patient stories and diaries used across pathways to identify touch points and `Always events'	Always Events will be implemented across the Trust	The initial *Always Event Project* has now been rolled out across all community nursing teams. The aim is to undertake an audit of patient feedback in May 18 in order to identify any changes or further actions that need to be taken having implemented the three initiatives developed as part of the project (guidance for the initial call and visit from the District Nursing Service, a service leaflet and face to face training which was co-designed with patients and carers). The Patient Experience Team will then audit the success of the this project every 6 months running a similar patient survey to that used during the pilot phase of the project to ensure that the scripts, training and leaflets continue to have a positive impact on the patient experience. As one of only three Trusts in the country who have successfully implemented Always Events, Jane Cummings visited the Trust on the 16th February along with members of her team to listen to the work that the Trust has undertaken to implement Always Events and to present the Trust with an award. Staff and a patient representative talked about the Always Event journey taken by the Trust, providing an overview of the work that has been undertaken and the impact that this has had on our patient and staff experience. Two further Always Events are being planned across End of Life Care and the Learning Disability service as noted earlier in the report.

	Continued use of patient stories by all services and shared at Divisional and Trust forums.	Patient stories continue to be collected by staff and the Patient Experience team and shared at divisional and Trust wide forums. The stories vary from written stories to video stories and provide a rich understanding of our patient's experience. The Patient Stories Annual report will be developed and presented to the Trust Quality Committee in July 2018.
	Develop a plan to implement patient diaries in services and how these can be used to inform service improvement.	The Pembridge volunteers have been trained in collecting Patient Stories and Patient Diaries to assist with this project. The Patient Experience Team has set up a Patient Experience Steering Group specifically for Pembridge patients. The members have now met on a number of occasions to discuss the best way to implement diaries with patients, volunteers and carers. The aim will be to pilot this in May 2018. This work continues to be complemented by the *Swan Song Project* which is an innovative way of collecting patient's stories/diaries, putting their experiences to music. Engaging patients to manage a personal experience diary upon admission to Alex rehabilitation ward has proven very difficult with a number of patients identified across Alex and Athlone, whom have failed to complete the diaries provided. However, as part of the rehabilitation transformation programme it has been agreed that the implementation of patient diaries will be included in the improvement metrics moving into 2018/19.
Patient feedback used to inform staff training	Implement patient feedback into the Trust Education Forum using complaints/ PALs and patient stories	The Modelling the Way Forum continues to have a standing agenda item for a staff or student story which outlines areas that have gone well and areas where improvements could be made. Incidents and patient feedback are also discussed at the Trust End of Life Care Operational Group and Learning Disability Forum to identify any specific training requirements.

	Identify opportunities for patients and carers to participate in training	Patients have been engaged with the development of patient videos to support the training for staff on collecting patient stories. Patients with a diagnosis of dementia and their carers continue to be involved in the Dementia Care Champion training listening to student's projects and providing advice on where improvements could be made. The first Patient led user group met at Pembridge Hospice on Monday 26th March, the group was attended by 6 patients and a carer and the discussion centred around improving the activities available to patients attending the day centre Patients have requested better visibility of 'you said, we did' on a specific notice board and more information about the Hospice itself and the newly formed user group on the charity website. The next meeting has been scheduled for 23rd May and will take a more formal approach with the TOR set to be agreed. The meetings will continue every other month. The Head of Patient Experience and Corporate Governance Manager have successfully recruited 12 patients to act as expert patient representatives on future recruitment panels. The training of these patients took place on 6th March and the aim is to now involve these patients on future recruitment panels in the North Division.
	Develop and implement patient stories as part of the learning from serious incident reviews, for example impact of a pressure ulcer/ fall.	The Patient Experience team are being invited to each of the 48-hour meetings for patients who have developed a pressure ulcer. The aim is to identify patients who can be interviewed. Unfortunately, there have not yet been any patients willing to share their stories, but this work will continue. When received it is planned to feed these stories into the Serious Incident Panel and the learning will be shared with the relevant teams and services.
	Patients to be members of the Quality Councils for education and training	Three of the shared governance councils continue to focus on the Positive Patient Experience Quality Campaign. Each of the council chairs are invited to the Trust Patient Experience Coordinating Committee to provide feedback and to ensure they are engaged and aware of Trust wide patient experience feedback and ongoing initiatives.

PREVENTING HARM

Key Outcomes	Measures of success 2017 -18	Update
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	Achieved. In terms of Safety Thermometer data, this has been achieved for new (CLCH) harm free care.
	Severity of PU and falls will continue to fall (5%)	We achieved >5% reduction for pressure ulcers Our severity of harm from falls has reduced. During 2016/17 a total of 26 serious incidents related to falls were declared; including internal and external SIs. For 2017/18, 15 were declared; 11 fewer falls serious incidents. As a Trust we report patients who fall three times or more on a bedded unit albeit with no harm as an internal SI. In 2016/17 there were 18 of these internal SIs reported and in 2017/18 there were 8.
	Red flag reporting will be embedded throughout organisation	Achieved
	Revised early warning system developed for patients in community setting including revised early warning assessments for falls and PU	As above
	0% PU in bedded areas	Not achieved, the Trust will continue to report all inpatient PU, undertake root cause analysis and ensure learning events continue with all clinical staff.
	100% RCA completed on time	Achieved – all 18 external SI RCAs due in Q4 were submitted on or ahead of schedule (excluding those de-escalated)

Safety culture and activities signed up to in ALL services	Trust maintains good or outstanding in NHSI learning from mistakes league table	The learning from mistakes league which was last published in March 2016 has not been published for 2017 or 2018.
	No outstanding actions from SIs that are out of date	Achieved
	All risk register actions are met by identified completion date.	Of the 87 approved clinical risks currently open, 26 have actions that were due before the end of Q4, which remain open / overdue. This is an increase from 16 open at the end of Q3, 19 open at the end of Q2 and the same open at the end of Q1 To assist managers in ensuring actions are completed, the Datix system now has automatic reminders turned on, and the Corporate Risk Facilitator has implemented a new reminder process.
Variations in practice identified and acted upon	All staff are aware of learning from incidents	In CLCH we use Spotlight on Quality, the Hub, CLIPS and meetings such as PSRG and team meetings to raise awareness of learning from incidents. We are now into the third quarter for divisions holding learning events about pressure ulcer serious incidents.

SMART EFFECTIVE CARE

Key Outcomes	Measures of success 2017/18	Update
Clinical staff use the most up to date clinical practices	CAS alerts	The Infection Prevention Team met the KPIs target, and achieved 100% compliance during the year.
	NICE – 75% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe.	Measures were put in place after the KPI target was not met in December 2017; as a result, the KPI compliance for January, February, March 2018 was 100%.
There will be a demonstrable culture of clinical enquiry and continuous improvement across the Trusts	76% staff able to contribute to improvements at work	Results from the National Staff Survey 2017 indicated that the Trust had achieved 74% compliance, a slight improvement from the 73% compliance achieved in 2016. It should be noted that the national average for community Trusts for this KPI in 2017 was 71%.
	Staff having access to analytics , training, tools and support via internet	Staff continued to have access to analytical tools and training via the improvement Resource library on the continuous improvement intranet page. Support and training were accessed from peers or the Improvement Team via the analytics and improvement networks using a web-based forum on the hub. In addition, the Clinical Effectiveness Team, alongside the Improvement and Transformation Office (ITO) provided training on how to interpret data, support with the development of analytical tools, auditing tools and provide support for analysing data.
CLCH will be a leader in innovative community practice	Develop a learning repository for lessons learnt regarding change projects	Lessons learnt from all ITO projects were documented and shared through fora such as the Strategic Improvement Group.
	PIDs to include section for on-going learning	A PID/QIA combined form was agreed as part of the QIPP Policy 2017. There was no section for capturing on-going learning, and it was expected this would be captured in the project workbook.

MODELLING THE WAY

Key Outcomes	Measures of success 2017/18	Update
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	Final versions of the Nursing and AHP (which includes dental, podiatry and pharmacy) have been completed. The skills required for staff have been outlined and associated competencies are in place for the majority of roles. The Nursing career framework was presented at the Nursing workforce event in March 2018 and is currently being updated to incorporate comments and feedback with the aim to launch this formally in May 2018. Work remains ongoing with staff to complete competency frameworks for all staff groups. The AHP career framework will be presented at the AHP workforce event in May 2018 for feedback and comments before being launched in June/July 2018. The career frameworks will be accessible as an interactive tool on the HUB. Work remains ongoing on the non-clinical pathway and the aim is to complete this by July 2018.
	The continued implementation of Apprenticeship roles	The Trust has re-launched an Apprenticeship forum to implement and monitor the Trust Apprenticeship Strategy. As a result, a new Apprenticeship policy has been developed to support Apprenticeships in the Trust. In addition, a communication plan is being developed to raise staff awareness and promote apprenticeships. Work is underway with divisions to establish the numbers and types of apprenticeships that will be supported. The Trust was successfully audited by the Education and Skills Framework Authority (ESFA) on 23rd January 2018. The audit was undertaken to provide assurance to the ESFA that as an employer provider of apprenticeships we have the required structures and processes in place as outlined in our initial Register of Apprentice Training Provider (RoATP) application. The Trust will also be subject to an Ofsted inspection which would normally be within 3 years of being accepted onto the RoATP or drawing down funding from the apprenticeship levy. Work has commenced on the completion of the Trust's self-assessment report (SAR) which will inform the development of the apprentice quality improvement plan (AQIP).

		Both of these documents are required as preparation for an Ofsted inspection. Procurement has been undertaken to appoint training providers for the following apprenticeships: • Healthcare Support Workers level 3 • Children & Young People level 3 • Assistant Practitioner level 5 • Customer Service level 2 • Operational management level 3 • Team Leader level 3 The successful bidders have been informed, and the contracts are in the process of being reviewed and completed. As a training provider, the Trust has commenced delivery of the Team leader level 3 apprenticeships which are incorporated into the Deputy Team Leader Development Programme. 7 staff commenced in October 2017 and a further cohort commenced in February 2018.
	The continued pilot of the Nurse Associate (TNA) role in Adults and Children services	The Trust remains involved in 4 pilot sites across London. 1 TNA has withdrawn from the programme for personal reasons and the remaining 9 adult TNA are progressing well and feedback from them has been very positive. The NMC have published draft Standards of Proficiency for Nursing Associates and Nursing Associate Skills Annex, it is expected that these will be approved by the NMC in Spring 2018. HEE have also published guidance in relation to the Administration of Medicines by Nursing Associates. The Trust will need to review policies and training in relation to this in preparation for the first cohorts of Nursing Associates who are due to qualify in January 2019.The Trust will be implementing 58 Trainee Nurse Associates across adult and children services in September 2018.

	The continued pilot of the Capital Nurse Foundation rotation programme	The Trust continues to recruit staff onto the Capital Nurse Foundation rotation programme and has achieved the target of having 16 staff recruited this year. 9 newly qualified staff commenced a rotation in January which focuses on community nursing and specialist nursing services within the Trust. The rotation programme has been very positively received by staff in divisions who feel that it will help attract staff into the Trust who wish to gain experience in a community setting. Trinity and North London Hospices are still keen to work with the Trust on the End of Life Rotation and we are currently shortlisting applicants for this rotation.
	The implementation of the staffing models into all clinical services following the safer staffing review	Safe staffing levels for the rehabilitation units are in place and staffing levels are reported monthly. The model of care is currently being reviewed as part of a rehabilitation transformation project taking place across each of the units. Safe staffing levels for Community nursing have been implemented in Harrow and all teams within the Inner division. In Merton and Wandsworth, work is currently being undertaken to understand the staffing levels required. The aim is to complete this for sign off in April 2018. In Barnet, the Trust is proposing to develop a long-term model of care. Work is currently being undertaken with the Community Nursing, Rapid response and the Integrated care teams to establish the type of model that will be implemented. In the Walk-in Centres, further analysis has been undertaken in order to establish the specific staffing levels and skill mix required. As a result, specific actions have been taken for each centre including the implementation of a trainee band 6 post supported by a band 6 development programme. This has resulted in reduced vacancy levels and greater retention rates within the service.
	The evaluation of existing fast track programmes and the development and implementation of further fast track programmes.	Following the evaluation of the fast track programme in December 2017, a number of recommendations have been implemented. These include increasing the length of the programme to 15 months and reviewing the management training to better support the development of these skills. A new cohort of 6 staff have been recruited for the inner division and are due to start in April 2018.

		A poster presentation was taken to the RCN Education Conference in March 2018 which described the Fast Track Programme and its benefits. The poster attracted interest from a number of organisations across the UK. Further development programmes have been developed including an 18 month Band 5 programme and a Band 6 development programme. The Education team are currently developing a Band 7 development programme with the aim that this will be implemented in June 2018.
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	As a part of the two recent Trust nursing workforce events, discussions have taken place about our model of professional practice. A workshop was undertaken in which staff were asked to consider what a professional practice model would look like for nursing. Staff developed 7 potential professional practice models which the Trust are now reviewing. The aim is to share these further with staff in order to obtain further comments. Once completed, the common themes will be collated and a revised model developed aligning with the Trust Quality Strategy and Clinical Strategy. Further presentations and engagement events will then take place across the Trust before a final decision is made on the Trust model in Summer 2018.
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	The Trust has incrementally increased the number of research studies that it is hosting, and therefore increased the number of opportunities for staff and patients to participate in studies. In addition more staff have undertaken research training, for example, Good Clinical Practice training. The Trust commissioned an external review of research in September 2017, which included significant stakeholder feedback and this was used to guide the new Research Strategy 2018 -2021 which was approved in March 2018.

HERE, HAPPY, HEARD & HEALTHY

Key Outcomes	Measures of success 2017/18	Update
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.	Membership of the Recruitment & Retention Group includes representation from the Quality Councils to ensure front line staff are contributing to recruitment and retention decisions. The North Quality Council based in Harrow (Honey Pot Lane) have changed their area of focus from the creation of a localised staff newsletter to a localised staff directory. This aims to facilitate the settling of new staff into the area and reduces the amount of staff stress and time wasted searching for local services and health professionals that they may need to contact. The Inner Quality Council that are aiming to address the lack of staff morale in the Inner division have conducted their surveys and are now in the process of holding staff f focus groups to discuss the results of the survey and further explore their answers. In the Children's division the Quality Council based in Merton have conducted another plan, do, study, act cycle in relation to their staff survey; they have refined the questions with the view to building confidence in the staff answering the questions. There was an anxiety from staff surrounding the confidentiality of their answers.
Staff turnover (voluntary) below 10% by 2020 **Staff vacancies below 10% by 2020**	Staff turnover (voluntary) below 15% (12% by 3/18) Staff vacancy rate below 15% by3/17 and 12% by 3/18	Turnover remains a pressure point. The CHD rate is starting to improve following the service change impact experienced in year but more staff are leaving as they view a lack of opportunity to progress internally or have found opportunities elsewhere; are feeling the pressure of balancing their work life or are unable to work with other staff in the organisation. The Recruitment and Retention Group is focusing on career development and ensuring opportunities are known and open to clinical staff which should aid with addressing the perception of a lack of opportunities and ease pressure on those leaving for promotion elsewhere. Clinical Vacancy rates are within acceptable tolerance levels and at the close of Feb

		2018 stand at 12.20%
Staff surveys are undertaken which demonstrate improving levels of staff engagement	Staff engagement index score of 3.88 or above	The Trust successfully achieved a score of 3.89 There are divisional variations marked in the body of the report.
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 because of work related stress in the 2017 Staff Survey. Sickness absence remains below target of 3.5%	The 2017 results from the **staff survey** show a reduction of 1% on work related stress.* The Sickness rate (12 month rolling) stands at 3.61% which is slightly outside the target range (in the amber rage).
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%	The Trust continues to meet the monthly and year to date agency ceilings with the weekly Executive Agency Reduction Group closely monitoring the position. Recruitment to bank is also well ahead of the targeted position and the ratio of bank to agency is strong at 72:28 in favour of the bank.

* The full results of the staff survey, including the Trust's performance in respect of the Workforce, Race Equality Standard (WRES) can be found here.
http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2017_RYX_full.pdf

VALUE ADDED CARE

Key Outcomes	Measures of success 2017 -18	Update
Clinical staff use the latest technology to improve care delivery	Each division has explored how technical innovation can be used to improve quality.	The CLCH Way programme is being developed to explore further use of mobile technologies, scheduling technology and self-booking systems to drive further improvements.
	Each division has used improvement tools to improve one service	As of 26th March 2018, six services and two quality councils have demonstrated all the requirements for this KPI (Merton Specialist Weight Management (SWM) Inner Inpatient rehabilitation, Inner Community Nursing, Harrow Community Nursing, ITO service, Partnerships, South Smart Effective Care (SEC) council and CHD Here, Happy, Heard, Healthy (HHHH) council). This represents a Trust position of 4.85% against a year-end target of 0.5%. The Trust and all operational divisions have met the year-end target for this KPI.
Front line staff lead new lean ways of working	5% staff to have been trained to basic level in improvement skills including lean	202 staff have achieved the Basic level improvement knowledge. This represents 6.03% of staff in post which is ahead of year-end target for the Quality KPI (4.0%). All divisions have achieved the target for staff to have basic level knowledge of quality improvement.

Divisional Quality Council Objectives	One objective with outcome measures	Two quality councils working on value added care have formed in January 2018. The first council will be looking at improving training adoption within the Trust and the second working on teams using visual management tools. The Improvement & Transformation Office will support the work of these councils as they begin to develop. All Quality Councils are required to use the CLCH improvement methodology within their council improvement projects.

TRUST QUALITY PROJECTS AND INITIATIVES

The Trust was also involved in a number of other quality projects and initiatives. These included the following:

Inner bedded areas have been taking part in a pilot regarding the 'Carter Review' which focusses upon how Trusts can save money, whilst improving care. The unit has been piloting the collection of a new metric around care *hours per patient day*. This pilot has enabled the units to roster staff more effectively, whilst ensuring safe staffing levels maintain patient safety.

Pembridge specialist palliative care community nursing team have been running a project to support nursing homes within the Borough Hammersmith and Fulham in providing end of life care to people who reside in the nursing homes. This has included training staff in recognising when individuals require specialist end of life care; managing symptom control and teaching staff to administer medication via syringe drivers. The project will support local commissioners understanding gaps that might exist in providing end of life care for people living in nursing homes.

Community adult nursing staff participated within the *Always Event* project which aimed to improve the way in which patients are involved within their care planning. This project involved co-design between staff and patients and focussed upon the design and implementation of a patient leaflet. The success of the *Always Event* led to the Trust receiving a level 1 *Always Event* recognition award.

Knowledge and skills framework for staff: during 2017-18 this was developed to support the development of a culture of continuous improvement. To support this, we launched a bespoke quality improvement e-learning module and delivered more than 40 face to face training sessions for over 200 CLCH leaders and staff on a range of subjects related to leading improvement, continuous quality improvement and change management.

North division In-patient areas: have taken part in the *Gold Standards* project. This involved asking patients and staff what their top 3 priorities are for providing excellent care. The top three themes for and patients were combined to come up with the top three standards for achieving *Gold Standard* care. This was shared with staff and we are looking at how we can embed the *Gold Standards* in all of our work.

Community teams: introduced *Wound Wednesdays* which involved reviewing all grade 3 and 4 wounds each Wednesday. The whole team reviews the patient to ensure all aspects of patient care are considered. Additionally peer reviews take place to ensure patients are receiving the best care they can. This approach has helped to embed ownership of patient care across whole teams.

Sexual health services: Following patient feedback, new clinics were introduced to support patients with LGBT issues and questions. This initiative has been nominated for a Health Service Jounal (HSJ) Award.

The **Improvement and Transformation office:** provided coaching and facilitation support for numerous project teams as well as the Quality Councils. This led to improvements across a range of services including one Quality Council running a quality improvement project which cleared a waiting list backlog for podiatry patients. This enabled patients to get seen quicker and reduce potential clinical risk.

The Care Home in Reach Team: are a team of advanced trained and experienced community nurses who are working as part of a trial in seven Care and Nursing Homes in Wandsworth. The nurses have been involved in replacing urinary catheters, prescribing antibiotics for urinary infections and chest infections, and prescribing to prevent constipation. These nurses have prevented 25 unnecessary admissions to hospital from the 77 patients seen since February.

STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANIZATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

We would like to thank those who reviewed and provided comments on our 2017 – 2018 Quality Account. We have considered the comments received and where appropriate the comments were or will be responded to in the current or future account or used to inform the quality of the services that we provide.

This section will be completed on receipt of comments.

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.

NHS Improvement 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 2017/18 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 2017 to xxx [the date of this statement]
  - papers relating to quality reported to the board over the period April 2017 to [the date of this statement]
  - feedback from commissioners dated xxxx
  - feedback from local Healthwatch organisations dated xxx
  - feedback from Overview and Scrutiny Committee dated xxxxx
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. (The complaints report is attached as an appendix the Quality Account).
  - the national patient survey
  - the national staff survey dated March 2018
  - CQC inspection report dated 8 January 2018.

The Quality Report presents a balanced picture of the NHS 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, is subject to appropriate scrutiny and review and

The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting 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

FEEDBACK AND FURTHER INFORMATION

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.

If you would like to comment on the account please e mail
Kate.wilkins6@nhs.uk

Alternatively you can send a letter to:
Kate Wilkins
2nd Floor, Parsons Green Health Centre
5-7 Parsons Green
London SW6 4UL

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 or writing to the PALS team at the above address.

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 HEALTHWATCHES

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

Central West London Healthwatch
Tel: 020 8968 7049
For Hammersmith and Fulham, Kensington and Chelsea and Westminster healthwatchcwl@hestia.org

Merton Healthwatch
Tel: 0208 685 2282
https://www.healthwatchmerton.co.uk/

Wandsworth Healthwatch
Tel: 0208 8516 7767
https://www.healthwatchwandsworth.co.uk/content/contact

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

Wandsworth CCG
Tel 0208 812 6600
http://www.wandsworthccg.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

Wandsworth
Tel: 020 8871 6000
www.wandsworth.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.

Allied Health Professionals (AHP): Allied health professionals (AHPs) provide treatment and help rehabilitate adults and children who are ill, have disabilities or special needs, to live life as fully as possible. They work across a wide range of different settings including the community, people's homes and schools, as well as hospitals.

Always Event: These are those aspects of the care experience that should *always occur* when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system. An Always Event must meet the following four criteria: Important, Evidence – based, Measurable and Affordable and Sustainable.

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.

Central alerting system (CAS) alerts: This is cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others.

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 (CQIN): The CQIN 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

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.

Nursing and Midwifery Council (NMC): The NMC are the nursing and midwifery regulator.

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.

Prevent: Prevent is one of f strands of the government's counter-terrorism strategy

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 to 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.

Awaited -

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Quality report 2017/18

This report will be proof-read and all corrections and additions will be made to the final version.

world class expertise local care

Quality report 2017/18

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

This will be included in the final version of the report.

1.2 Our trust: Implementing a Group model to deliver world class expertise with local care for a larger population.

Our journey- July 2014 to June 2017

July 2014

- Barnet and Chase Farm Hospitals NHS Trust became part of the Royal Free London Hospital Foundation Trust.

January 2015

- The Royal Free London submitted an application to become a 'vanguard site' for a new care models programme. The purpose of the vanguard was to develop new arrangements for hospitals to improve quality and the experience of care to our patients.

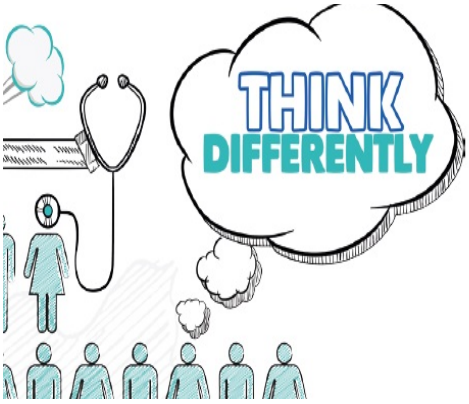
August 2016

- The trust received a 'good'rating from the Care Quality Commission and based on our performance and progress in designing the group model, the trust was accredited to become a vanguard site (leading a group (or chain) of NHS providers

June 2017

- The senior leadership team at each hospital site (Barnet, Chase Farm and the Royal Free) was in place. The teams were responsible for providing local support, leadership and operational oversight for services on a day-to-day basis.

Our Group structure: Collaboration and partnership working



Across the group structure there is a common vision to make the RFL the best place to work and to be treated in the NHS and to become the best hospital group in Europe.

Our staff are doing a fantastic job under growing pressure - treating more people than ever before. To manage this increasing demand we had **to think differently about the way we delivered our services.**

We had the opportunity of a generation to improve the care we deliver to our patients through the NHS vanguard programme.

For far too long, hospitals and other healthcare services have worked independently - **collaboration and partnership working had to be the way forward**

We were chosen to **set up and lead a group of NHS providers** who will share services and resources in order to improve the experience of our staff and patients.

As a result of this, during 2017 we moved to a group model structure. Working side-by-side with other healthcare experts we can share ways of working which we know deliver the best outcomes. By working collectively we can reduce variations in patient care and the cost of treatment that we see across the group, **increasing our purchasing power**.

by doing things differently… We have a new operational structure with:

- local hospital management teams in place
- a group board and group executive team
- new divisional structures

Our plan was to bring together a range of acute providers to create a 'group' of hospitals, connected by a single group centre – similar to models seen internationally, such as Intermountain Healthcare in Utah, USA. Individual trusts will be able to join the group under a range of membership options, from full membership to arrangements such as buddying.

To improve the experience of our staff and patients … By working as a group, we can bring together larger numbers of clinicians to share their knowledge about the very best ways to treat patients in line with the very best care available across the globe.

Under the group model, there would be one consistent approach, based on the shared experiences of clinical practice groups.

Barnet Hospital

Our senior management team:

From left to right

Sally Dootson, director of operations

Dr Steve Shaw, chief executive

Dr Mike Greenberg, medical director

Julie Meddings, director of nursing

During 2017-18 we are particularly delighted with the progress that we have made in improving our ambulance waiting times, Developing a back pain service in primary care, our performance in the national stroke audit and the work undertaken within our maternity and paediatric clinical pathway groups.

Improving our emergency pathway: improving ambulance waiting times.

What was the issue?

- Consistent underperformance with London Ambulance Service (LAS) turnaround times
- Multiple ambulances waiting to off load patients
- Potential delays in patient care
- Delay in ambulance crew being able to respond to 999 calls

What did we do?

- Implemented the national 'fit to sit' initiative which supports patients being admitted to hospital by the most appropriate method
- We questioned if the patient was ambulant and capable of mobilising independently?
- We promoted the use of a wheelchair first, rather than a stretcher or trolley (as often patients are conveyed on ambulance stretcher for safety).
- Challenge ambulance staff about transporting patients to the Emergency Department

What was the outcome?

- We made improvements in the patient's journey
- We are now in the top 5 performing London hospitals for LAS times.

A specialist-led back pain service in primary care

Advanced Practice Physiotherapists working as first contact practitioners

Overview

A team of spinal specialist Advanced Practice Physiotherapists (APPs) worked within a GP practice to introduce a new back pain service to manage the whole patient pathway.

The challenge

There is increasing pressure on GPs due to a national shortage and 30% of their workload is musculoskeletal. Of these patients a large proportion will present with back pain. The service sought to improve patient experience, decrease wait time and reduce pressure on GP colleagues.

Intervention

The team of APPs managed the whole patient pathway, including investigations, prescribing, referrals to secondary care and listing for spinal injections. Innovative aspects included self-referral to a first contact APP, and links to secondary care directly listing patients for injections or surgery.

Staff and patient feedback

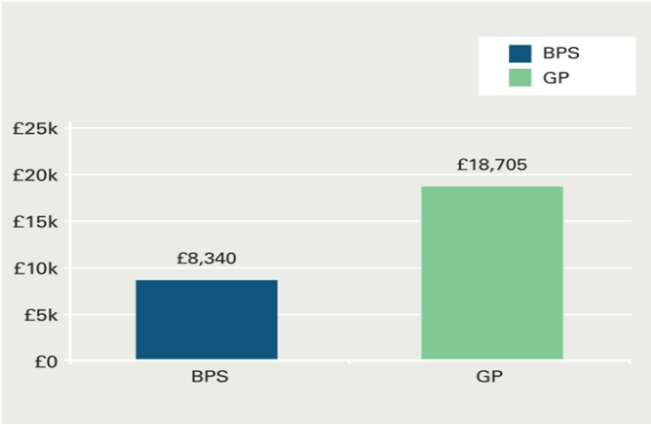
"It is a great service for our patients. Brilliant feedback and problem solving. Saved on referral and patient waiting in pain." – Staff

"I feel reassured regarding my back issues and have come away with lots of helpful advice. Very impressed!"
– Patient

Results

The service ran for 12 months and saw 474 new patients with a total of 611 contacts. It received a 100% friends and family recommendation while helping to reduce demand. 80% of patients weredischarged after their first appointment,3.5% were referred to secondary care and less than 1% of patients were referred back to the GP. The pilot delivered a reduction in secondary care referrals and investigations that translated to cost savings of over £10,000 (65% saving on 500 patients). In addition, patients had to wait an average of nine weeks from initial consultation to injection, compared to 31 weeks on the previous pathway.

Cost of investigations and secondary care referrals. GP vs BPS for 500 patients.



Lessons learned

Robust data collection is essential to compare data across the new and previous pathways. Experienced clinicians are vital to successfully run this service.

Next steps

This pilot shows that APPs can successfully manage back pain patients in primary care with 100% patient satisfaction and with reduced costs. This new model of care is being used to inform how future musculoskeletal services will be delivered in Barnet and Enfield.

The Health Foundation | BPS Back Pain Service | Royal Free London NHS Foundation Trust

Key achievements made within National Clinical Audits.

Top marks for our stroke unit

The stroke unit at Barnet hospital has been awarded an A, in the recent stroke national audit.

Several factors which contributed to the achievement included:

- the work of therapists
- early identification of stroke patients in emergency areas
- strict adherence to the London Stroke pathway

Our physio, speech and occupational therapists have to work under incredible pressure to ensure that each one of our 24 patients gets the appropriate level of therapy. We only score well in the stroke audit if our patients receive the mandated amount of therapy.

Our stroke co-ordinator is incredibly proactive in visiting the acute admission areas in the morning to ensure that stroke patients have been identified and referred to the hyper-acute stroke unit (HASU).

Barnet Hospital is part of the pan-London stroke network, which includes eight HASUs where immediate care is given to stroke patients by expert specialist staff. Patients are then transferred to their local acute stroke unit (ASU), such as Barnet Hospital, for ongoing acute management and rehabilitation. The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. The audit is carried out three times a year.

Chase Farm Hospital

Our senior management team:

"We aim to have zero avoidable harm"

Dr Alan McGlennan
Medical Director

From left to right

Dr Alan McGlennan, medical director
Natalie Forrest, chief executive and director of nursing

During 2017-18, the redevelopment of Chase Farm Hospital has remained a priority, as we aim to prepare for the opening of the new building and clinical moves in June 2018. The new hospital will provide out-patient services including:

- Diagnostics,
- Musculoskeletal therapies
- Women's services,
- Urgent care centre (with paediatrics and an older persons' assessment unit),
- Day surgery,
- Endoscopy
- Medical day cases including a chemotherapy unit.

We plan to integrate the work undertaken within the relevant CPG programs and using of a HIMSS level 6 a digital platform (See glossary for information on HIMSS) which will further provide the best care for our patients.

In line with the overall trust objective, we also aim to have zero avoidable harm in the six months that following the clinical moves.

Royal Free Hospital

Our senior management team

Kate Slemeck, Chief executive

"There is something very special about this hospital, mainly thanks to its committed staff who are focused on doing everything they can to ensure that every patient who walks through our doors gets the best possible care. My ambition is to take this hospital from being rated 'good' to one that is rated 'outstanding' in the eyes of our patients, staff and regulators."

Kate Slemeck
Chief executive

From left to right

Dr Robin Woolfson, medical director

Sarah Dobbing, director of operations

Dr Chris Streather, Group medical director

Rebecca Longmate, director of nursing

During 2017-18, we have made several key achievements that we are proud off.

These include:

- Teamwork to achieve a trio of transplants
- Robot-doc to the rescue!
- Tackling the quiet cancer

Teamwork delivers a trio of transplants

Three life-saving operations were carried out in the space of 18 hours at the RFH – a record for the liver transplant team. Off-duty surgical staff showed their dedication and compassion by coming to work to make sure that the patients had the eight to 12 hour procedures quickly after donors became available.

Two of the cases were emergencies and designated as 'super urgent' which meant it was essential that the patients received the new livers immediately before their condition deteriorated further. The other transplant was for a patient who had been on the list for some time and the team had to operate quickly when a suitable match was identified. Time, in all cases, was of the essence.

Professor Joerg-Matthias Pollok, clinical lead for hepato-pancreato-biliary (HPB) surgery and liver transplantation at the RFH, and the consultant surgeon for the second operation, said: "I would like to express my pride in what we achieved for our patients and their families, who put their trust in us. "Many have given their best and joined the team, even though they weren't on call.

This has truly been a team effort from all disciplines involved in transplantation; coordinators, hepatology, theatre, anaesthetic, surgical and intensive care teams. It feels good to be part of a team with such tremendous spirit."

"I would like to express my pride in what we achieved for our patients and their families, who put their trust in us. "Many have given their best and joined the team, even though they weren't on call."

Professor Joerg-Matthias Pollok, Clinical lead for hepato-pancreato-biliary (HPB) surgery and liver transplantation.

Dinesh Sharma, the consultant who carried out the first transplant, said: "To do three liver transplants in 18 hours – two of them in sick super-urgent listed patients – is to my mind a heroic and unprecedented effort. A sincere and big thanks for everyone who made this possible. It's teamwork like this that has helped us become being the fastest growing liver transplant programme in the country."

"To do three liver transplants in 18 hours – two of them in sick super-urgent listed patients – is to my mind a heroic and unprecedented effort. A sincere and big thanks for everyone who made this possible. It's teamwork like this that has helped us become being the fastest growing liver transplant programme in the country."

Dinesh Sharma, Consultant HPB, Hepatology, Gastroenterology and Liver Transplantation.

Dr Doug Thorburn, clinical director for liver transplantation, HPB and hepatology, said: "Our achievements have been reached through demonstrable cohesion across the whole transplant multi-disciplinary team. Enormous credit for this goes to the whole team. "Our contribution to UK transplantation has not gone unnoticed. To me it is an honour to work with such an enthusiastic and committed team who put the patient at the centre of what we do and consistently exhibit world class values."

"Our achievements have been reached through demonstrable cohesion across the whole transplant multi-disciplinary team. Enormous credit for this goes to the whole team.

It is an honour to work with such an enthusiastic and committed team who put the patient at the centre of what we do and consistently exhibit world class values."

Dr Doug Thorburn, clinical director for liver transplantation, HPB and hepatology

Robot-doc to the rescue!

An ambitious team of seven at the specialist centre for kidney cancer, led by urology consultant Ravi Barod, carried out three nephrectomy (surgical removal of a kidney) operations on a single Saturday, as opposed to the usual two, with the help of the da Vinci Xi robot.

Ravi said: “We had no extra resources but we selected relatively straightforward cases and ensured the team was briefed and motivated. Performing three operations can effectively increase theatre efficiency by 50 per cent. “The plan is to perform three cases on all of our Saturday lists from now on, with the aim of doing an extra 52 cases a year, and see how we can make this work for weekday lists, when the operating department is much busier.”

Instead of the surgeon using standard tools via keyhole surgery they use a console to control the robot which carries out the operation with a greater range of movement than the human hand.

The RFH purchased the robot 18 months ago to offer the best possible treatment for patients and help meet the increase in demand as it is a specialist centre for kidney cancer, with five surgeons who solely operate on the disease.

Using the robot results in a quicker recovery time for the patients, as there is less bleeding and less pain.

This coupled with the enhanced recovery after surgery programme, which gets patients moving and avoids strong pain-killers.

Using the robot results in a quicker recovery time for the patients, as there is less bleeding and less pain. This, coupled with the enhanced recovery after surgery programme, which gets patients moving and avoids strong pain killers, meant that two of the three patients went home the next day and the third patient left less than 48 hours after their surgery. Prior to this, patients stayed in hospital for four to five days after this operation.

The operations, from first incision to last stitch, took an average of 90 minutes with actual operation time of less than an hour. Usually patients need only this surgery as their treatment for kidney cancer.

Ravi added: “The key thing is case selection. We carefully selected non-complex patients – they’d had no previous surgeries and required the whole kidney to be removed. It’s also important to build an effective working team so people remain motivated.”

The RFL is the specialist treatment centre for kidney cancer across north central London, north east London and west Essex. It’s the highest volume kidney cancer centre in the UK and last year it saw 360 patients for nephrectomy.

Celebrating the 20th anniversary of the neuroendocrine tumour (NET) unit at Royal Free Hospital

In February 2018, Patients and staff celebrated the 20th anniversary of the neuroendocrine tumour (NET) unit at the Royal Free Hospital, which is helping tackle a rare condition known as neuroendocrine (carcinoid) tumour, sometimes referred to as the 'quiet cancer'.

To mark the anniversary, patients have contributed to a series of films discussing their experiences of this rare cancer, as well as the NET unit. In addition 250 patients and their carers, as well as more than 100 physicians, nurses and researchers attended a special 20th anniversary event, at the Royal College of Physicians.

The Royal Free Hospital NET unit receives approximately 20 new referrals each month, from across the UK and abroad. Since it was established in 1998, the service has grown from 30 to more than 1,800 patients.

NETs are rare and is referred to by some as the 'quiet cancer' as it can often take years for patients to be diagnosed. NETs develop from cells of the neuroendocrine system, which are found in organs including the stomach, bowel and lungs. Symptoms can include tummy pain, changes in bowel habits, flushing, and shortness of breath, loss of appetite and weight loss.

John Sullivan, 75, from Edgware, London, who took part in filming, said: "I was diagnosed with irritable bowel syndrome (IBS) and treated for IBS for 10 years but in fact I had a NET on the outside of my bowel. I won the lottery when I walked into the Royal Free Hospital because for the first time in years I was speaking to someone who knew what the matter was. You have to 'own' your illness. I feedback to the team about the drugs I'm taking because, with respect, I'm the one who knows how it feels and I always attend the patient forums when I can as you learn something every single time."

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

This section describes the following:

- Priorities for improvement: progress made against our priorities during 2017/18.
- Outline on our quality priorities for improvement chosen for 2018/19
- Feedback on key quality measures as identified within the mandatory statements of assurance from the board.

2.1 Priorities for improvement

Following consultation with our key stakeholders, the trust agreed that during 2017/18 we would continue to focus on three areas of quality; patient experience, clinical effectiveness and patient safety. During the year, progress to achieve our quality priorities have been led by a designated senior executive lead and monitored at our board level committees. Further reporting were held with our Group Executive Committee (GEC) and council of governors with overall approval given by our trust board. Overall the results presented relate to the period April 2017 to March 2018 or the most recent available period.

Priority one: Improving patient experience: delivering excellent experiences

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. We chose the following priorities as they were linked to specific strands of ongoing work within the trust, in support of our vision to have strong positive patient experience leaders so we can effectively serve our communities.

Our quality priorities for 2017/18 were:

1	**What did we aim to do?**
	To achieve trust certification for the 'Information Standard' by 2018
	What did we achieve?
	During 2017-1 the following measures were gained towards achieving the Information Standard accreditation: • Since the implementation of the patient information policy in 2016, we now have over 100 patient information resources approved in line with the policy. We also have over 250 leaflets which have been submitted for review and are at various stages of the processes outlined in the policy. • We have worked with our radiotherapy, imaging and ophthalmology departments to embed the practice of evidence based information production, a key requirement of The Information Standard. • We are also in the process of updating our patient information policy based on feedback from staff and to incorporate changes and new requirements of The Information Standard in readiness for an application which is expected in late 2018.

2

What did we aim to do?

To improve how patients, carers and families can provide feedback to the trust.

What did we achieve?

The trust has identified three ways of gaining feedback from our patients regarding their experience. These include:

- **The National Department of Health funded approaches -** The uptake of patients using NHS Choices has increased and is regularly used as an engagement tool.
- **Social Media** - the trust frequently uses Twitter and Facebook as ways of allowing patients to feed back on their experience of care
- **Patient Advice Liaison Service (PALS) –** the trust is seeking to move from a static PALS approach to one of flexibility around patients and increased response times for email and phone queries.

3

What did we aim to do?

To systematically analyse the experience of bereaved families and friends.

What did we achieve?

During 2017-18, the trust chose to explore how the experience of bereaved families and friends could be improved.

A bereavement survey is given to all persons who collect a Medical Certificate Cause of Death from the hospital. It is recognised that there may not be an easy time to ask for feedback as the return rates on the survey have been low. Therefore a web based survey is being launched which may be easier for providing feedback.

The surveys continue to be distributed and returns collated for analysis. The results of the survey and response rates will be discussed at the *Acute Hospital End of Life Care Community of Practice,* which brings together those involved in and those who can influence End of Life Care (EOLC) education in acute hospital trusts across London, Essex, Hertfordshire and Bedfordshire.

(A further update will be presented in the final report)

4

What did we aim to do?

To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy by 2018.

What did we achieve?

During 2017-18, the trust has continued to focus on improving the experience for our patients with dementia and their carers. Through the dementia strategy (2017-2019) several key initiatives have been identified and steady progress has been made. This has been monitored through the Dementia Implementation Group (DIG).

These included:

- **Flexible visiting times for carers in line with the principle of John's Campaign**. In 2016/17 71% of our in-patients wards were compliant. In December 2017, all our in-patients wards (100%) are now compliant with John's Campaign.

- **Improving the environment**- Dementia-friendly refurbishment of 10N (in-patient ward at our Royal Free site) commenced in September 2017.

- **Joint working-** The DIG is partnering with associated Clinical Practice Group (CPG) to produce a world class dementia care pathway across organisation (currently in process-mapping phase).

5

What did we aim to do?

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 patent 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.

What did we achieve?

Recruitment remains underway across the trust and is further supported by Camden Clinical Commissioning Group (CCG).

(A further update will be presented in the final report)

Through the Patient and Staff Experience Committee (PSEC) and the by the Quality Improvement and Leadership Committee (QI&LC) we have monitored, measured and reported progress to achieving our priorities.

A trip down memory lane: Improving care for our patients with dementia

The refurbishment on 10N ward (at our Royal Free Hospital site) has transformed the clinical area into a therapeutic and reminiscence space for elderly patients. This renovation is the first of its kind at the RFH. Patients can be transported back to Hampstead High Street in the 1970s thanks to the refurbishment.

The corridor walls, which show headlines from the past, will be used to stimulate conversation and memories. The patient day room has also been transformed into a living dining room complete with a fireplace, dining tables and a TV playing hit films from the 60s and 70s.

The refurbishment of the ward was made possible by the generosity of the Community Infrastructure Levy fund and the support of the Royal Free Charity and the clinical and executive teams at the RFL.

Our main challenge is to build a world in which we can communicate with them and build a relationship. “This new ward environment is almost like a set – it creates the perfect space to perform those interactions and form the connections that are essential in the care of dementia patients.”

> For a person with dementia, their main priority when in hospital is about establishing where they are, who we are and what we are going to do.
>
> Our main challenge is to build a world in which we can communicate with them and build a relationship. “
>
> **Danielle Wilde, trust dementia lead**

The ward is also equipped with a post box, bus stop and a working hair salon, so patients can experience familiar settings during their recovery.

Eduarda Rodrigues, ward matron, said: “The designs were all chosen by our patients and the multi-disciplinary team on 10N.” Stacey Brown, healthcare assistant on 10N said: “It’s brilliant. It makes our working environment much brighter as well – particularly with the flower-themed bays and the nurse’s station

Priority two: improving clinical effectiveness: delivering excellent outcomes

These priorities were chosen because they directly aligned to our trust wide plans to focus on the reduction

of unwarranted clinical variation. This will strengthen the delivery of the local and national effectiveness agenda and support the delivery of significant improvements in the quality of patient care. Our clinical effectiveness priority had two strands 1. Creating Clinical Pathway Groups (CPGs) 2. Driving quality improvement.

During 2017/18 the trust commenced the deployment of a trust-wide methodology to manage unwarranted variation in clinical care, through the creation of Clinical Practice Groups (CPGs).

To support this approach, the trust is implementing a unified approach to Quality Improvement (QI) 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.

We will redesign care pathways using evidence based principles and current best practice to deliver the best possible outcomes for our patients.

John Connolly
CPG Programme director

An example from one of our CPGs

Title:	**The Child aged 2-15 years admitted with a wheeze**
Aim:	**To improve the care of children that present with wheeze aged 2-15 years of age**

This cohort of children accounted for the majority of admissions into Accident and Emergency and was subject to large amounts of unwarranted variation in the care they received. The CPG easily identified where the variation in care was and planned a future state pathway based on best local and national evidence.

The children are now categorised on admission within 15 minutes into one of three categories and a plan of care for that category ensues. Subsequent to that, the child will also receive reassessment at 20 minute intervals. It is anticipated that this CPG will reduce the amount of children admitted onto the ward and reduce the amount of readmissions at 7 days following discharge from A&E.

The CPG have tested the pathway and undertaken PDSA cycles to test the proforma and changes have been made to improve the process. The CPG also designed a discharge leaflet to improve the education that the child and parents go home with. Throughout the redesign of this pathway the views of both staff and patients have been sought.

Our quality priorities for 2017/18 were:

Clinical Pathway Groups (CPGs)

1	**What did we aim to do?**
	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 Clinical Practice Groups.
	What did we achieve?
	The trust has made progress in developing the clinical pathways and at present there are over 30 pathways spanning across the four clinical divisions. Each CPG programme is an example of an integrated quality improvement methodology. The Clinical Pathway Groups (CPGs) have been developed through a series of workshops occurring from May 2017 to April 2018. From the workshops we have further achieved the following: • Excellent engagement by North Middlesex clinicians at the workshops • Development of a detailed measurement plan for all pathways • Ongoing analysis of patient pathways using random sampling techniques. • Development of proposed future state pathway and timetable for testing • Engaged heads of finance on all hospital sites who attended the workshops for all CPGs in November • UCL evaluation researcher introduced at all the CPG workshops to the teams • Engaged Cerner for real time study of Emergency workflow and Firstnet upgrade

Further examples from our Women's and Children's Clinical Pathway Groups (CPGs).

Title:	**Keeping mothers and babies together**
Aim:	**To prevent avoidable term admissions by improving care after birth from delivery suite and post-natal ward.**

Nationally between 2011 and 2015 there had been a 30% increase in term babies admitted to levels 1, 2 and 3 neonatal units. The Royal Free London NHS Foundation Trust is committed to reducing avoidable admissions to the neonatal unit and improving the care that mothers and babies receive while on the delivery suite and post-natal ward.

The Service undertook a current state process mapping exercise and used the learning from this process to re-design the pathway with the main focus being on improving improve neonatal care within the first hour following delivery. The data collected supported this decision in highlighting the number of babies that were admitted to the neonatal unit with respiratory distress syndrome and associated co-morbidities such as hypothermia and hypoglycaemia.

A new New-born Early Warning Score (NEWS) observation sheet has been designed to improve the recording of observations both for low risk and high risk babies and observations required for high risk babies have been standardised. PDSA cycles were completed in order to understand how effective the new NEWS chart was and how it was received by staff in practice. Similarly, Nudge Theory has been applied and an amber coloured hat is in use for all the "at risk babies" who have been renamed "Hat Risk Babies". PDSA cycles are underway to test this change idea, which will reflect how staff and families feel about this process. This CPG is a priority pathway and it is planned that it will be digitised by September 2018.

Title:	**Ladies who are admitted to the Early Pregnancy Unit (EPU) with Per Vaginal (PV) bleeding and abdominal pain.**
Aim:	**To introduce a one stop clinic for women who are admitted with PV bleeding and pain in pregnancy.**

There are large numbers of women that visit the Trust's Early Pregnancy Unit with both vaginal bleeding and abdominal pain. The Royal Free London NHS Foundation Trust is committed to the Royal College of Gynaecologists and Obstetricians guidelines and recommendations. Indeed baseline data collected as part of the project showed that women were waiting far longer that the recommended time to have an ultra-sound and subsequent review and plan of care.

The evidence suggests that the women`s experience is greatly improved if they are seen in a "One Stop" environment. In real terms this would require a woman to be reviewed on admission, scanned and counselled by the same clinician. The team undertook patient co-design and asked the women what would be their preference and they supported the introduction of a 'One Stop' EPU.

The CPG project team have designed a Self-assessment form that women complete on admission, ultra-sonographers are being trained and supported to provide counselling to the women and nurses are accompanying ultra-sonographers into the scan room, to provide counselling when the ultra-sonographers feel they are not able to. The project has led to women being seen in a 'One Stop' environment which has resulted in their time to scan and time from admission to the Early Pregnancy Unit and plan of care being greatly reduced. A survey of the women using the service indicated that these women have high levels of satisfaction with the new service and they report feeling cared for throughout their visit.

Title	Induction of labour with a Cook's balloon
Aim:	To improve the clinical outcome for women who undergo an Induction of Labour.

The induction of labour was chosen as a CPG mainly because it was a large volume pathway that had a vast amount of variation in the care delivery. Following the evidence from a randomised control trial in 2016 it was decided that the default method of induction of labour would be a Cook`s Balloon.

The evidence demonstrated that there was improved satisfaction for the women alongside improved clinical outcomes. The maternity service undertook a small pilot which supported the research findings. Women had grater satisfaction with the induction process as it meant that they could remain at home and return when it was time to commence the next stage of their induction. Uterine hyper stimulation was greatly reduced in the pilot group compared to those women who received Propess for induction.

The CPG project group developed a pathway for women undergoing outpatient induction of labour with the Cook's cervical ripening balloon and tested the pathway. The project team are currently looking to improve the care pathway for women who have had their Cook`s Balloon removed and are ready to advance to the next stage of their induction by introducing admission directly to Labour ward for an artificial rupture of membranes for women who have previously had a baby in order to further streamline the pathway and reduce long waiting times for induction of labour.

Title:	Better births pathway
Aim:	To provide continuity of carer to 20% of women delivering at the Trust by 2019 and for all women to take part in a choice conversation of place of birth with their midwife during their 16 week appointment. This is part of the national Maternity Transformation Strategy

Following the National Maternity Review there was a national drive to promote choice of place of birth to all women and to provide a package of care that was more personalised. The choices include both Barnet and the Royal Free Hospital, or the alongside midwifery led units at Barnet and the Royal Free Hospitals or the stand-alone unit at Edgware Hospital.

The evidence to support the place of birth was based upon the Birth Place Study (2011) and a decision tool was designed to facilitate these conversations between the midwife and the woman. The CPG's work continues to support this process and staff co-design has taken place to find out how this can be improved.

The Maternity Transformation Board has stipulated that by March 2019, 20% of women booking into maternity services will receive continuity of carer for their antenatal, intrapartum and postnatal care. The CPG has supported the process whereby two of the vulnerable women's teams are now providing continuity of carer during the ante-natal, post-natal and intra partum period to a significant number of their women with a view to extending this over time.

Similarly the Edgware birth team are providing continuity of carer throughout the pregnancy journey to all women who book to deliver their baby at Edgware Birth Centre. Work is underway with all community midwives to encourage them to promote all choices to their women and to actively promote Edgware Birth Centre as an option.

Driving Quality Improvement

2

What did we aim to do?

To have at least 50 active Quality Improvement (QI) projects in place across the Group. The projects should exhibit the core features which we want to see in all our QI work including: a clear, patient-relevant aim, change logic, ongoing PDSA and measurement linked to learning.

What did we achieve?

During 17/18 we formed a small QI support team and entered a strategic partnership with the Institute for Healthcare Improvement (IHI). Together, these are significant enablers to embed QI across the Royal Free Group. The QI programme for 17/18 focused on building QI capability in our workforce. This has taken place through four main training programmes, summarised below:

- ***QI for all*** – QI for all encompasses resources available to all staff at RFL, this includes Intranet learning resources such as IHI's Open School e-learning and the LifeQI project management tool. 25 members of staff have completed 30% of IHI open school
- ***QI practitioners*** – Staff members become QI practitioners through attending Improvement Science in Action (ISIA), a five day, team-based programme pairing learning QI methodology with application to a real-life project relevant to their work. We now have 123 QI practitioners across the organisation.
- ***QI team coaches*** – Our Quality Improvement Team Coach Development Programme (QITCDP) trains staff to become QI team coaches. QI team coaches have greater knowledge of QI methodology and work to support teams who are doing a QI project. We currently have 33 QI team coaches across the organisation.
- ***Improvement Advisors (IA)*** – Improvement advisors have expert QI knowledge form the core of our QI support faculty. We currently have 3 trained IAs.

Through building increased skills and knowledge of the science of improvement and by leaders reinforcing the importance of QI, more teams are running QI projects as part of their normal work.

We now have over 80 known QI projects in place which have made differing levels of progress. Most of these projects have been set up through the ISIA QI training programmes, our Clinical Practice Group work and the Patient Safety Programme. We assess the maturity of QI projects on a 0-5 scale, where 5 is the most mature. Currently:

- 23 QI projects are at level 3-5 across RFL, this means they have demonstrated modest to significant improvement through successful PDSA cycles
- 14 QI projects are at level 2-2.5 maturity, meaning the team has started to test changes but sustainable improvements have not yet been evidenced
- 47 QI projects are at level 0.5 -1.5 maturity: these teams are largely setting up their project through establishing their aims and deciding on change ideas.

In order to support increased quality improvement activity it is important we build a strong infrastructure to ensure support is available to teams.

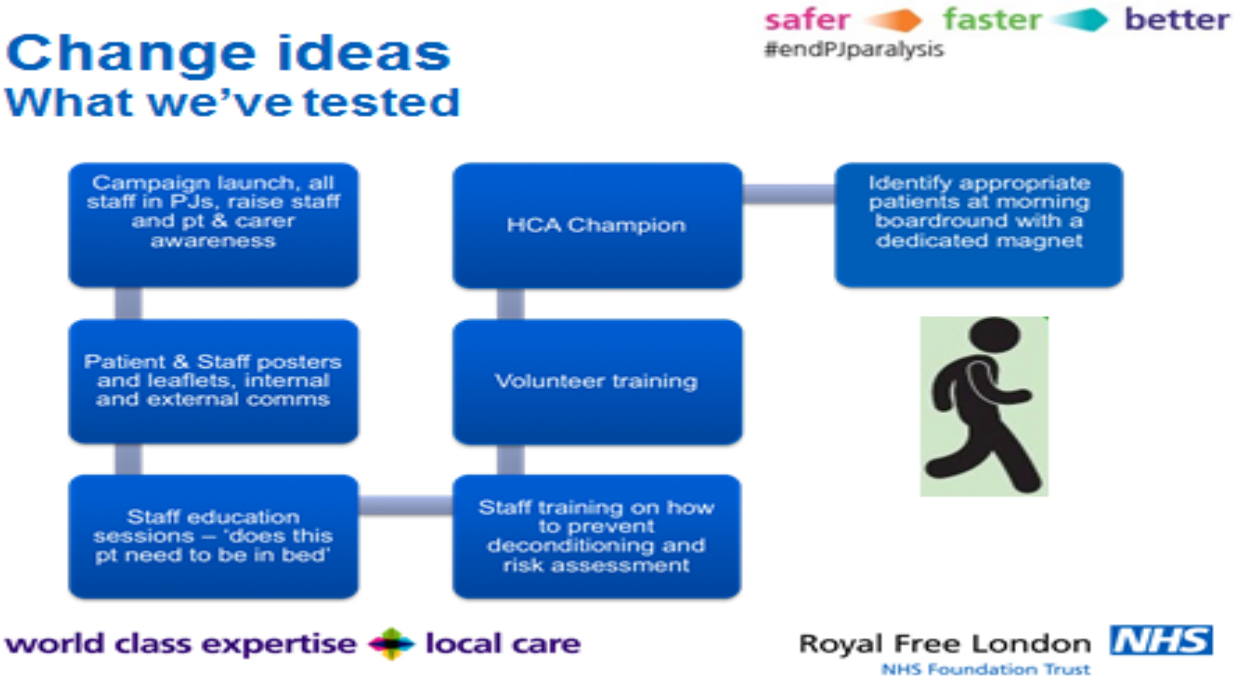
During 2017/2018 we started work to create local learning systems. Initial achievements include:

- QI clinics now run on each major site providing as an opportunity for staff to ask questions and problem solve QI queries with experienced QI faculty

- QI forums run monthly on each major site, open to all staff. At each forum, examples of work are shared and we focus learning on a particular QI tool or technique, using a combination of discussion, video and exercises to support learning.

The trust continues to work in partnership with the Institute for Health improvement (IHI) as QI partner. In September 2017, 29 teams started their Improvement practitioner training each with a QI project as central to their work. Through the Quality Improvement and Leadership Committee we have monitored, measured and reported progress to achieving our priorities.

Positive outcomes achieved from a QI project



Our staff promoting the end to PJ paralysis as part of the national initiative

Priority 3: Our focus for Safety

Our over-arching aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the trust through discrete pieces of work. Our targets were set out in our three year Patient Safety Programme (PSP) improvement plan (2015-2018) and we will be delivering key milestones along the way.

While the quality report'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. Through the Patient Safety Committee (PSC), and more recently, the Clinical Standards and Innovation Committee we have monitored, measured and reported progress made during 2017-18 to achieve the set priorities. The committee reports to the trust board.

Our quality priorities for 2017/18 were:

Falls

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days (OBDs) from a mean of 4.9 in 2014/15 to a mean of 3.7 in 2017/18
- To reduce by 20% the proportion of patients that experience moderate harm or above from falls from a mean of 0.134 in 2014/15 to a mean of 0.107 in 2017/18

Our milestones for 2017-18 were:	What did we achieve?
To evaluate phase 1 of the 24/7 Falls Free Care.	We completed the evaluation on phase 1 of the 24/7 Falls Free Care.
To initiate phase 2 of the programme by recruiting 6-7 wards	A 'buddying system' has been used to join two to three wards together to increase collaborative working across all hospitals. In total we recruited a further 9 wards to phase 2 of the programme, which meant that in total 17 wards were recruited.
Implementation and spread of new falls prevention plan and bedrail assessment tool across the trust	The new falls prevention plan and bedrail assessment tool has been implemented across the trust, which includes our inpatient wards at our hospital sites.
To harmonise the bedrail policy	Our bedrail policy has been harmonised across our hospital sites.

Acute Kidney Injury (AKI)

- To increase by 25% the survival for inpatients with AKI, by increasing from a mean of 73% to 80% by 2018.
- To increase by 25% the proportion of patients who recover renal function from 68% to 85% by 2018.
- To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days by 2018.
- To measure and improve patient experience and wellness scores by the end of March 2018.

Our milestones for 2017-18 were:	What did we achieve?
Through testing the new AKI app at RFH, we will develop an implementation plan for the trust	We completed the implementation plan for the trust.
Through PDSA cycles, we will co-design the AKI proforma to support the local clinical teams to deliver interventions specific to AKI pathology.	We successfully completed the AKI proforma to support our local renal, The Patient at Risk & Resuscitation Team (PARRT) and renal pharmacy teams.
Identify high prevalence areas and co-design an educational package to increase recognition and treatment of AKI.	We identified high prevalence areas which are now prioritised for blood sampling through phlebotomy services.
Develop methods for patient involvement with the programme.	Previous co-designing and testing of the AKI patient experience survey has been adopted with randomly selected AKI patients. This survey has evolved through collaborative working with AKI patients and the Trust's Patient experience Team.

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

Our milestones for 2017-18 were:	What did we achieve?
Spread and Implementation of tested methods to deliver robust processes of care at steps 1 & 5 (brief & debrief)	All theatres have been participating in using the WHO Safer Surgery checklist and its key components and in the introduction of a new policy and procedure Swab, instruments, sharps and disposable items count. A total of 10 theatres have tested the running debrief tool (currently on version 17) and cumulatively this has been used and observed >2,240 times.
By scaling up our plan-do-study-act (PDSA) cycles, we will develop locally driven methods to robustly embed the quality of step 4(counting swabs, needles and instruments)	Active PDSA cycles include: running debrief, count boards, escalation ladder, thematic analysis of incidents, counting bags, distraction & interruptions, white boards and emoji feedback.
To help co-ordinate the development of theatre team human factors skills and knowledge. This will include a framework for theatre etiquette and WCC behaviours	Where unnecessary distractions and interruptions occur, teams responsible for surgical invasive procedures will be asked to consider the severity of these distraction/ interruptions; local common causes of distractions and interruptions within their context and to identify the opportunities to build resilience in system to reduce potential adverse impact from frequent and severe the episodes.

Deteriorating Patient

- To reduce the number of cardiac arrests from 1.17 at Barnet Hospital and 2.4 at Royal Free Hospital to less than 1 per 1,000 admissions (as measured for ICNARC) at both Barnet and Royal Free Hospitals by March 2018

Our milestones for 2017-18 were:	What did we achieve?
We will use one primary pilot ward to test continual PDSA cycles to improve processes & mechanisms to enhance timely communication within and between teams through the use of SBAR handover tools and enhanced ward rounds, board rounds and safety huddles.	We used 10W ward for piloting tests such as whiteboard communication and our safety huddles have been used.
We will use ward-based metrics such as cardiac arrest rates, PARRT referral and numbers of Multidisciplinary team meetings triggered to track progress.	This is happening monthly on our cardiology ward at our RF hospital site.
We will develop the 'champion' role further in this pilot area to enable long term sustainability.	Staff have continued to change and new champions recruited to enable long term sustainability.
Implementation and spread of tested communication mechanisms and processes to other areas in the organisation.	Data collection is underway to identify new area

Deteriorating unborn baby

- To reduce by 50%, the number of claims relating to deterioration of the unborn baby from a mean of 2 per year to a mean of 1 per year, during 3 years.

Our milestones for 2017-18 were:	What did we achieve?
To scope current processes around Elective caesarean sections performed before 39 weeks gestation and identify areas that could be improved to reduce preventable C Sections.	This work stream has merged into 'Keeping mum and babies together CPG' . This will; ensure that areas of good practice are embedded across the trust.
We will improve team communications of potential expected admission to NICU – through adopting PDSA cycles to implement team huddles and SBAR handovers.	We have successfully introduced daily cross-site huddles (see following example on safety huddles).
To undertake staff confidence survey associated with CTG interpretation; using this information to co-design teaching and skills package to improve CTG confidence in staff.	This was completed.
Using PDSA cycles we will plan methods of standardising the administration of Oxytocin infusion.	The administration of oxytocin infusion is now standardised across business units.

Safety huddles: An example of excellent practice.

Delivering world class care at the right time in the right place by the right team'.

The huddle is probably the single most effective meeting teams can have.

The maternity and neonatal departments from Royal Free and Barnet hospitals have been holding daily ten minute cross-site safety huddles during the week to help staff from both sites share critical information on mothers and babies who are at risk as well as highlight other safety issues.

The huddles, which started in June 2017, have proved a great way to engage with staff.

A survey on staff satisfaction showed that nearly 70 per cent of those involved found the huddles either very useful or extremely useful in reducing risks to patients.

Over 80 per cent of staff also said they wanted the huddles to take place seven days a week, 365 days a year and are themselves driving the roll out of the maternity safety huddles over the weekend.

"The huddle is a vital element of forward planning to minimise the risk of increased activity having a detrimental effect on safety levels." Karen Griffin, Delivery suite coordinator.

Dr Shanthi Shanmugalingam, neonatal consultant said the huddles were a "fabulous example of truly collaborative cross site working. Since introducing huddles, we have seen a reduction in ex-utero transfers of preterm babies.

"We are making huge strides to achieve our aim of 'delivering world class care at the right time in the right place by the right team'.

Sepsis

- To reduce by 50% severe sepsis-related serious incidents across all sites from 1 in 2014/15 to zero in 2017/18
- To increase survival by 50% for those patients on the sepsis bundle across all sites from a mean of 83% (2014/15) to a mean of 91% (2017/18).

Our milestones for 2017-18 were:	What did we achieve?
We will be further consolidating sustained improvement in existing pilot areas.	The sepsis improvement work is underway in the following pilot areas: • **Royal Free Hospital** : Emergency department (ED), Paediatric ED, 10S, 10E, 8N, 6E, 7W and labour ward (see the table 1: clinical specialities) • **Barnet Hospital** : ED and labour ward, Paediatric ED • **Chase Farm Hospital** : Urgent Care Centre (UCC)
We will be planning and implementing a sepsis work stream plan of spread across the organisation with all key stakeholders, including establishing mechanisms to continue monitoring progress beyond the formal life of the work stream.	We have co-designed and developed local sepsis pathways with multidisciplinary teams using PDSA cycles specific to each of the new pilot areas due to their local and unique environments
We will be sharing the learning from the 10 pilot sites in the work stream with everyone involved and impacted by this spread, including further expansion of the 'champion' role to support long term sustainability	Sepsis capability is also being developed through e-Learning packages and tools appropriate to each clinical area

Table 1: Wards involved in our sepsis work and their clinical specialist area

	Our wards at Royal Free hospital	Specialist area
	6 East (6E)	Medical assessment unit
	7 West (7W)	Vascular surgery
	8 North (8N)	General medicine
	10 East (10E)	Renal
	10 South (10S)	Renal

Our Priorities for improvement (2018/19)

This section of the quality report 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 strategic committees and our trust board as illustrated in figure 1.

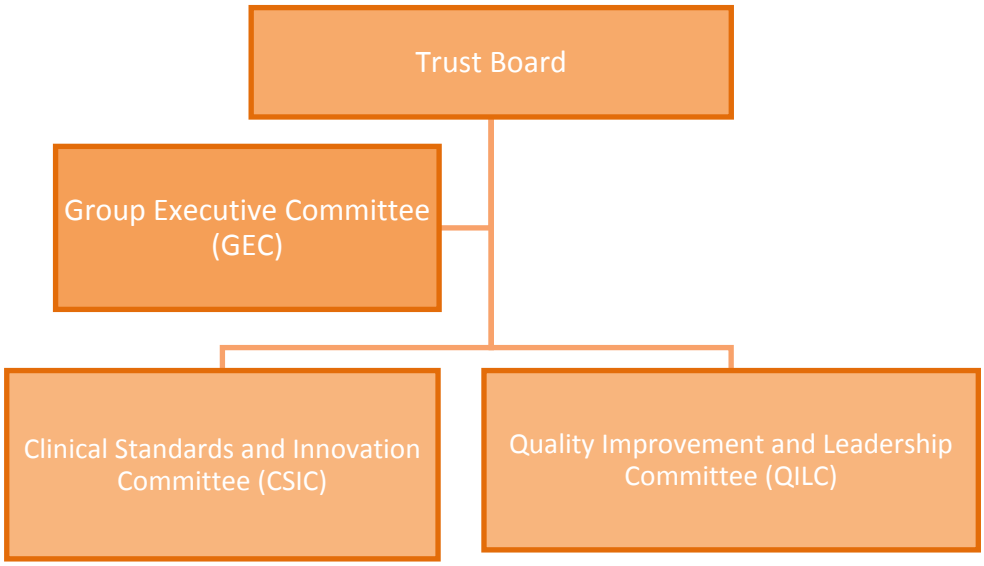


Figure 1: Strategic committees and trust board

Our consultation process

As part of our consultation process, the trust held various consultation events and our key stakeholders were invited to attend. The main stakeholder's engagement event **(Showcasing Clinical Excellence)** was held on the 2 February 2018. Attendees included staff, commissioners, governors and members from healthwatch.

In addition, an online survey was conducted with our council of governors and ran from the 20 – 27 February 2018. The governors were asked to provide feedback on the proposed priorities and to indicate if there was anything else that we should be prioritised for 2018/19. On the whole, the respondents were in agreement with our proposed priorities.

Priority 1: Improving patient experience: Delivering world class experience

We aim to put the patient, carers and our staff at the heart of all we do in delivering excellent experiences. Building on our strategy we will continue to make improvements for those who use our services.

Progress reports will be sent to the Dementia Implementation Group , Quality Improvement and Leadership Committee (QILC) and updates to our commissioners via Clinical Quality Review Group

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To achieve trust certification for 'The Information Standard'.	✓ (previous performance shown in section 1.1)	• To work with CPGs to embed the patient information approval process and ensure information produced via these channels are in line with the Information Standard requirements. • To submit an application for to The Information Standard for information produced by the radiotherapy department - the department will act as our exemplar for further rolling out the standard.

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy	✓ (previous performance shown in section 1.1)	• To fully implement the National Audit of dementia action plan. • To embed the updated "8 things about me" document and filing information in the notes. • To continue to work on the delirium pathway as part of the Frailty Clinical Pathway Group.

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To improve our involvement with our stakeholders	✘ (new priority for the trust)	Specific measures will be confirmed and included in the final version of this report

Priority 2: Improving clinical effectiveness

The over-arching plan for 2018/19 is to continue to further dovetail our clinical effectiveness priorities with our quality improvement initiatives; thus facilitating the alignment of our trust wide plans to focus on the reduction of unwarranted clinical variation through Clinical Pathway Groups (CPGs).

Progress reports will be sent to the Group Executive Committee (GEC) and updates presented to commissioners via Clinical Quality Review Group meetings.

Quality Improvement priority:

RFL has a strategic objective to embed continuous quality improvement (QI) into daily work. For maximum benefit, QI needs to be reinforced by our management systems. During the coming year we will build on the foundations laid in 2017/18.

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
Our priorities for 2018/19 include continuing to build capability in the workforce and developing our infrastructure. In order to develop a strong infrastructure that supports our QI programme we require an online QI project tracker tool. This will provide real-time intelligence on the status of QI projects across the trust, as well as providing vital project information including project maturity.	✓ (previous performance shown in section 1.1)	We will also continue to build local learning systems, characterised by the following: • Ability to prioritise QI projects based on local/Group need • Local ownership, at service, divisional and hospital unit level • Provide access to site-based QI help and support, site-based learning and access to expert QI knowledge • Create opportunities to share learning across the site and Group.

Clinical Pathway Group priority:

Variation in clinical practice and process leads to worse patient outcomes these results in higher costs. Therefore the goal of the program is to reduce unwarranted variation in clinical practice and process.

As part of the Global Digital Excellence Programme 20 pathways will be digitised over the next 2 years, prioritisation for pathway digitisation has been agreed with the goal of seven pathways digitised at the time of roll out of Millennium Model Content and opening of the new Chase Farm Hospital**.**

The intervention at the heart of the program is implementation of evidence based standardised clinical practice and processes as core operating standards across the trust.

Priorities for 2018/19	**Continuation from 2017/18**	**Key measures for success**
To develop a superior change-management capability this puts clinicians in charge of their clinical pathway to deliver high quality care to their patients across the RFL group.	✓ (previous performance shown in section 1.1)	To have 7 pathways prioritised for digitation which are as follows: 1. Preoperative Assessment 2. Elective Hip 3. Elective Knee 4. Right Upper Quadrant Pain 5. Induction of Labour 6. Pneumonia 7. Admissions to Neonatal Unit ('Keeping Mothers and Babies together')

Patient safety priorities

The RFL Group safety priorities are: zero Never Events, reducing avoidable deaths and zero avoidable hospital-acquired infections. In line with these, for 2018/19, the patient safety priorities in the quality accounts will be:

- Safer surgery
- Learning from deaths
- Infection prevention and control.

Data and information on these patient safety aims will be reported to the Clinical Innovations and Standards Committee (CSIC). Updates will be presented to commissioners via Clinical Quality Review Group meetings

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
Safer surgery and invasive procedures	✓ (previous performance shown in section 1.1)	• To achieve zero Never Events by the end of March 2019 • To increase by 75% the number of Local Safety Standards for Invasive Procedures (LocSSIPs) in place by the end of March 2019

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
Learning from deaths (LfD)	✘ (new priority for the trust)	• To increase by 10% the percentage of reviews of patient deaths recorded centrally by the end of March 2019 • To improve by 5% the sharing of the learning from serious incidents and patient deaths considered likely to be avoidable; as measured by staff survey data, by the end of March 2019

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To improve infection prevention and control	✘ (new priority for the trust)	• To achieve 10% reduction by year of E.coli bacteraemias. • To achieve Trust-attributed zero *Clostridium difficile* (C.diff) infections due to lapses in care by end of March 2019

Reports to be sent to trust level infection prevention and control committee (Chaired by Director for Infection Prevention and Control (DIPC) and the site level clinical performance and patient safety committees.

Statements of assurance from the board

During 2017/18, the Royal Free London NHS Foundation Trust (RFL) provided and/or sub-contracted 40 relevant health services.

The RFL has reviewed all the data available on the quality of care in 40 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2017/18.
(final number to be confirmed)

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 that we have evidence of improvements made to practice.

During 2017/2018 44 national clinical audits and 9 national confidential enqu
health services that the Royal Free London NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in, during 2017/18 are listed in table 2:

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in, during 2017/18 are also listed in table 2:

The national clinical audits and national confidential enquiries that RFL Trust participated in, and for which data collection was completed during 2017/18, 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, including case ascertainment rates in 2017/18.

Case ascertainment relates to the proportion of all eligible patients captured by the audit during the sampling period compared to the number expected according to other data source, usually Hospital Episode Statistics (HES) data. HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

Key:

Yes = data submitted during 2017/18 and relates to 2017/18

* = timeframe for data collection

Name of Audit	Data collection completed in 2017/18	Trust Eligibility to participate	Participation 2017/18	Case ascertainment
British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit	Yes	Yes	RFH BH and CFH service not available	121.4% *2014/16
BAUS: Nephrectomy audit	Yes	Yes	RFH and BH CFH service not available	134%*2014/16
BAUS: Percutaneous nephrolithotomy (PCNL)	Yes	Yes	RFH BH and CFH service not available	152%*2014/16
Cancer: National bowel cancer audit	Yes	Yes	RFH and BH CFH service not available	290 (109%)*2015/16
Cancer: National lung cancer audit	Yes	Yes	RFH and BH CFH service not available	N=381
Cancer: National oesophago-gastric cancer audit	Yes	Yes	RFH and BH CFH service not available	N=202 (81-90%) *2015/16
Cancer: National prostate cancer audit	Yes	Yes	RFH, BH and CFH	N=428 *2015/16
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care	Yes	Yes	RFH and BH CFH service not available	60%
COPD audit programme: Pulmonary rehabilitation	Yes	Yes	RFH BH and CFH service not available	N=1 (100%)
Diabetes: National foot care in diabetes audit	Yes	Yes	RFH BH and CFH service not available	N=59 (100%)
Diabetes: National diabetes in-patient audit (NaDIA)	Yes	Yes	RFH and BH CFH service not available	BH=32 RF=66
Diabetes: National pregnancy in diabetes (NPID)	Yes	Yes	RFH and BH CFH service not available	BH = 65 *2014/16 RF = 54 *2014/16
Diabetes: National diabetes audit (NDA)	Yes	Yes	RFH BH and CFH	Awaiting figures
Diabetes: National diabetes transition audit	Yes	Yes	RFH and BH CFH service not available	Audit extracts data from NDA and NPDA submission. Data reported at national-level only

Diabetes: National paediatric diabetes audit (NPDA)	Yes	Yes	RFH BH and CFH	BH = 112 *2016/17 CFH = 60 *2016/17 RFH= 51 *2016/17
Elective surgery (National PROMs programme)	Yes	Yes	RFH BH and CFH	Pre-operative questionnaires n=1033 [42.5%]*2015/2016 Post operative questionnaires n=589 [65.9% *2015/2016]
Endocrine and thyroid national audit	Yes	Yes	RFH and CFH BH service not available	n = 432 *2011/15
Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database	Yes	Yes	BH RFH and CFH service not available	n=156 *2016
FFFAP: Inpatient falls	Yes	Yes	RFH and BH CFH service not available	n = 30 (100%)
FFFAP: National hip fracture database	Yes	Yes	RFH and BH CFH service not available	BH = 391 (98.7%) *2016 RFH= 201 (102.9%)
Heart: Cardiac rhythm management	Yes	Yes	RFH and BH CFH service not available	BH= 304 *2015/16 RFH = 167 *2015/16
Heart: Myocardial infarction national audit project (MINAP)	Yes	Yes	RFH and BH CFH service not available	BH = 297 *2015/16 RFH = 268 *2015
Heart: National audit of percutaneous coronary interventions	Yes	Yes	RFH BH and CFH service not available	n = 867 *2015
Heart: National heart failure audit	Yes	Yes	RFH and BH CFH service not available	BH = 470 *2015/16 RFH = 303 *2015/16
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care	Yes	Yes	RFH and BH CFH service not available	BH = 1021 *2016/17 RFH = 1793 *2016/17
ICNARC: National cardiac arrest audit (NCAA)	Yes	Yes	RFH and BH CFH service not available	BH = 141 *2016/17 RFH = 359 *2016/17
Inflammatory bowel disease (IBD) registry: Biological therapies audit (Adult)	Yes	Yes	RFH and BH CFH service not available	Audit due for completion 2018/19
IBD registry: Biological therapies audit (Paediatric)	Yes	Yes	RFH BH and CFH service not available	Audit due for completion 2018/19
National audit of breast cancer in older people	Yes	Yes	RFH BH and CFH service not available	n = 600* 2015
National audit of dementia	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18
National audit of dementia - Delirium spotlight audit	Yes	Yes	RFH and BH CFH service not available	BH = 25 (100%) RFH = 25 (100%)
National audit of pulmonary hypertension audit	Yes	Yes	RFH BH and CFH service not available	719 *2016/17
National audit of seizures and epilepsies in children and young people	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18
National clinical audit of care at the end of life (NACEL)	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18
National clinical audit for rheumatoid and early inflammatory arthritis (NCAREIA)	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18

National comparative audit of blood transfusion programme: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	Yes	RFH BH and CFH	
National comparative audit of blood transfusion programme: 2017 National comparative audit of transfusion associated circulatory overload (TACO)	Yes	Yes	RFH BH and CFH	
National comparative audit of blood transfusion programme: Audit of patient blood management in scheduled surgery	Yes	Yes	RFH BH and CFH	Audit did not collect data in 2017/18
National comparative audit of blood transfusion programme: Audit of the use of blood in lower GI bleeding	Yes	Yes	RFH BH and CFH	Audit did not collect data in 2017/18
National emergency laparotomy audit (NELA)	Yes	Yes	RFH and BH CFH service not available	BH = 83 *2015/16 RFH = 118 *2015/16
National joint registry (NJR)	Yes	Yes	RFH BH and CFH	BH= 37 CFH = 586 RFH = 384
National maternity and perinatal audit (NMPA)	Yes	Yes	RFH and BH CFH service not available	BH = 100% *2015/16 RFH= 100% *2015/16
National neonatal audit programme (NNAP)	Yes	Yes	RFH and BH CFH service not available	BH = 100% *2016 RFH= 100% *2016
National ophthalmology audit: Adult cataract surgery	Yes	Yes	RFH BH and CFH	552 *2015/16
National vascular registry	Yes	Yes	RFH BH and CFH service not available	368 *2014/16
Royal College of Emergency Medicine (RCEM): Fractured neck of femur	Yes	Yes	RFH and BH CFH service not available	BH= 52 (100%) RFH=75(100%)
RCEM: Pain in children	Yes	Yes	RFH and BH CFH service not available	BH=51 RFH= 99
RCEM: Procedural sedation in adults	Yes	Yes	RFH and BH CFH service not available	BH = 50 RFH =21
Sentinel stroke national audit programme (SSNAP)	Yes	Yes	RFH and BH CFH service not available	BH= Clinical Audit: 90+% (Level A) RFH= Clinical Audit: 90+% (Level A)
Serious hazards of transfusion (SHOT): UK national haemovigilance scheme	Yes	Yes		
Trauma audit research network (TARN)	Yes	Yes	RFH and BH CFH service not available	BH = 34% RFH = 90%
UK Parkinson's Audit	Yes	Yes	RFH BH and CFH	100%

During 2017/18, the Trust did not participate in the below national audit as service is not provided by the organisation.

National audit title
Adult cardiac surgery
BAUS: Radical prostatectomy audit
BAUS: Cystectomy
BAUS: Urethroplasty audit
Head and neck cancer audit (DAHNO)
Mental health clinical outcome review programme
National audit of anxiety and depression
National audit of intermediate care (NAIC)
National bariatric surgery registry (NBSR)
COPD audit programme: Primary care
National clinical audit of psychosis
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)
National congenital heart disease (CHD)
National lung cancer audit: Consultant-level data
National neurosurgical audit programme - Consultant-level data
National oesophago-gastric cancer audit (NOGCA) - Consultant-level data
Paediatric intensive care (PICANet)
Prescribing observatory for mental health

The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2017/18:

During 2017/18, the trust participated in several other national audits which were not in the HQIP 'Quality accounts' list, published in December 2017. These included the following:

National audit title
7-day service audit
Health records audit
National audit of cardiac rehabilitation
National benchmarking pharmacy technician audit
NHSBT: kidney transplantation
NHSBT: liver transplantation
Potential donor
Renal registry
Royal College of Anaesthetists: National of perioperative anaphylaxis
Society for Acute Medicine Benchmarking Audit (SAMBA) study
The iBRA-2 study: a national prospective multi-centre audit of the impact of immediate breast reconstruction on the delivery of adjuvant therapy

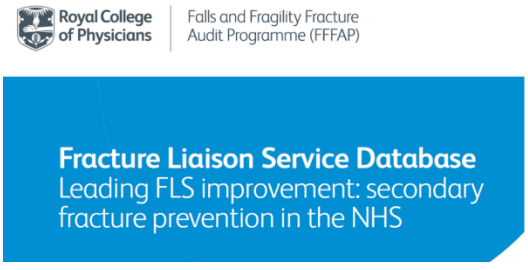
The reports of 44 national clinical audits were reviewed by the provider in 2017/18 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

- 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.

(specific actions to improve quality are presented in table 3)

Table 3: Specific actions to improve quality

Specific actions to improve quality as the result of a national audit	
	The Royal Free Hospital has successfully bid for funding from the NHSE Diabetes Transformation Fund for Multidisciplinary Foot Teams which will soon enable us to provide a 7 day Hot Clinic, improving service delivery, patient pathways and outcomes as well as compliance with the National Footcare Diabetes Audit at the Royal Free Hospital.
	The Royal Free Hospital remains one of the leading participants and one of the best hospitals nationally to achieve case ascertainment, presenting mortality rates below the national average. We have now implemented a new operating theatre booking form that requires the stratification of the risk of death calculated prior to surgery which will improve our compliance in documenting the risk of death. We have also appointed a geriatric surgical specialist making sure all of our elderly patients are reviewed post-surgery. As a service we continuously monitor and review every unplanned admission to critical care addressing any issues arisen.
	More multidisciplinary team (MDT) input to ensure the 4AT (a tool for assessing delirium) is completed. Discussion with physiotherapy to try and have a Sunday service to mobilise patients first day post-op. On-going attempt to reduce time to theatre.

Summary of our key achievements relating to national audits

A **top** 'green' **rating** was achieved by **Barnet Hospital, Chase Farm Hospital** and Royal Free Hospital for **90 day mortality and revision rates** for both **elective hip and knee surgery**	Our **stroke patients receive a world class stroke service** with **Royal Free Hospital** amongst the **top 23% of teams** nationally	**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
Royal Free Hospital is in the **best 25% of hospitals** nationally for **diabetes care in pregnant women** for **blood glucose control in the first trimester and third trimester**	The Trust participated in **53** national audits and confidential enquiries	**Pregnant women** delivering at **Barnet and Royal Free Hospitals** are **achieving outcomes** that are **lower than expected** for **induction of labour, instrumental births and 3rd and 4th degree tears**
Royal Free Hospital intensive care unit • Achieved a **green rating (good to excellent) for all RAG-rated quality measures** • **Improved compared to previous for 4 out of 7 re-audited measures.**	**Barnet Hospital** achieved the **top 'green' rating** for **6 out of 10 RAG rated quality indicators for emergency laparotomies**: •	Compared to other hospitals nationally **more people with type 1 diabetes** treated at the **Royal Free Hospital** are receiving best practice care by: • **Receiving insulin pump therapy** • **Receiving all 8 recommended key care processes** • **Meeting all 3 treatment targets**
Barnet Hospital: • Is in the **best 25% of hospitals** nationally **for 8 best practice care processes and outcomes** for **hip fracture** patients • Achieved the **lowest rate in London** for **hip fractures sustained as an in-patient** and is amongst the best 25% of hospitals nationally	**Royal Free Hospital** emergency department Is in the **best 25% of hospitals** nationally for **6 out of 13 best practice criteria relating to the timely treatment of severe sepsis and septic shock**	**Barnet Hospital** is in the **best 25% of hospitals** nationally for the care of **patients with dementia** for 5 out of 7 key domains – **governance, nutrition, staff rating of communication, carer rating of communication and carer rating of patient care**

The National COPD Audit Programme

COPD Secondary Care Audit Programme

During 2017-18 the trust participated in the COPD Secondary Care Audit Programme. The programme is in two parts. Part one is a continuous audit of patients that have been admitted to hospital with exacerbations, and a part two is a snapshot audit of the organisation and resourcing of care.

The programme is also linked to a 'Best Practice Tariff'- (BPT), which is a national price that is designed to incentivise quality and cost effective care.

Since the start of the tariff in April 2017, the trust has met all the standards required, which is a notable achievement, as only 58 out of 137 acute trusts have managed this.

National confidential enquiries for inclusion in quality report 2017/18

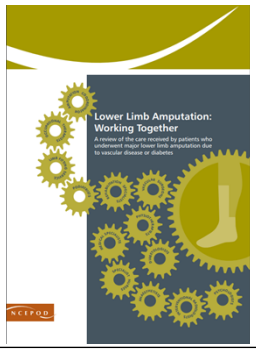
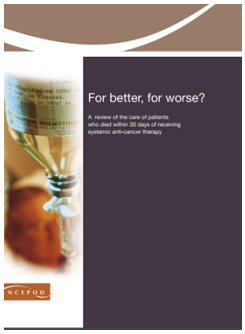
Name of Audit	Data collection completed in 2017/18	Trust Eligibility to participate	Participation 2017/18	Case ascertainment
Child health clinical outcomes review programme: Young people's mental health	Yes	Yes	RFH BH and CFH	BH = Clinical Questionnaire: n = 6/9 (67%) CFH = Casenotes: n = 5/9 (56%) Organisational Audit: n = 2/2 (100%)
Child health clinical outcomes review programme: Chronic neurodisability	Yes	Yes	RFH and BH CFH service not available	BH = Clinical Questionnaire: n = 14/16 (87.5%) Casenotes: n = 12/16 (75%)
Child health clinical outcomes review programme: Chronic neurodisability	Yes	Yes	RFH and BH CFH service not available	9/9
Child health clinical outcomes review programme: Long-term ventilation in children, young people and young adults	Yes	Yes	RFH BH and CFH	Enquiry in development
LeDer: Learning disability review programme	Yes	Yes	RFH BH and CFH	Enquiry due for completion 2018/19
Medical and surgical clinical outcomes review	Yes	Yes	RFH and BH	Clinical Questionnaire: n = 10/10 (100%)

programme: Acute heart failure			CFH service not available	Casenotes: n = 9/10 (100%) Organisational Audit: n= 2/2 (100%)
Medical and surgical clinical outcomes review programme: Pulmonary hypertension	Yes	Yes	RFH and BH CFH service not available	Enquiry in development
Medical and surgical clinical outcomes review programme: Non invasive ventilation	Yes	Yes	RFH and BH CFH service not available	Clinical Questionnaire: n = 5/5 (100%) Casenotes: n = 5/5 (100%) Organisational Audit: n = 2/2 (100%)
Medical and surgical clinical outcomes review programme: Perioperative diabetes	Yes	Yes	RFH BH and CFH	Enquiry due for completion 2018/19
Medical and surgical clinical outcomes review programme: Cancer in children, teens and young adults	Yes	Yes	RFH and BH CFH service not available	Clinical Questionnaire: n = 10/10 (100%) Casenotes: N/A Organisational Audit: N/A
Maternal, newborn and infant: Maternal programme 2015 data	Yes	Yes	RFH and BH CFH service not available	100%
Maternal, newborn and infant: Perinatal programme 2015 data	Yes	Yes	RFH and BH CFH service not available	100%

The trust continues to review National Confidential Enquiries into Patient Outcomes and Death (NCEPODs) on an annual basis until they are fully implemented. Progress is reported at both divisional and corporate levels.

Table 4: Specific actions to improve quality

Specific actions undertaken to improve quality	
NCEPOD Surgery in Children: Are we there yet? (SIC) **R**eviewed and updated: August 2017 	All hospitals that undertake surgery in children must hold regular multidisciplinary audit and morbidity and mortality meetings that include children and should collect information on clinical outcomes related to the surgical care of children. We are in the process of setting up a joint MDT meeting for General Surgery with RFL and GOSH.
NCEPOD Peri-operative Care: Knowing the risk (POC)	Mortality risk is assessed by using risk stratification score by the consultant surgeons and anaesthetists. Mortality risk is communicated to the patient in the consent procedure but not

Reviewed and updated: August 2017	documented on the consent form. However we are compliant with the legal requirements which are reflected in the Trusts consent policy.
NCEPOD Lower Limb Amputation: Working together. Reviewed and updated: December 2017 	We are in the process of establishing formal pathways for access to medical specialists pre- and post-amputation. There is an ongoing business case for additional physiotherapists to improve care.
Subarachnoid Haemorrhage: Managing the flow	Guidance for Subarachnoid haemorrhage is currently being drawn up.
NCEPOD Systemic Anti-Cancer Therapy: For better, for worse? Published: Nov-08 	The Oncology department has undertaken repeat audits 2009, 2013, 2014, 2016 and planned for 2018 (5th repeat). The audit studies the treatment and management of all patients who died within 30 days of receiving SACT, Outcomes measured are : treatment initiated and prescribed appropriately, and complication of treatment managed appropriately. All death cases are reviewed at mortality and morbidity meetings, and learning shared.
NCEPOD Acute Kidney Injury (AKI): Adding Insult to Injury. Published: Jun-09	The recommendations from this report was embedded as part of our Patient Safety Programme work stream until autumn 2017. It is now part of the AKI Clinical Pathway Groups.

Clinical audit remains a key component of improving the quality and effectiveness of clinical care, ensuring that safe and effective clinical practice is based on nationally agreed standards of good practice and evidence-based care. The Trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research. Through our four clinical divisions, work is in progress to dovetail our clinical audits and quality improvement initiatives which will provide better outcomes for our patients.

The reports of 23 local clinical audits* were reviewed by the provider in 2017/18 and RFL intends to take the following actions to improve the quality of healthcare provided.

- (* the local audits undertaken relate to the quality improvement projects previously described om page 22 which demonstrated modest to significant improvement through successful PDSA cycles)

Actions to improve the quality of healthcare provided:

- To ensure that all local audits/ quality improvement projects are monitored effectively throughout our clinical divisions, with an increased focus on identifying the outcomes and embedding recommendations

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 active participation in research leads to better patient outcomes.

Our reputation attracts outstanding staff and researchers from many different countries. The close collaboration between staff and the research department of the medical school is one of our unique strengths - 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 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was **10, 985**

The figure includes **4140** patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and **6845** patients recruited into studies that are not on the NIHR portfolio. This figure is l**ower** than that reported last year.

The Trust is supporting a large research portfolio of over 700 studies, including both commercial and academic research**. 159** new studies were approved in 2017/18. The breadth of research taking place within the Trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

Celebrating research success

Research is of huge strategic importance to the trust and to help us achieve even greater success in the future. In July 2017 the trust launched a new three-year strategy. Its aim is to advance clinical outcomes, quality and experience through access to world-leading clinical research for all our patients and staff, across all of our healthcare sites.

Our vision is that by 2020, clinical research will be part of our core business and that we'll be ranked in the top ten nationally for clinical research outputs and performance.

Adele Fielding, director of research and development, states:

'This inaugural clinical research and development strategy is a crucial step towards the trust securing its rightful position as a top-ten ranked NHS provider of nationally adopted high quality clinical research.

Its delivery will ensure that all of our patients and staff have the same opportunity to participate in clinical research, regardless of the site they are treated or work at. This in turn will contribute to improved patient outcomes and enhance the experience of being a patient or member of staff at the trust. As R&D director and an active clinical researcher, I am very excited about implementing the strategy and the opportunity it will bring to advance clinical research at the trust.'

CQUIN Payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment Framework.

(Further details of the agreed goals for 2017/18 and for the following 12-month period will be presented in the final report).

CQUIN scheme priorities 2017/2018	**Objective rationale**
Staff health & well being	This national initiative made up of three areas of improvement: 1) Improvement of health and wellbeing of NHS staff with a focus on MSK and stress 2) Healthy food for NHS staff, visitors and patients 3) Improving the uptake in 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 a empiric review of antibiotic prescriptions. Antimicrobial resistance has risen alarmingly over the last forty years and inappropriate plus overuse of antimicrobials is a key driver.
Mental health in A&E	Reducing the number of frequent attenders who would benefit from mental health and psychosocial interventions The Trust has worked closely with mental health providers and other partners (including police, ambulance, substance misuse, social care and the voluntary sector) to ensure that people presenting at A&E with primary or secondary mental health requirements have these needs met by an improved integrated service.
Advice & Guidance	Scheme requires the Trust to set up and operate Advice & Guidance services for non-urgent GP referrals allowing GP's to access consultant advice prior to referring patients in to secondary care.
e-Referral	CQUIN designed to encourage a move away from any paper based processes so that all referrals to first outpatient services are available electronically by April 2018.
Supporting proactive & safe discharge	Unnecessary delays in discharging patients from hospital is a systemic problem and a rising trend. In particular with older patients longer stays in hospital can lead to worse health outcomes and an increase in long term care needs. CQUIN supports systems to streamline discharge pathways, embed and strengthen discharge to assess pathway to maximum effect and to understand the capacity

	within community services to support improved discharge.
Hep C Virus – Improving pathways	The Trust is a lead provider in reducing harm from Hepatitis C. This is a continuing CQUIN that forms part of a long term project with the end goal being the elimination of Hepatitis C as a major health concern by 2030.
Medicines optimisation	This CQUIN supports the optimisation and use of medicines commissioned by specialised services in identified priority areas.
Cancer dose banding	Supporting the implementation of nationally standardised doses of SACT across England using dose banding principles and dosage tables published by NHS England.
Optimising palliative chemotherapy decision making	To support optimal care by ensuring that, in specific groups of patients, decisions to start and continue further treatment are made in direct consultation with peers and then as a shared decision with the patient.
Complex device optimisation	To ensure that complex implantable cardiac device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded.
Multisystem Autoimmune Rheumatic Disease	This CQUIN oversees 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).
Breast screening	Increasing uptake of screening programmes through MECC (making every contact count) in both clinical service and admin hub.
Dental	Collection and submission of data on priority pathways procedures by Tier using the CQUIN dashboard. Participation in the Acute Dental Systems Resilience Group (SRG), including supporting data requests to contribute to a Pan London approach to demand and capacity modelling. Active participation in consultant led MCN with collaborative oversight of appraisal of performers.

In 2017/18 the Clinical Commissioning Group (CCG) monetary total was xxxxx and the NHS England (NHSE) monetary total was xxxx conditional upon achieving quality improvement and innovation goals.

(The final monetary total will be presented in the final report).

Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against the Royal Free London NHS Foundation Trust during 2017/18.

The Royal free London NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 19 February 2018 review of services for looked after children and safeguarding in Barnet (details are presented below).

The Royal Free London NHS Foundation trust has not yet received the final report conclusions of this review.

The CQC undertook the following unannounced responsive and announced inspections during 2017 at the Royal Free Hospital Hampstead site (Further details are provided on page 69).

Information on the quality of data

Good quality information ensures that 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 ethnicity and other equality data 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 2017/18 to the Secondary Uses service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data that included the patients' valid NHS numbers was:

% of records	2014/15	2015/16	2016/17	2017/18 (April to September)
For admitted patient care	98.8%	98.6%	98.15%	

				98.7%
For out-patient care	99.2%	98.6%	98.65%	99.1%
For accident & emergency care	92.6%	94.4%	94.89%	95.6%

General Medical Practice Code

In order to transfer clinical information from the trust to our patient's GP, It is essential that the information sent is accurate. Data which included the patients' valid General Medical Practice Code was:

% of records	2014/15	2015/16	2016/17	2017/18 (April to September
For admitted patient care	99.8%	99.95%	99.92%	99.8%
For out-patient care	99.9%	99.96%	100%	99.9%
For accident & emergency care	99.9%	99.94%	100%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 68% and was graded satisfactory (green)

	2015/16	2016/17	2017/18
Information governance assessment score	**68%**	**66%**	**68%**
Overall grading	**green**	**green**	**green**

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 for 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:

- Implementing a new Trust wide data quality dashboard on Qlikview during Q1 2018/19 which will provide access to a range of KPIs that cover the main datasets and will ensure visibility and standardisation throughout the Group model. Specialities that are performing poorly against the targets set will be reviewed by the Data Quality team and action plans will be put in place to resolve the issues.

- An external partner will be used to implement a Data Assurance Framework. The Data Assurance Framework will assess current data quality, provide KPIs to internally measure data quality and develop a programme of regular audit to continually assess progress.

Learning from deaths

Learning from deaths

Hundreds of patients come through our doors on a daily basis. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly and inevitably, some patients will die here.

While most deaths are unavoidable and would be considered to be "expected", there will be cases where sub-optimal care in hospital may have contributed to the death. The Trust is keen to take every opportunity to learn lessons to improve the quality of care for other patients and families.

A Care Quality Commission review in December 2016, "Learning, Candour and Accountability" found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

The Trust is committed to fully implementing the national guidance and has published a "Learning from Deaths" policy which outlines its processes for identifying, reviewing and learning from deaths and the roles and responsibilities for staff involved in that process.

Details to follow.

2.3 Reporting against core indicators

Details to follow.

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 2017/18 against indicators and national priorities selected by the board in consultation with our stakeholders.

Performance against key national indicators

The charts and commentary contained in this report represents the performance for all three of our hospital sites. This approach has been taken to ensure consistency with the indicators the trust is required to report on by the NHS Improvement Single Oversight Framework.

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.

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 Infections
Clinical effectiveness	• referral to treatment (RTT) • A&E performance • cancer waits
Patient experience	• friends and family test

Definitions

The following table sets out the definition for each performance measure. These are, to the best of our knowledge, consistent with standard national NHS data definitions. There has been no change in the basis for calculation for any of these measures since 2015/16.

Indicator / Metric	Description / Methodology
Accident and Emergency – 4hr standard	Percentage of A & E attendances where the patient was admitted transferred or discharged within 4 hours of their arrival at an A & E department.
Summary Hospital Mortality Indicator (SHMI) and Hospital Standard Mortality Ratio (HSMR)	These measures uses routinely collected data to calculate an overall "expected" number of deaths if the trust matched the national average performance. The result is a ratio (calculated by dividing the observed number of deaths by the expected deaths). The main differences between these measures are found in the data coverage: (a) while HSMR only considers around 80% of deaths the SHMI metric ostensibly covers all hospital spells, (b) definition of death in HSMR includes in-hospital mortality only whilst SHMI captures any death occurring 30 days post discharge), and (c) adjustments are made for palliative care in HSMR only.
Average length of stay	Measured in days, the average length of stay is the result of calculating the difference between the admission date and the discharge date for each patient treated as an Inpatient over the period.
Day-case rate	The proportion of elective admissions that are treated on a day case basis with no overnight stay.
Readmission rate	The relative risk of a patient being readmitted as an emergency within 28 days of a previous discharge. The result is a ratio (calculated by dividing the observed number of emergency readmissions by the expected volume emergency readmissions).
RTT Incomplete Performance - % waiting less than 18 weeks	Percentage of patients on the incomplete RTT patient tracking list who are waiting 18 weeks or less for treatment or discharge from Referral.
2 Week Wait - All Cancer	Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment or diagnostic.
2 Week Wait -symptomatic breast	Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for their first outpatient appointment.
31 day wait diagnosis to	Percentage of patients waiting no more than one month (31 days)

treatment	from diagnosis to first definitive treatment for all cancers.
31 day wait - subsequent surgery	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery.
31 day wait - subsequent drug treatment	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is a drug regimen.
31 day wait - subsequent radiotherapy	Percentage of patients waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy.
62 day wait - from urgent GP referral	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.
62 day wait - from screening service referral	Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for cancer.
C. Difficile Lapses in care	Number of Clostridium Difficile infections due to lapses in patient care
Friends and Family IP & AE Score	The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP & AE friends and family tests. (Neither Likely or not likely excluded from responses)

Notes on the charts

This year the presentation of the data has changed to ensure that it is in line with Healthcare Statistics best practice[1]. Two chart types are now used: control charts and funnel plots.

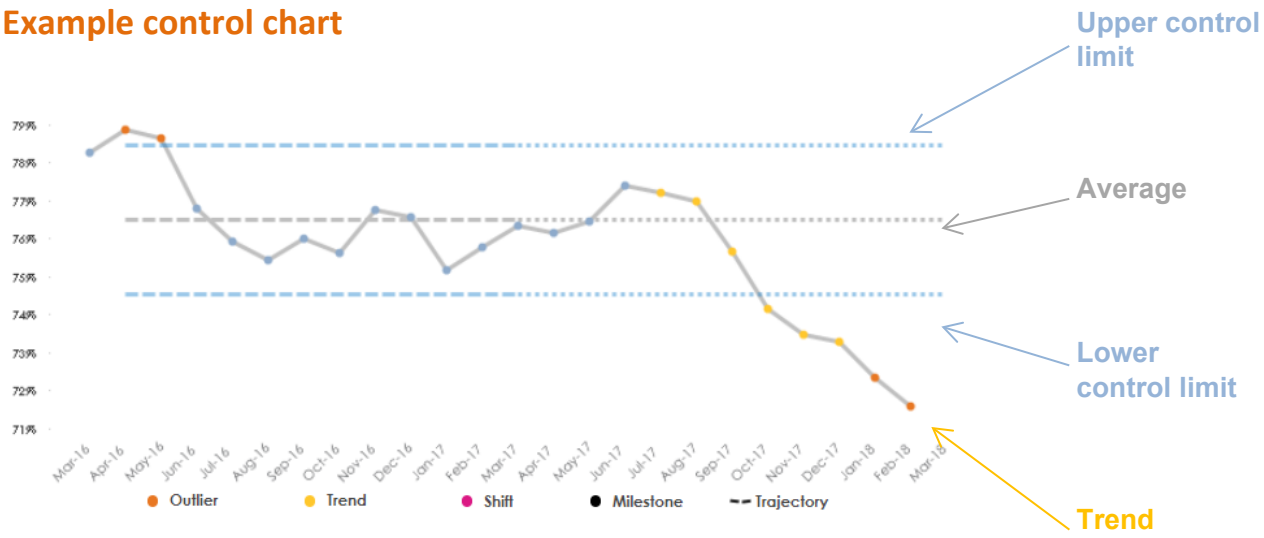
Control charts

The control chart is a graph used to study how a process changes over time. Data are plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).[2]

Where there has been variation that signals a change in the underlying process, this is marked on the chart as:

- Outlier - data points either above the upper control limit or below the lower control limit
- Trend - 6 or more points either all ascending or all descending
- Shift - 8 or more points either all above or all below the average line

Example control chart



[1] See, for example, "The Health Care Data Guide", Provost & Murray

[2] http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html

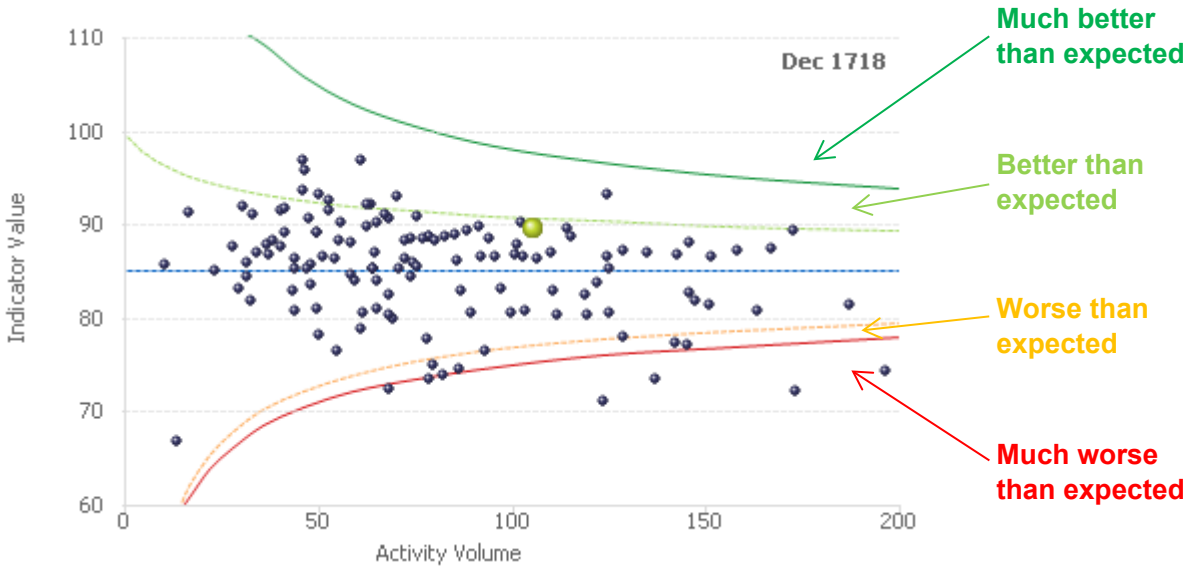
Spine charts

Spine charts are a way of displaying variation data that is derived from a funnel plot. A funnel plot shows data for a range of organisations at a single point in time. The denominator (count of activity, population etc.) is plotted on the X axis and the value of the measure (mortality rate, readmission rate) on the Y axis.[3] The central line represents the mean for all organisations on the chart.

If the trust is within the central portion of the chart, it means that performance on this indicator does not differ from the national mean by more than can be explained by random chance. If the trust is within a coloured region, these can be interpreted as follows:

- Dark green: the rate is much better than expected by chance
- Light green: the rate is better than expected by chance
- Amber: the rate is worse than expected by chance
- Red: the rate is much worse than expected by chance

Example spine chart



Source: Stethoscope benchmarking tool, Methods Analytics 2018

These charts can also be used to display measures that have been adjusted for case mix.

[3] Methods Analytics methodology, 2018

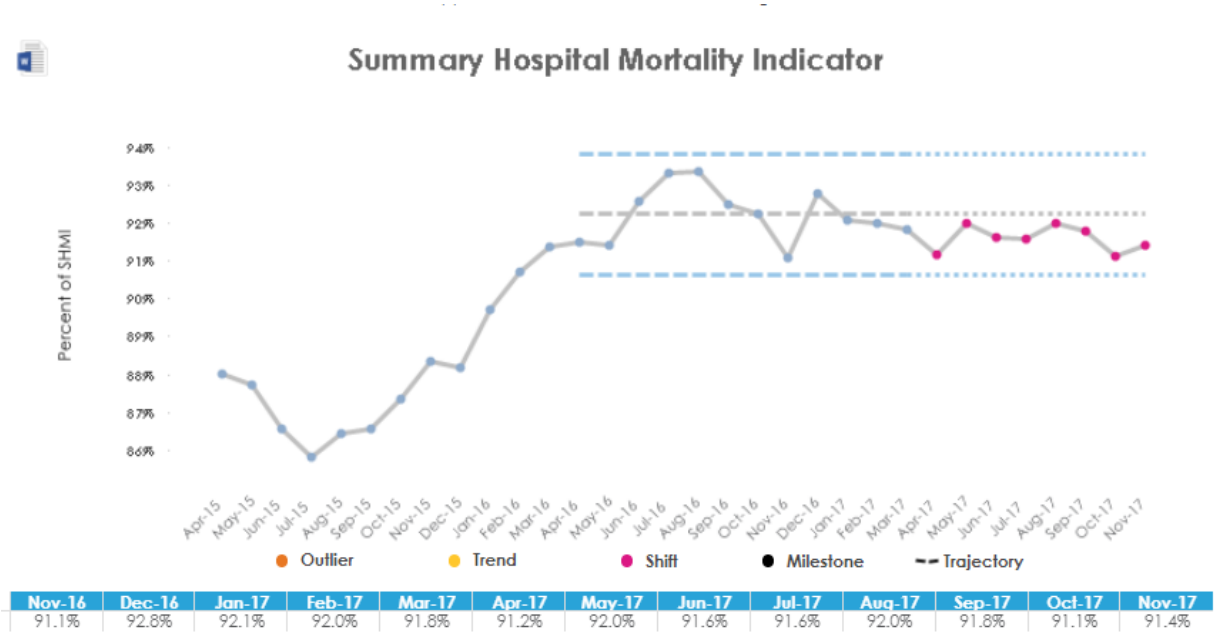
Patient Safety

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 groups 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 below for April 2015 to November 2017. This shows a recent improvement in the trust's score to a mean of 91.7 or 8.3% better than expected over the months April to November 2017.

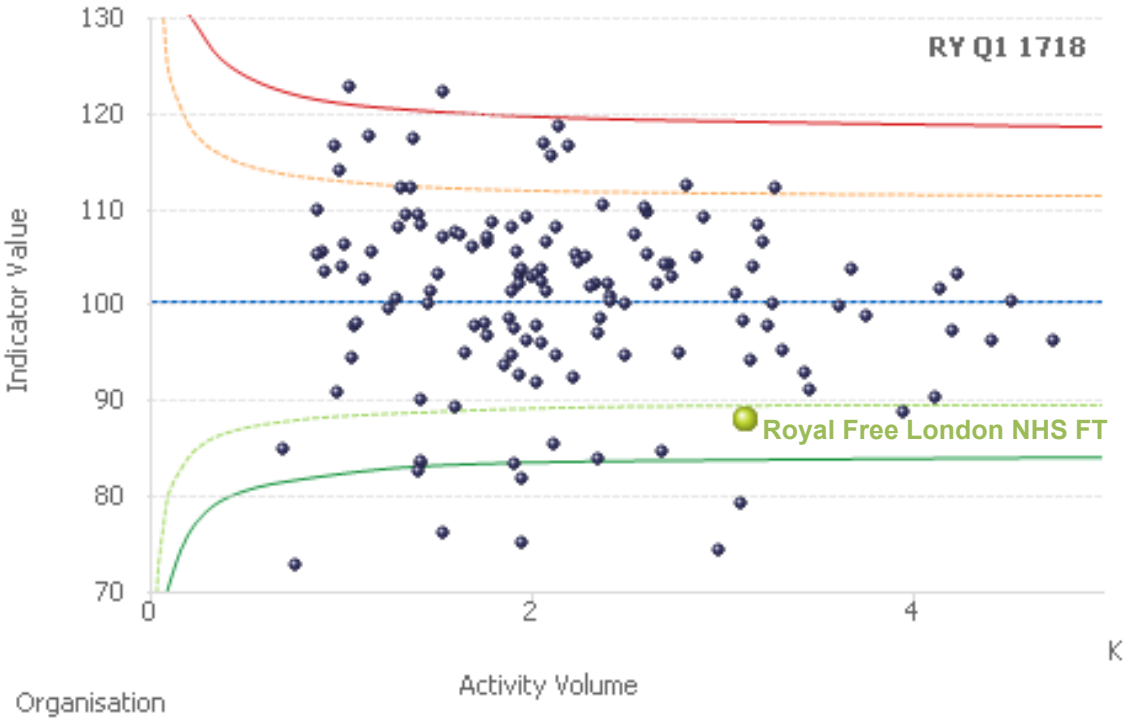


Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
91.1%	92.8%	92.1%	92.0%	91.8%	91.2%	92.0%	91.6%	91.6%	92.0%	91.8%	91.1%	91.4%

Source: Royal Free London NHS Foundation Trust

The chart below shows the Royal Free London SHMI performance compared to all other acute NHS trusts for the rolling year ending Q1 2017/18 (the latest for which information is currently available). The Royal Free SHMI was 15th lowest out of 134 acute trusts and was statistically lower than expected.

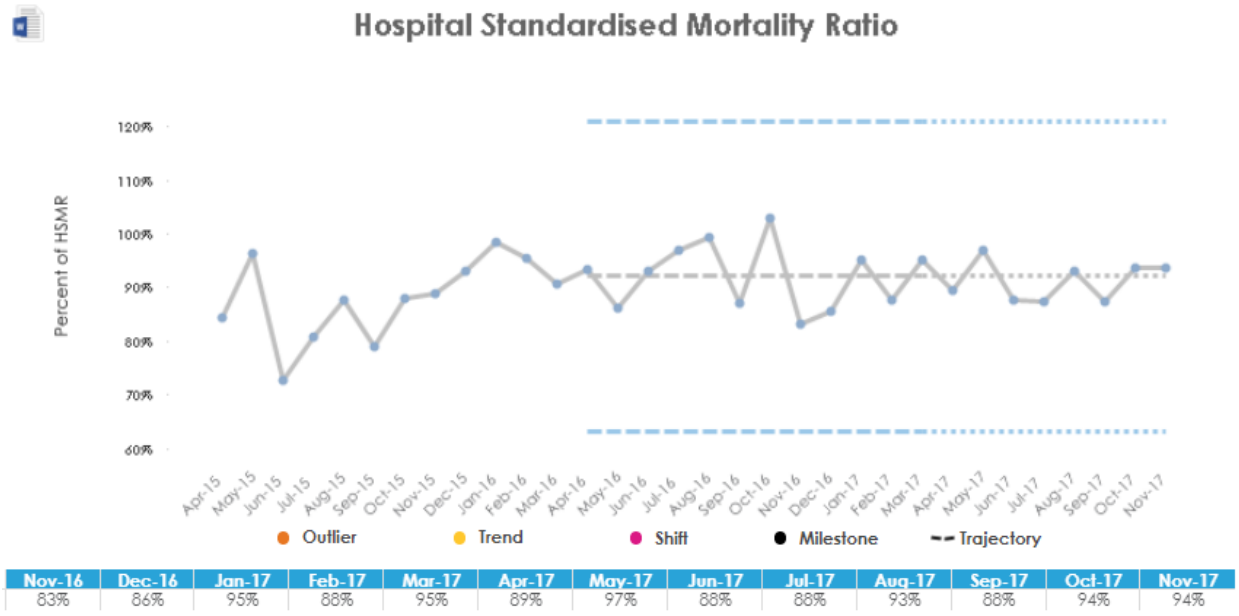
Chart: Summary Hospital-level Mortality Indicator by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2018

Hospital Standardised Mortality Ratio (HSMR)

The HSMR (Hospital Standardised Mortality Ratio) includes 56 diagnoses groups responsible for 80% of deaths and only includes in-hospital mortality. Our data shows that there has been no significant change in our HSMR over the year to November 2017; our average over the period has been 92 or 8% better than expected.

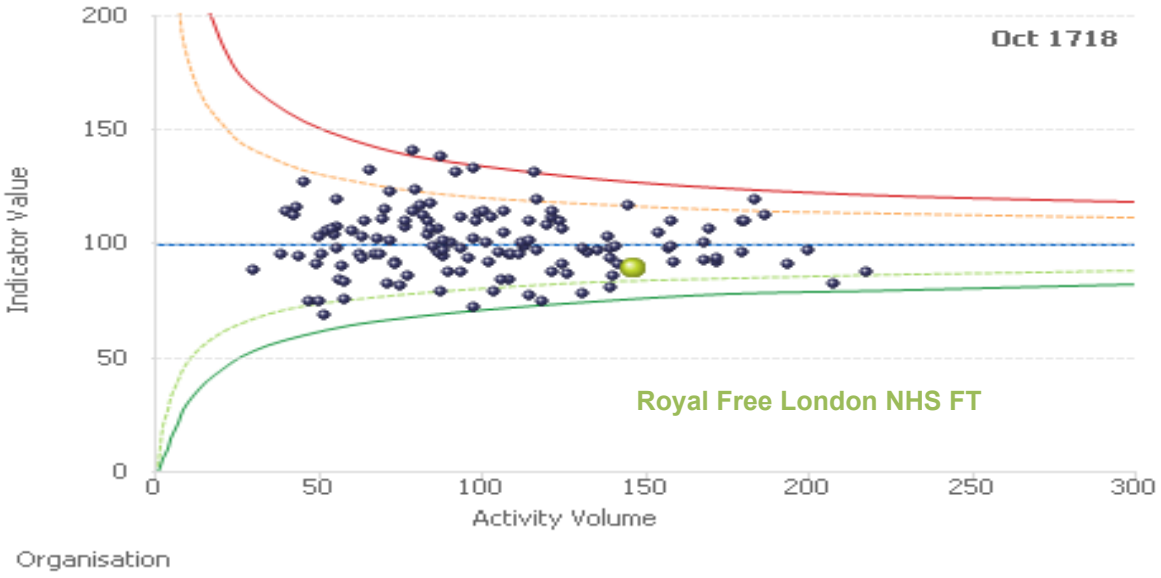


Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
83%	86%	95%	88%	95%	89%	97%	88%	88%	93%	88%	94%	94%

Source: Royal Free London NHS FT

However, benchmarking shows that on this measure the Royal Free London does not differ from the national mean by more than can be explained by random chance. This is consistent with previous performance.

Chart: Hospital Standardised Mortality Ratio by NHS acute trust



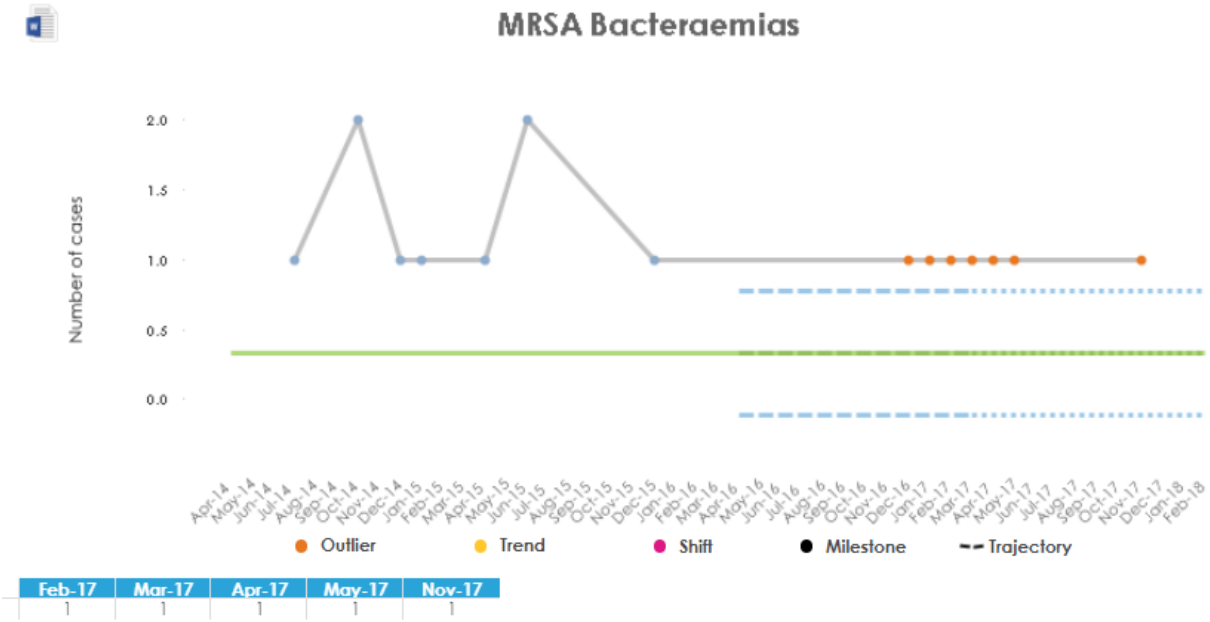
Source: Stethoscope benchmarking tool, Methods Analytics 2018

Data shows that for October 2017 the Royal Free London NHS Foundation Trust recorded the 27th lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 89.0 which is 11% below (statistically significantly better than expected) (Data source: Methods Analytics).

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.

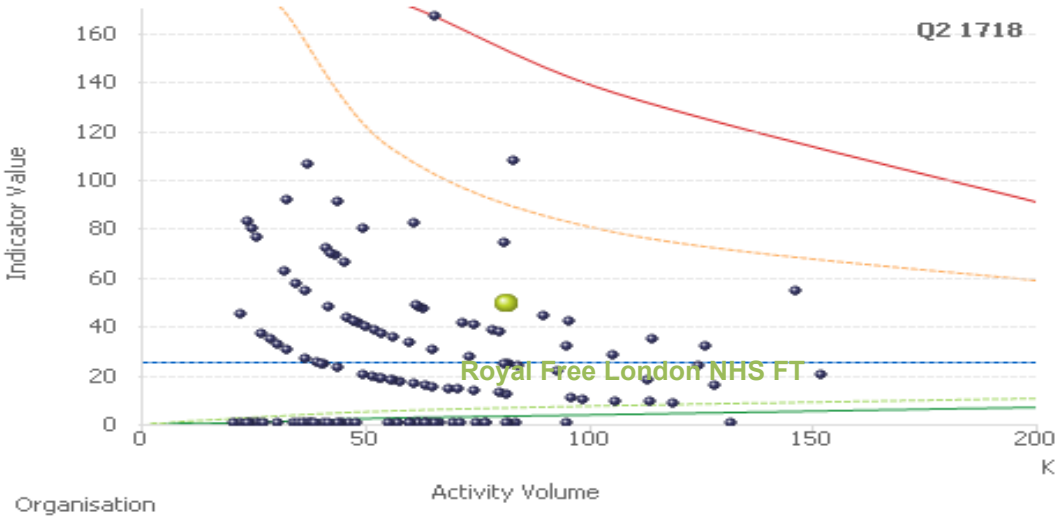
Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative of the degree to which our hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.



Source: Royal Free London NHS FT

In the twelve months to the end of February 2018 the Royal Free reported 4 MRSA bacteraemias, with none reported since November 2017. The chart below shows the Royal Free London Q2 2017/18 MRSA rate per 1,000,000 occupied bed days benchmarked against all other NHS trusts. This shows that our MRSA rate does not differ from the national mean by more than can be explained by random chance.

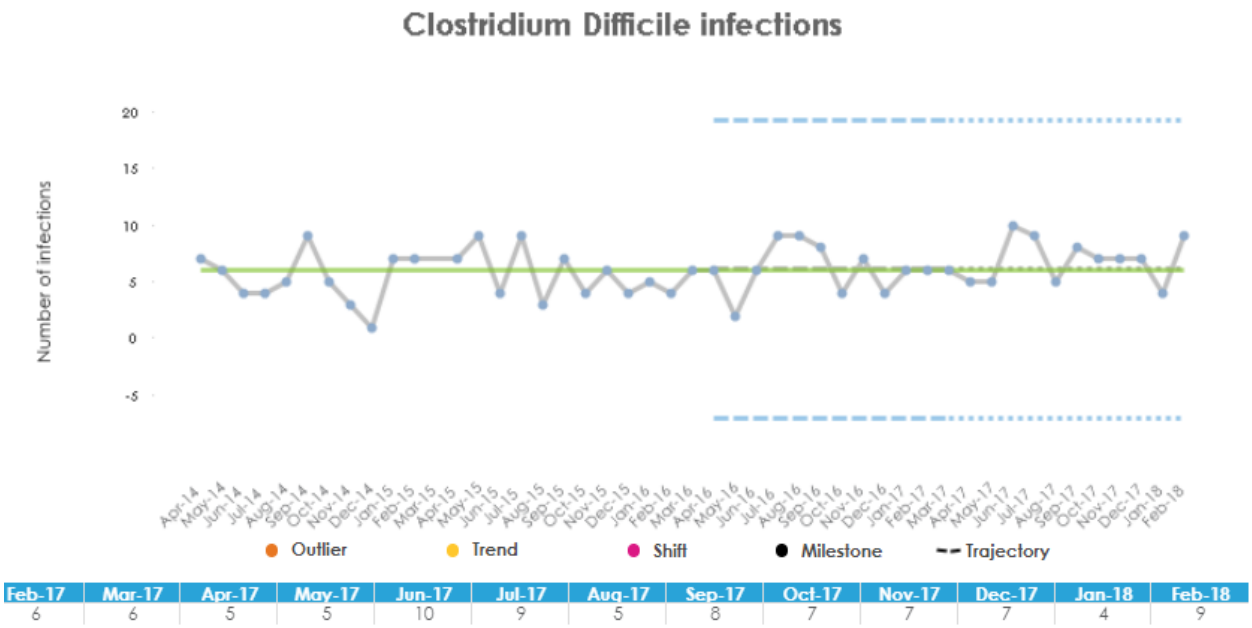
Chart: MRSA bacteraemia, rate per 1,000,000 occupied bed days by NHS acute trust Q2 2017/18



Source: Stethoscope benchmarking tool, Methods Analytics 2018

C. difficile

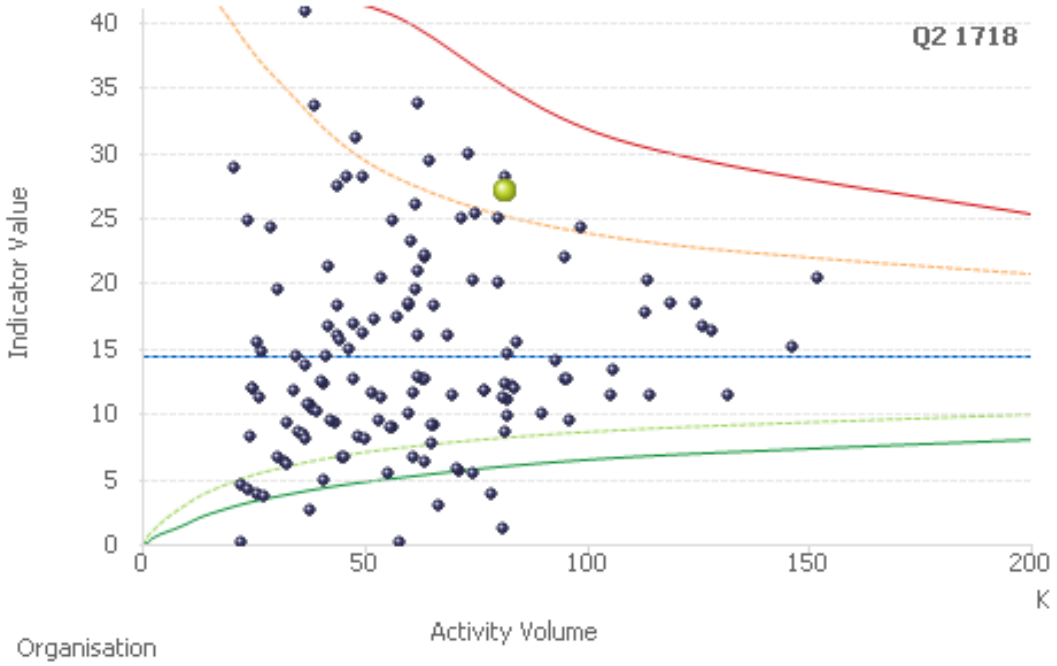
In relation to C. difficile the trust saw no change in 2017/18 from 2016/17 in terms of the rate of infections, with an average of 6 per month.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
6	6	5	5	10	9	5	8	7	7	7	4	9

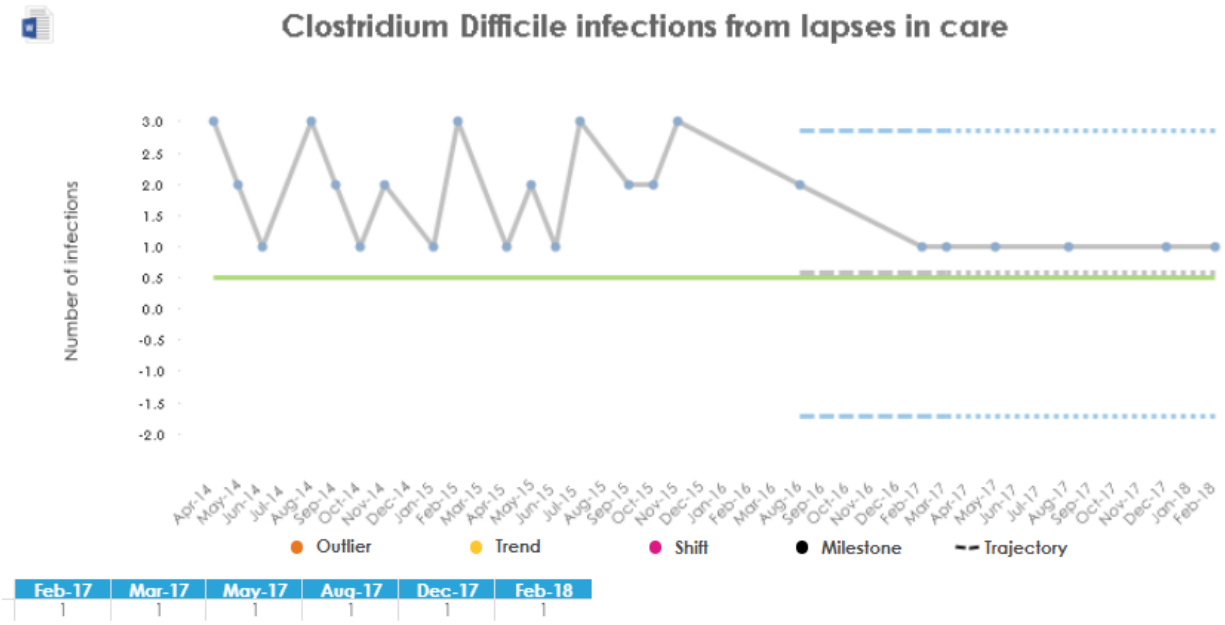
According to our benchmark information for Q2 2017/18, this indicates that our infection rate per 100,000 occupied bed days is higher than would be expected by chance.

Chart: C. Difficile infection rate per 100,000 occupied bed days by NHS acute trust Q2 2017/18



Source: Stethoscope benchmarking tool, Methods Analytics 2018

However, our C. Difficile volumes that can be attributed to "lapses in case" by the trust are significantly lower. Against this measure of performance the trust has seen 5 incidents in the 12 months to February 2018.



Source: Royal Free London NHS FT

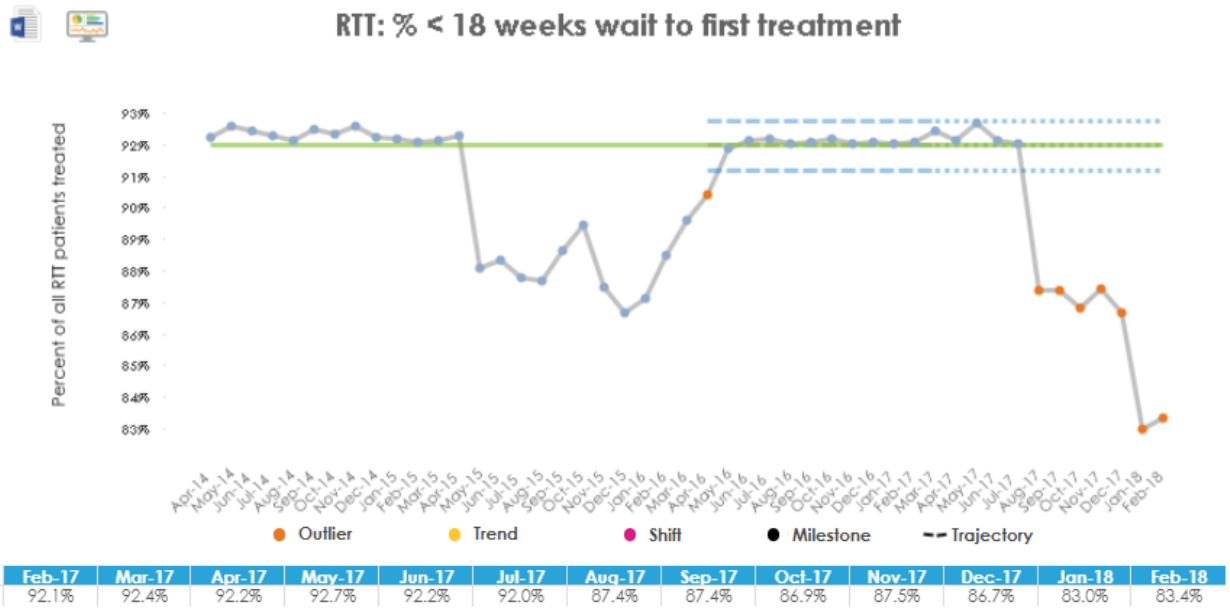
Clinical Effectiveness

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.

From September 2015, NHS England has used as the single measure of compliance with the NHS Constitution, the proportion of pathways where the patient has yet to receive treatment and is actively waiting. For these pathways the national standard requires that no more than 8% of patients should be waiting longer than 18 weeks for treatment i.e. 92% should be waiting 18 weeks or less.

As shown in the chart below, the trust returned to compliance against the incomplete pathway standard in June 2016. However, since August 2017, the trust has failed the standard. Performance in February 2018 was 83.4%.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
92.1%	92.4%	92.2%	92.7%	92.2%	92.0%	87.4%	87.4%	86.9%	87.5%	86.7%	83.0%	83.4%

Source: Royal Free London NHS FT 2014-2018

This was primarily a result of improvements the trust made to the way in which it tracks patient pathways using a Patient Tracking List (PTL). During 2017/18 the Trust worked on improving the PTL for two main reasons:

1. In order to better link patient encounters together to identify whole pathways
2. To eliminate the need for the number of exclusion rules that were in place in the original PTL

The new PTL was also designed to ensure that we no longer need to repeatedly validate the same patients, whose validation was being lost by the old logic.

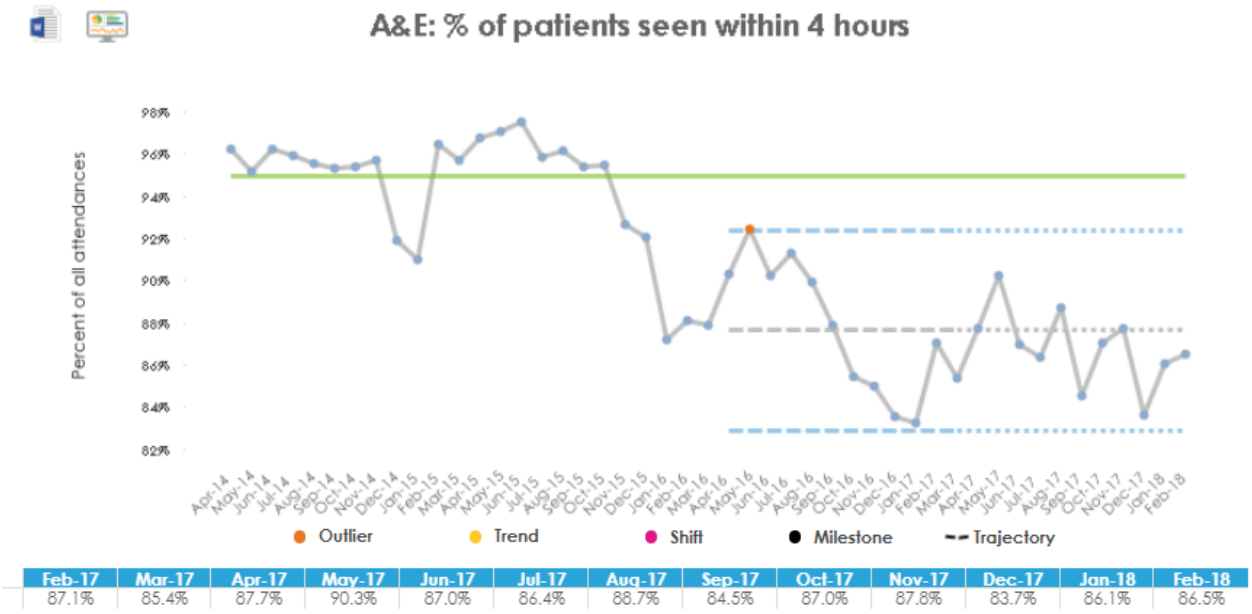
This revised PTL was originally planned for delivery in December 2016 but due to a number of technical issues it was released on 1st August 2017. Upon release, the volume of breaches across the trust increased significantly and 35 patients waiting over 52 weeks were identified. This was expected as it identified the whole set of patients whose past validation had been lost by the old logic as well as patients that had been suppressed.

[To include: updated chart with comparative data from Stethoscope once Methods have amended methodology]

A&E performance

The Accident and Emergency Department is often the patient's point of arrival. The graph summarises the Royal Free London's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of London A&E departments. The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within 4-hours of arrival.

During the period April 2017 to February 2018, the Royal Free London NHS FT achieved an average monthly performance of 86.8%. This was not significantly different from average performance in 2016/17.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
87.1%	85.4%	87.7%	90.3%	87.0%	86.4%	88.7%	84.5%	87.0%	87.8%	83.7%	86.1%	86.5%

Source: Royal Free London NHS FT 2014-2018

[To include: updated chart with comparative data from Stethoscope once Methods have amended methodology]

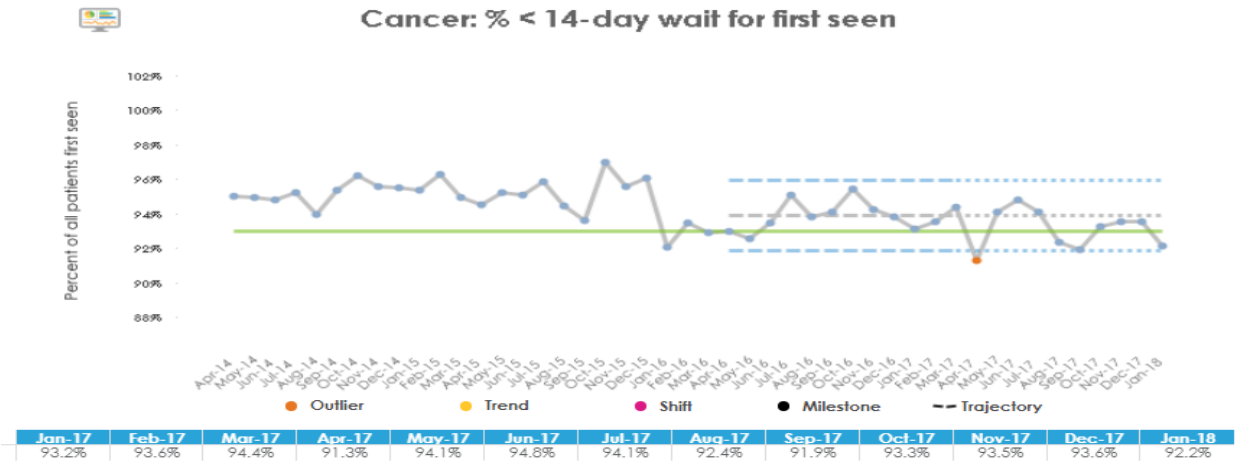
Pressure on A&E's has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare. In response, the trust has invested in rebuilding the Royal Free hospital site A&E department, the last elements of which will open early in 2018/19. In addition, the trust has been working closely with system colleagues to improve flow of patients through the hospital.

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 for an outpatient or diagnostic appointment within 2 weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

For 2017/18 to January, the trust met the standard to see at least 93% within 2 weeks from GP referral in 7 out of 10 months. The main factors influencing this were the holiday periods for Easter, summer and Christmas. The trust has been improving its holiday planning processes to ensure that no capacity is lost and that patients are brought in as quickly as possible following the end of the holiday period.

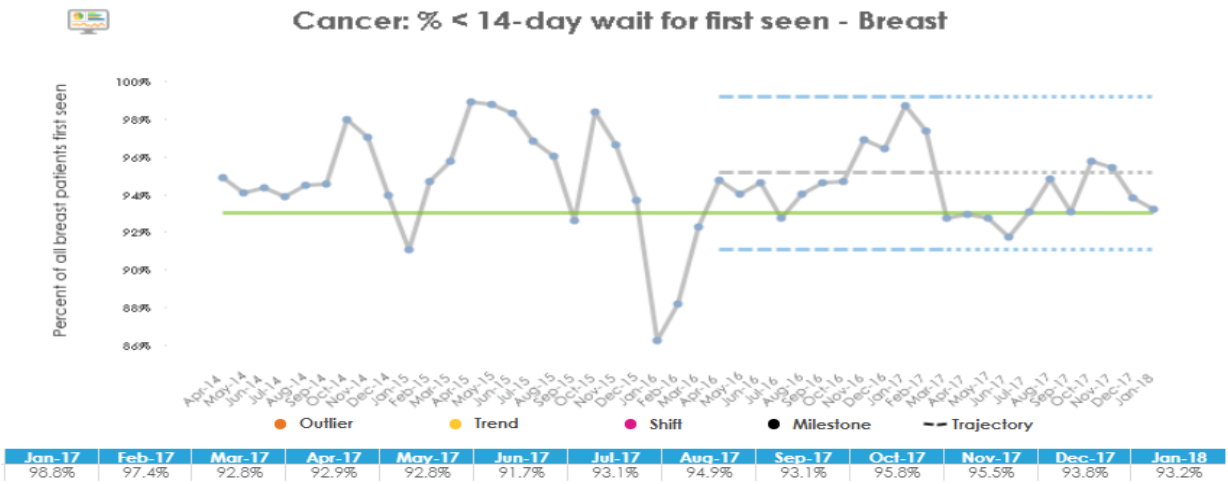


Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
93.2%	93.6%	94.4%	91.3%	94.1%	94.8%	94.1%	92.4%	91.9%	93.3%	93.5%	93.6%	92.2%

Source: Royal Free London NHS FT 2014-2018

Breast Urgent referral 2 week waits

In 2016/17, the trust on average each month saw 93.8% of patients on an urgent breast referral pathway within 2 weeks, meeting the national standard.



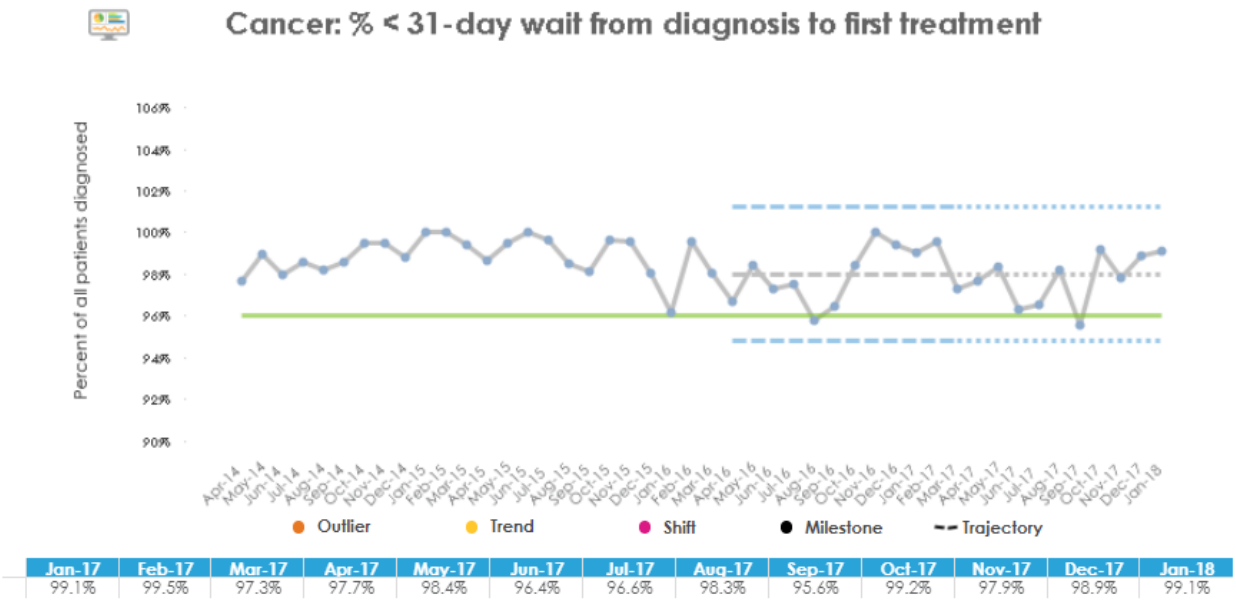
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
98.8%	97.4%	92.8%	92.9%	92.8%	91.7%	93.1%	94.9%	93.1%	95.8%	95.5%	93.8%	93.2%

Source: Royal Free London NHS FT 2014-2018

This was not significantly different from 2016/17 when we also met the standard.

First definitive treatment within 31 days

In 2017/18, the trust met the standard to see 96% of patients within 31 days for their first definitive treatment for cancer, in every month except September 2017, meeting the national standard for the year overall.



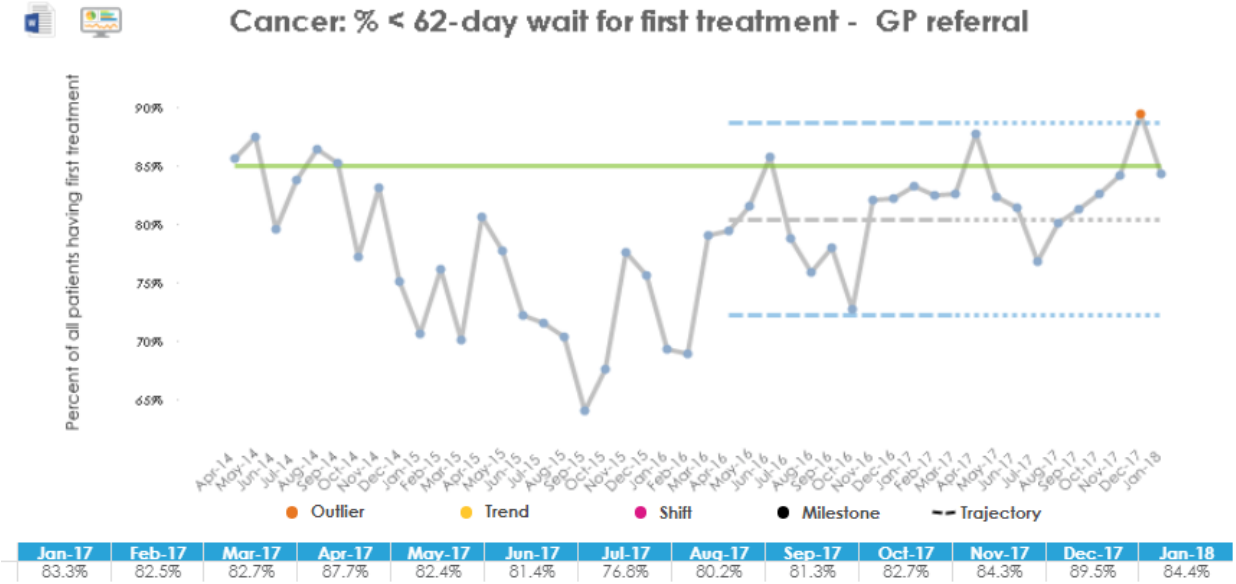
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
99.1%	99.5%	97.3%	97.7%	98.4%	96.4%	96.6%	98.3%	95.6%	99.2%	97.9%	98.9%	99.1%

Source: Royal Free London NHS FT 2014-2018

This is similar performance to 2016/17 when we also met the standard.

First definitive treatment within 62 days of an urgent GP referral

The trust did not meet the 62 day standard in 2017/18, with 83.1% of patients receiving first treatment within 62 days of a GP referral. This represents an improvement on 2016/17 where 80.5% of patients met the standard and on 2015/16 when 72.7% of patients met the standard.



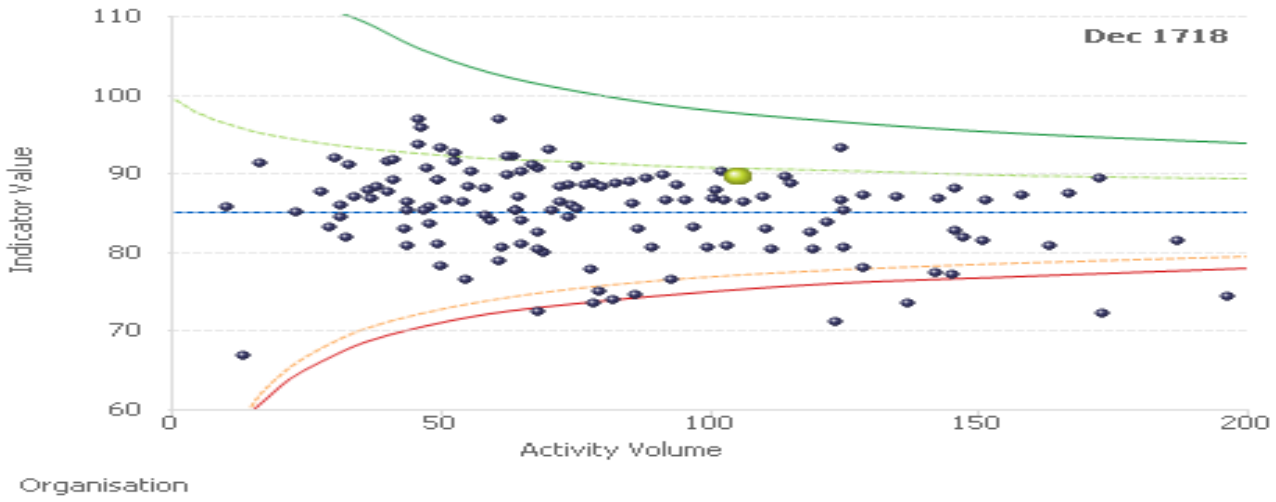
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
83.3%	82.5%	82.7%	87.7%	82.4%	81.4%	76.8%	80.2%	81.3%	82.7%	84.3%	89.5%	84.4%

Source: Royal Free London NHS FT 2014-2018

The trust has had a recovery plan in place for cancer since July 2016 which has been working through improvement actions across all tumour sites. Q3 2017/18 was the first quarter of compliance since 2014. In 2018/19 the trust plans to strengthen the improvements already made and aim to deliver compliance across the year.

When comparing Royal Free London to benchmarks in December 2017, this suggests that performance did not differ from the national mean by more than can be explained by random chance. This is an improvement on previous years where performance has been worse than expected when compared to other trusts' performance.

Chart: Cancer 62 day wait for first treatment from GP referral, all acute trusts, December 2017



Source: Stethoscope benchmarking tool, Methods Analytics 2018

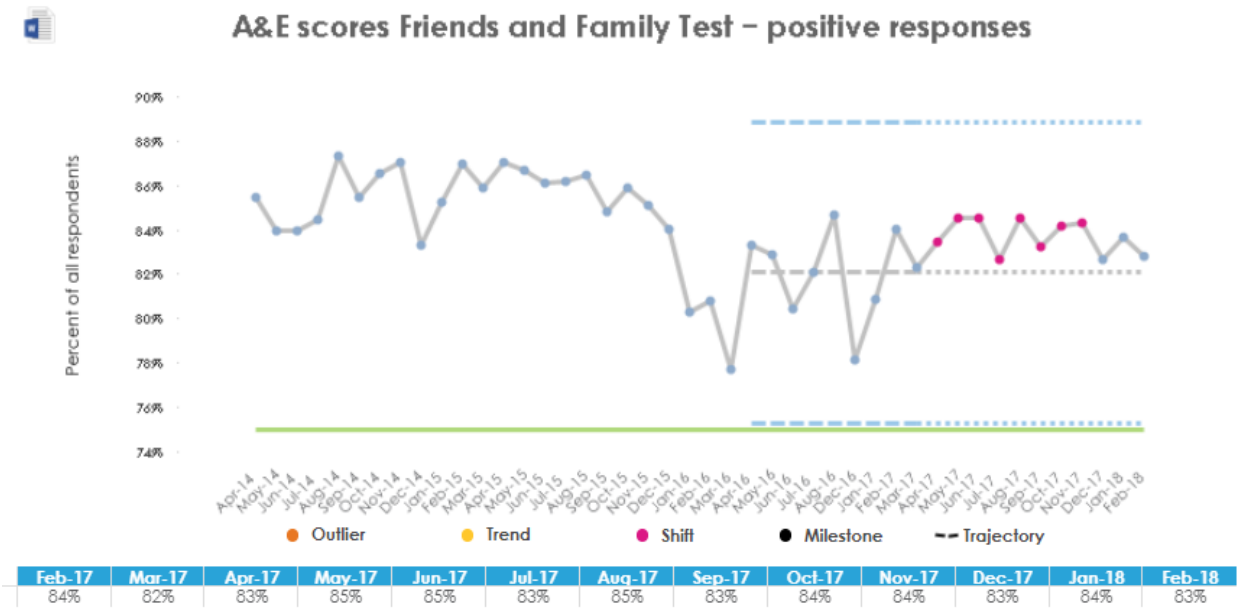
Patient experience indicators

Friends and family test (patients)

The Friends and Family Test (FFT) was introduced in April 2013. Its purpose is to track and therefore improve patient experience of care. FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services.

The data below shows our performance from April 2014 to February 2018 with regards to our A&E, Inpatient and Maternity FFT scores.

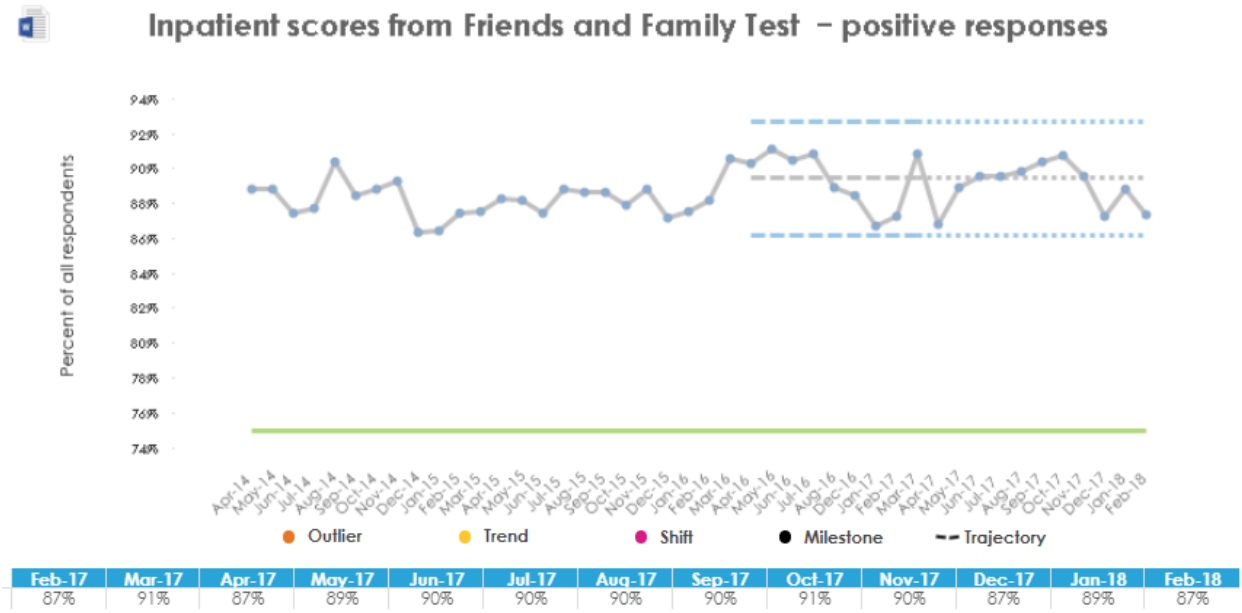
The scores for A&E suggest that there has been a significant improvement in our FFT scores that started in April 2017 and has been maintained since then. This has been driven by an improvement at the Royal Free Hospital site, likely to be linked to the opening of the new Emergency Department in 2017.
For all other areas we have maintained performance over the last year.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
84%	82%	83%	85%	85%	83%	85%	83%	84%	84%	83%	84%	83%

Source: Royal Free London NHS FT 2014-2018

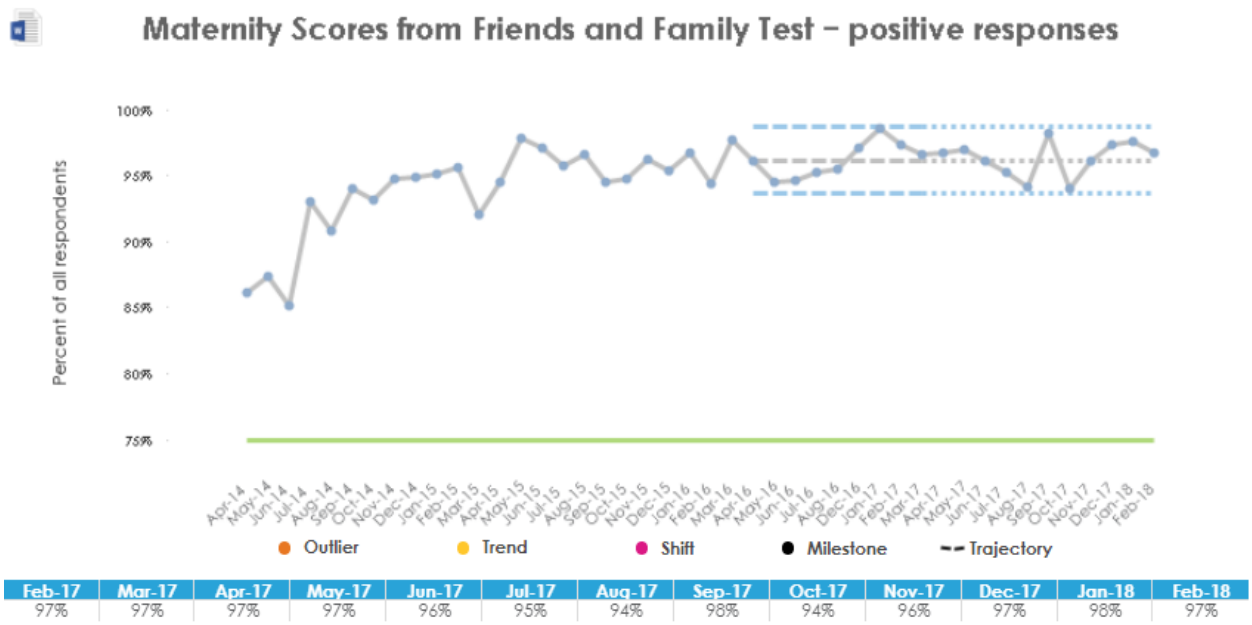
The FFT scores for inpatients have remained stable over 2017/18. Any variation has been within expected limits.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
87%	91%	87%	89%	90%	90%	90%	90%	91%	90%	87%	89%	87%

Source: Royal Free London NHS FT 2014-2018

The FFT scores for maternity have remained stable over 2017/18. Any variation has been within expected limits.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
97%	97%	97%	97%	96%	95%	94%	98%	94%	96%	97%	98%	97%

Source: Royal Free London NHS FT 2014-2018

[To include: benchmark information from Methods once charts have been updated]

3.2 Performance against key national indicators

The following indicators are reported in accordance with national indicator definitions.

Monitors Indicators of Governance	Target	Q1	Q2	Q3	Q4	2017-18
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	>=95%	88.4%	86.5%	86.2%	TBC	TBC
**C difficile number of cases against plan	18/Qtr	20	23	21	TBC	TBC
**Maximum time of 18 weeks from point of referral to treatment in aggregate for patients on an incomplete pathways (reported as proportion of waiting list at end of quarter waiting under 18 weeks)	>=92%	92.3%	87.3%	86.7%	TBC	TBC
**Cancer: two week wait from referral to date first seen						
All cancers	>=93%	93.6%	92.9%	94.0%	TBC	TBC
Symptomatic breast patients	>=93%	92.5%	93.7%	95.1%	TBC	TBC
**All cancers: 31 day wait from diagnosis to first treatment	>=96%	97.5%	96.9%	98.6%	TBC	TBC
**All Cancer 31 day second or subsequent treatment -						
surgery	>=94%	98.4%	96.0%	98.5%	TBC	TBC
drug	>=98%	100%	100%	100%	TBC	TBC
radiotherapy	>=94%	100%	100%	100%	TBC	TBC
**All Cancer 62 days wait for first treatment:						
from urgent GP referrals:	>=85%	83.5%	79.4%	85.1%	TBC	TBC
from a screening service	>=90%	85.7%	96.3%	89.2%	TBC	TBC

Our plans: Details of CQC inspections during 2017/18 and implementing the priority clinical standards for seven day hospital services.

This section contains details on our CQC action plans following both announced and unannounced inspections undertaken at both our Royal Free and Barnet hospital sites and our plans to implement the priority clinical standards for seven day hospital services.

Care Quality Commission (CQC): details of our inspections and action plan

The CQC undertook the following unannounced responsive and announced inspections during 2017 at the Royal Free Hospital Hampstead site.

11 July 2017

Further to the initial raised concerns in December 2016, the CQC has received further raised concerns for the services at Mary Rankin Dialysis Unit and in response to this, undertook an unannounced inspection to the unit on 11 July 2017. The inspectors found that patients had been left for short periods of time during staff breaks but there was no evidence that patients had been harmed to the inspection but it was considered to be an unnecessary risk.

The CQC did not provide a rating of the unit and identified 6 specific areas of practice that the trust should consider making improvements relating to personal protective equipment (PPE) , sharps bin labelling, storage of cleaning solutions, fire evacuation instructions, recording of patient competence and the supervision and support of staff by managers.

The trust has developed a responsive action plan in relation to the improvements identified. The Royal Free Hospital Executive committee monitors the implementation of the improvement actions and receives the updates from the clinical service leads for the Mary Rankin Dialysis Unit.

18 July 2017

The CQC undertook an unannounced inspection of the Royal Free hospital critical care unit on 18 July. The inspection was undertaken because the CQC had received anonymous information that the implementation of a new patient record IT system had meant that patients had been harmed and was creating an ongoing risk to patient safety.

During the inspection the CQC found no evidence that patients had been harmed or were at a higher risk of harm as a result of the implementation and use of the new IT system. The CQC did not provide a rating of the unit and found evidence of significant and persistent disagreement and conflict between staff at different levels of responsibility. The senior leadership team had not demonstrably addressed this nor implemented timely strategies to reduce pressure on affected staff.

In response to the inspection the trust undertook targeted work with NHS Elect regarding staff in ITU at the Royal Free site to deliver a listening/engagement exercise with all staff groups to support the development of the ICU strategy. The aim is to build consensus on the aspirations, goals, and ambitions for the unit.

The Royal Free Hospital Executive committee monitors the implementation of the ICU strategy and receives the update of the improvement actions from the clinical service leads for Intensive care.

1 September 2017 and 7 December 2017

The CQC carried out a focussed inspection of Camden and Islington NHS Foundation Trust's psychiatric liaison service 30 August to 1 September 2017 Across Three acute trusts:

• The Whittington Health NHS Trust
• University College London Hospitals NHS
• The Royal Free London NHS Foundation Trust (1 September and 7 December 2017)

In response to a serious incident that took place at The Whittington Hospital in November 2016 that resulted in a patient death.

The CQC did not provide a rating as this was a focussed inspection and identified six specific areas of practice that the Camden and Islington trust should consider. These included:

- making improvements relating to observations of mental health patients that these are carried out effectively by suitably trained staff.
- Ensure they update the environment of the assessment rooms as planned and complete risk assessments of the furniture.
- Reduce the number of patients leaving the ED before being assessed, especially at the Whittington.
- Ensure it provides patients with all relevant information about their care in a suitable format.
- Continue to recruit to the liaison teams across all three sites and complete full and detailed care records, including the time and full detail of assessments.

The Royal Free London NHS FT alongside the other two acute trusts has engaged with Camden and Islington to develop a joint action plan following the serious incident involving the death of a patient.

The trust receives from Camden and Islington liaison staff regular training sessions delivered to acute staff working in ED to develop their knowledge of mental health patients.

The trusts assessment rooms in the ED offered appropriate levels of privacy and provided an environment where patients could wait in comfort, however these will be further improved on the completion of the Royal Free Hospital emergency department refurbishment plans.

The Royal Free Hospital Executive committee monitors the implementation of the emergency department refurbishment and receives the update of the improvement actions from the clinical service leads for emergency care.

19 February 2018

The CQC undertook a review of services for looked after children and safeguarding in Barnet. The inspection focussed on the quality of health services for looked after children, and the effectiveness of safeguarding arrangements for all children in the area.

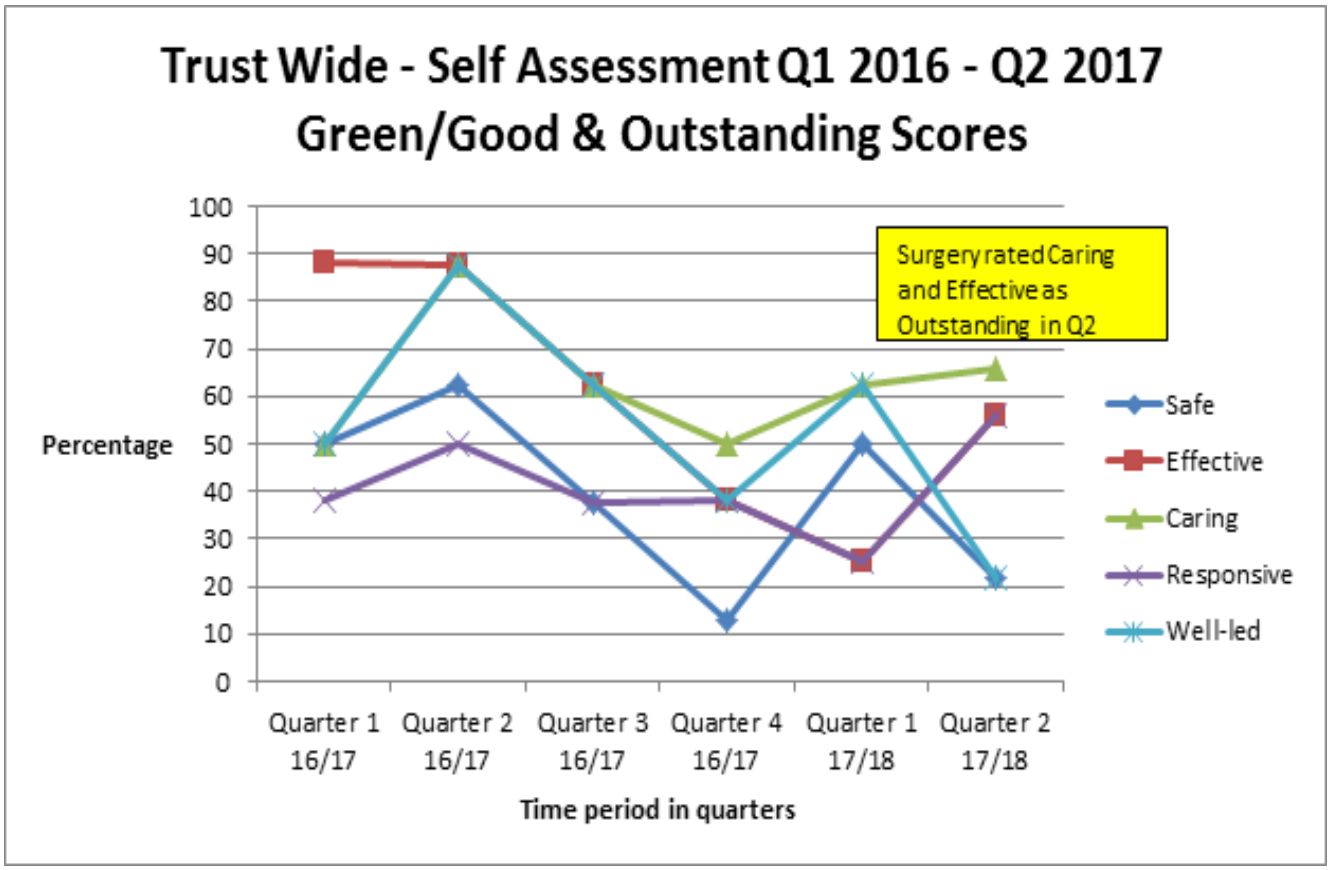
The inspection included paediatric and maternity services at Barnet Hospital. The trust is awaiting the final outcome report of this inspection although initial verbal feedback given to the trust in February was very positive.

Action planning for improvement:

The quarterly CQC 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 developed responsive quality improvement initiatives across sites which further spreads and shared knowledge in areas of best practice amongst services in response to quality and safety outcomes.

Action planning following self-assessment enables the opportunities for teams to work collaboratively between operational and clinical intentions in order to drive the implementation of quality improvements as well as share ideas and best practice particularly amongst cross site clinical teams.



Percentage scores are derived from the number of green scores identified for each of the eight core services reported throughout the 2016/17 and 17/18 quarterly self-assessment executive panel review meetings.

NB: The chart above will be updated with Q3 and Q4 scores by final submission.

In line with the Trusts Quality Goals all sites are aiming to be the top 10% at self-assessing core services as CQC Outstanding.

Further to the trust comprehensive inspection in 2016, a list of improvement actions have been undertaken in response in addition to the following improvement work.

Summary of key achievements (Trust CQC Inspection and Must / Should Do Actions)

The Royal Free London NHS Foundation Trust should review and ratify the Safer Surgery Policy. In September 2016 the policy was ratified and has been aligned to the Safer Surgery Quality Improvement Work-stream across the organisation.	Barnet Hospital **should** successfully complete a **15 Steps Challenge audit** and was undertaken on a paediatric ward. Results from the audit were **good** and from the patient feedback further **improvements are now underway.**	**10 North** at the Royal Free Hospital officially **opened an activity day** on the 5th December 2017 room adapted specifically for dementia and elderly patients. Since the opening 10 North have increased **discharge rates, patient experience** and **reduced length of stay.**
The Trust should ensure that Referral to Treatment Time is met in accordance to national standards and in June 2016 the Outpatient services successfully met the 90% target.	**Critical Care services should** be regularly collecting and submitting data to ICNARC and since the last CQC inspection the Trust has been **consistently contributing** to the ICNARC report and benchmarking performance against other similar hospitals.	**Endoscopy services** were **awarded a JAG accreditation** in 2017, an award that is only awarded to **high quality** gastrointestinal endoscopy services. Endoscopy services have met the competence to deliver against the set criteria set out in the JAG standards.
Theatre recovery staff must receive PILS training which has begun at Barnet Hospital. PILS training is now mandatory and along with the PARR Team, up to ??% of staff have been trained at Barnet.	In January 2018 the Surgical Assessment Unit **(SAU) opened** at Barnet Hospital, freeing up 16 bays for medical patients and **improving patient flow** at the hospital. The surgical team can now accept patients referred directly by GPs or from the emergency department (ED), **reducing ED waiting times** and improving patient experience.	Since February 2018 all clinicians at the Urgent Care Centre **(UCC)** at Chase Farm Hospital are now **successfully recording all patient records on an electronic system.** Patient records are now more secure, current and accessible and Chase Farm Hospital is closer to becoming a **paperless site.**
Urgent and emergency care must and did complete removing all emergency drugs such as Sodium Bicarbonate and Adrenaline from Resuscitaires.		

Implementing the priority clinical standards for seven day hospital services

The trust is part of a regional support group for the 7 day services implementation and audit (North Central London 7-day service Network Group). The purpose of the group is to discuss the audit process, share ideas on how to approach it and provide a safe space for open discussion. The group includes representatives from University College London Hospital (UCLH), Royal Free, North Middlesex hospital and the Whittington hospital and NHS England.

The RFL Group's performance on the NHSE 7 day services audit in October 2017 showed that for Standard 2, 63% of patients were seen by a consultant within 14 hours of the decision to admit against a national average performance of 73%. Barnet Hospital and Royal Free hospital each carried out an internal audit in February 2018 in order to obtain a snapshot to further understand the issues related to our performance against standard 2.

We are now preparing for the fifth round of audit and are focusing on the need to embed standardised audit processes within divisions and our hospital sites. In the longer term, this lends itself to a quality improvement project and this will be considered by our working group on seven day services when this first convenes in 2018-19.

The following steps will be undertaken to support the implementation of the priority clinical standards for seven day hospital services.

Seven Day Services Review Board

- Development at group level with site based ownership to help drive improvement work, alongside Clinical Practice Groups
- Review provision of services outside of standard working hours
- Ensure consistent quality of services for acutely unwell patients on a 24/7 basis
- Achieve compliance with National Seven Day Service standards (priority Standard 2)
- Review evidence base and audit data to inform improvements in care provision and support the trust efforts to manage flow.

Engagement

- Involvement of junior and senior clinicians in audit process and steering board
- Multi-divisional support for audit process and review of data
- Clear ownership for 7 Day Services Review process to inform business as usual
- Consider small scale QI project to test Standard 2 (such as asking patients to track number of hours to consultant review) as part of trust target of 50 QI projects

Audit process

- Consider the continuation of a prospective approach to ensure high quality data and adequate engagement with clinicians during audit week
- Operational and site based ownership and involvement to help drive audit and data collection
- Enhanced communications to clinical and non-clinical staff
- Embed any lessons learnt from previous audits (including the Health care records audit) and ensure that the results are triangulated and communicated effectively

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, Imagining available	In practice most of this information is discussed before, so this is used as a final check. Surgeons may use this opportunity to check that antibiotics prophylaxis has been administered.
4. Sign out	Before staff leave theatre	**Confirmation of recording of procedure:** • instruments, swabs and sharps correct • specimens correctly labelled. • equipment issues addressed • Post-operative management discussed and handed over
5. Debriefing	At the end of the list	Evaluate list Learn from incidents Remedy problems, e.g. equipment failure Can be used to discuss five–step process

Glossary of Terms

Term	Explanation
ASA	The ASA physical status classification system is a system for assessing the fitness of patients before surgery adopted by the American Society of Anesthesiologists (ASA) in 1963.
Best Practice Tarriff (BPT)	A BPT is a national price that is designed to incentivise quality and cost effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review. The aim is to reduce unexplained variation in clinical quality and spread best practice.
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.
DeepMind.	DeepMind is a technology company that is in partnership with the Royal Free London NHS Foundation Trust which has created a new app called Streams. The new app detects early signs of kidney failure and is now being used to improve care for some of the Royal Free's most vulnerable patients by directing clinicians to patients who are at risk of or who have developed a serious condition called acute kidney injury (AKI).
HIMSS	Healthcare Information and Management Systems Society (HIMSS) are a not-for-profit organisation that is based in Chicago with additional offices in North America, Europe, United Kingdom and Asia. Their aim is to be leaders of health transformation through health information and technology with the expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare and care outcomes. HIMSS drives innovative, forward thinking around best uses of information and technology in support of better connected care, improved population health and low cost of care.
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	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

(PARRT).	(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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AGENDA ITEM 10

Barnet Health Overview and Scrutiny Committee

24 May 2018

Title	Barnet Breastfeeding Support Service
Report of	Strategic Director for Adults, Communities and Health
Wards	All
Status	Public
Key	No
Urgent	No
Enclosures	Appendix A – Minutes Extract: Barnet Health Overview and Scrutiny Committee Meeting, 5 February 2018, Agenda Item 6a (Member's Item in the name of Councillor Alison Cornelius) Appendix B: Update Report from CLCH, LBB and Joint Commissioning Unit Appendix C - Summer Term 2018 Barnet Support Service Group Timetable
Officer Contact Details	Anita Vukomanovic Anita.Vukomanovic@barnet.gov.uk 0208 359 7034

Summary

At its meeting on 5 February 2018, the Committee received a Member's Item in the name of Councillor Alison Cornelius. Following the consideration of the Member's Item, the Committee resolved to receive a report at their May 2018 meeting and instruct Officers to liaise with CLCH detailing the breastfeeding support services and locations including the provisions of the contract extension. The document attached at Appendix B sets provides this report. Officers will be in attendance on the evening to respond to questions from Member of the Committee.

Recommendations

1. **That the Committee note the report.**

1. WHY THIS REPORT IS NEEDED

The Committee have requested to a receive a report on Breastfeeding Support Services at their May 2018 meeting.

2. REASONS FOR RECOMMENDATIONS

2.1 The report provides the Committee with the opportunity to be briefed on this matter. They are empowered to make further recommendations should they wish.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 The views of the Committee in relation to this matter will be considered by the Health Overview and Scrutiny Committee.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.11 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 Not applicable.

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 The Council's Constitution (Article 7) 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."

5.5 Risk Management

5.5.1 There are no risks. Not receiving this report would present a risk in that the Committee might not be properly appraised of the breastfeeding support service.

5.6 Equalities and Diversity

5.6.1 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.

5.6.2 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.*

5.6.3 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.

5.7 Consultation and Engagement

Not applicable.

5.8 **Corporate Parenting:**

Not applicable.

6. BACKGROUND PAPERS

6.1 None.

Appendix A: Minute Extract from Member's Item in the name of Cllr. Alison Cornelius at the meeting of the Barnet HOSC on 5 February 2018

The Chairman introduced the Member's item in her name and noted that at the January Full Council meeting, the Leader had confirmed the extension of the Breastfeeding Support Service beyond the end date of the current contract with CLCH.

Upon invitation of the Chairman, Councillor Helena Hart, Chairman of the Health and Wellbeing Board, joined the meeting. Councillor Hart informed the Committee that in accordance with the Joint Health and Wellbeing Strategy 2015-2020, the Health and Wellbeing Board as a partnership is fully signed up to promoting successful breastfeeding particularly among younger and first time older mothers.

One of the ways in which this is currently supported is through a breastfeeding peer support service Contract with CLCH – the future of which is due for consideration by the Policy and Resources Committee on 13 February 2018. Councillor Hart noted that the Committee will be updated following the decision of the Policy and Resources Committee and the outcome of the ongoing discussions with CLCH.

RESOLVED that:

The Committee requested to receive a report at its next meeting on 24 May 2018 and instructed Officers to prepare a report detailing the provision of all Breastfeeding Support Services in Barnet, the delivery locations and details of the contract extension with CLCH.
(**Action**: Forward Work Programme)

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Appendix B: HOSC Paper regarding Breastfeeding peer support service in Barnet

24 May 2018

The Barnet breastfeeding peer support service, which was established in 2014, provides a pathway of breastfeeding support services within hospital and community settings. The service provides universal support with an added focus on those vulnerable mothers. It has achieved UNICEF UK Baby Friendly Initiative accreditation at level 2.

The Breast Feeding Service is funded through the public health grant and is provided by Central London Community Healthcare Trust. It consists of a coordinator and a team of paid breastfeeding support workers who provide training, advice and support to parents and professionals. There are also a small number of breastfeeding support volunteers who work alongside the peer supporters in drop in's within the borough.

The contract was renewed as part of the Public Health Nursing contract until March 2020 following a Policy and Resources committee decision in February 2018. As part of the extension a transformation is underway so the service can deliver the healthy child programme in Barnet. A steering group and stakeholder group have been set up, with specific workstreams to design the delivery model for the next two years.

The intention is that the service will continue by being embedded in a variety of services so that the support given to parents is mainstreamed and becomes part of business as usual. It will be embedded within the 0-19 hubs and form part of the multi-agency early help offer building on the work that already takes place in children's centres through the breast feeding buddies (who are children's centre staff). Health visitors, midwifery and nursery nurses will also form part of this service and will offer breast feeding support too. Breastfeeding support is also available from national sources e.g. NHS choices and the national breastfeeding network.

The intention is that the following services will continue to be available to Barnet residents:

- Breastfeeding drop in sessions for advice and support in a number of settings, including children centres and health visitor clinics.
- Staff trained to give advice to mothers when they have breastfeeding questions or need support, whether at home or in a clinic or children centre group
- Telephone advice from the health visitors and children centres and signposting to national information e.g. NHS choices.
- Access to the national breastfeeding support telephone helpline

There is a planned engagement event on the 24 May on breast feeding support, which is being designed to elicit the views and wishes of Barnet residents and stakeholders about breastfeeding support to inform the future detailed design of the service, including local and national support.

Clare Slater-Robins, Senior CYP Commissioner, Joint Commissioning Unit, LBB

Janet Lewis Director of Operations, Central London Community Healthcare Trust

Collette McCarthy, Director of Commissioning, LBB

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Central London Community Healthcare NHS
NHS Trust
Your healthcare closer to home

Barnet Breastfeeding Support Service Drop in Timetable

Summer Term 2018 (17/04/2018 – 25/05/2018)

Monday	Tuesday	Wednesday	Thursday	Friday
Parkfield Children's Centre 44 Park Road, Hendon, NW4 3PS 1:30 – 3pm With Rachel	**Coppetts Wood Children's Centre** Coppetts wood primary school Coppetts Road, Friern Barnet, N10 1JS 10.00am – 12.00pm With Miriam/Rachel (Term time only)	**Torrington Park Health Centre** 16 Torrington road, Finchley, N12 9SS 1pm – 3pm With Georgie (Term time only)	**Hope Corner Community Centre** 185 Mays Lane, EN5 2DY 10.30am – 12.30pm With Cheryl *Baby play Group with breastfeeding support*	**Barnfield Children's Centre** Silkstream Road, Edgware HA8 0DA 10am – 12pm With Sadie *Antenatal & Postnatal breastfeeding advice*
Newstead Children's Centre 1 Fallows Close, London N2 8LG 11am – 1pm With Natalie *Baby play group with breastfeeding support* (Term time only)	**Fairway Children's Centre** (based at Fairway School) The Fairway, Mill Hill NW7 3HS 1pm – 3pm With Sadie	**All Saints Church Hall** 122 Oakleigh Road North,N20 9EZ 1pm – 2.30pm With Sadie *Baby play group with breastfeeding support*		**Underhill Children's Centre** Mays Lane, Barnet EN5 2LZ 11.30 am – 1.30pm with Georgie (Term time only) & the midwives

- This is a free drop in service.
- Please note Breastfeeding Supporters listed are not always at the same group each week and sometimes change venue.
- Last mum will be seen 30mins before end of each session

Like our Facebook page: "Breastfeeding Support in Barnet" to be kept updated with the groups. Alternatively call 07815717055, Mon – Fri, 9am – 5pm to check the group you wish to attend is running.

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London Borough of Barnet Health Overview and Scrutiny Forward Work Programme May 2018 – April 2019

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AGENDA ITEM 11

Title of Report	Overview of decision	Report Of *(officer)*	Issue Type (Non key/Key/Urgent)
24 May 2018			
NHS and Hospice Quality Accounts	Committee to receive the Annual Quality Accounts from NHS Trusts and the North London Hospice	Strategic Director for Adults, Communities and Health	**Non-key**
Breastfeeding Support Service	Committee to receive a report on the Breastfeeding Support Service	Strategic Director for Adults, Communities and Health	**Non-Key**
12 July 2018			
Healthwatch Homecare Report	Committee to receive Healthwatch Barnet's Homecare Report		
18 October 2018			
21 November 2018			
21 February 2019			
To be allocated			
Enter and Revisit reports	Report on the enter and revisit reviews by Healthwatch.	Healthwatch Barnet	**Non-key**
Suicide Prevention in Barnet	Committee to receive an annual report from Public Health on Suicide Prevention in Barnet	Public Health Team	
Update Report: Finchley Memorial Hospital	Committee to receive an update report as a standing item on Finchley Memorial Hospital	Barnet CCG	**Non-Key**

London Borough of Barnet Health Overview and Scrutiny Forward Work Programme May 2018 – April 2019

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AGENDA ITEM 13

Title of Report	**Overview of decision**	**Report Of** *(officer)*	**Issue Type (Non key/Key/Urgent)**
24 May 2018			
NHS and Hospice Quality Accounts	Committee to receive the Annual Quality Accounts from NHS Trusts and the North London Hospice	Strategic Director for Adults, Communities and Health	**Non-key**
Breastfeeding Support Service	Committee to receive a report on the Breastfeeding Support Service	Strategic Director for Adults, Communities and Health	**Non-Key**
12 July 2018			
Healthwatch Homecare Report	Committee to receive Healthwatch Barnet's Homecare Report		**Non-Key**
18 October 2018			
21 November 2018			
21 February 2019			
To be allocated			
Enter and Revisit reports	Report on the enter and revisit reviews by Healthwatch.	Healthwatch Barnet	**Non-key**
Suicide Prevention in Barnet	Committee to receive an annual report from Public Health on Suicide Prevention in Barnet	Public Health Team	**Non-Key**
Update Report: Finchley Memorial Hospital	Committee to receive an update report as a standing item on Finchley Memorial Hospital	Barnet CCG	**Non-Key**