

MEETING

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

WEDNESDAY 15TH MAY, 2019

AT 7.00 PM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

Chairman: Councillor Alison Cornelius
Vice Chairman: Councillor Val Duschinsky

Councillors

Councillor Golnar Bokaei Councillor Linda Freedman
Councillor Geof Cooke Councillor Anne Hutton
Councillor Saira Don Councillor Alison Moore
Councillor Paul Edwards

Substitute Members

Councillor Lachhya Gurung
Councillor Kath McGurik
Councillor David Longstaff
Councillor Ammar Naqvi
Councillor Barry Rawlings

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10am on the third working day before the date of the committee meeting. The deadline for public questions or comments is **10am, Friday 10 May 2019**. Requests must be submitted to tracy.scollin@barnet.gov.uk.

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

Andrew Charlwood – Head of Governance

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Decisions of the Health Overview and Scrutiny Committee

21 February 2019

AGENDA ITEM 1

Members Present:-

Cllr Alison Cornelius (Chairman)
Cllr Val Duschinsky (Vice-Chairman)
Cllr Golnar Bokaei
Cllr Paul Edwards
Cllr Saira Don
Cllr Linda Freedman
Cllr Anne Hutton
Cllr Alison Moore
Cllr Barry Rawlings (Substitute)

Also in attendance

Ms Dawn Wakeling – Strategic Director, Adults, Communities and Health
Dr Jeff Lake, Consultant in Public Health, LB Barnet
Dr Steve Shaw, Chief Executive of Barnet Hospital, Royal Free London NHS Foundation Trust
Ms Linda Cregan, Food Service Director, ISS Barnet
Ms Karin Hafner Operations Manager, Barnet Education
Mr Eugene Prinsloo – Developments Director, Community Health Partnerships (CHP)
Ruth Donaldson, Director of Commissioning, Barnet CCG
Colette Wood, Programme Lead, Care Closer to Home Integrated Networks (CHINs), Barnet CCG

Apologies for Absence

Cllr Geof Cooke

1. MINUTES (Agenda Item 1):

The Chairman asked Dr Shaw, Chief Executive of Barnet Hospital, Royal Free London NHS Foundation Trust to follow up on a query (page 10 of the previous Minutes): the Committee had asked whether the data on Quality vs Reference Costs 2017/18 for the Royal Free Group could be broken down into individual hospitals. Dr Shaw agreed to follow this up.

Action: Dr Shaw

Dr Shaw confirmed that the Barnet Hospital patient discussed at the last meeting had returned to North Lincolnshire (page 10, previous Minutes).

Resolved - the Minutes of the meeting held on 21 November were approved as an accurate record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies were received from Cllr Cooke, who was substituted by Cllr Rawlings.

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

None.

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

None.

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

None.

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

None.

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

The minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting held on 30 November 2018 were noted.

The Chairman reported that Caroline Clarke had recently been appointed Group CEO of the Royal Free London NHS FoundationTrust.

The next meeting of the JHOSC would be held on Friday 15 March in Islington.

8. DIABETES PREVENTION UPDATE (Agenda Item 8):

The Chairman invited the following to the table:

- Dr Jeff Lake - Consultant in Public Health, LB Barnet
- Colette Wood – Programme Lead, Care Closer to Home Integrated Networks (CHINs), Barnet CCG

Dr Lake reported that a wide range of initiatives around diabetes prevention, detection and management had been introduced in recent years in Barnet. He thanked Cllr Caroline Stock for championing a successful local campaign, including public events.

In addition, Dr Lake reported that a Pre-Diabetes Service (the National Diabetes Prevention Programme – NDPP) has been delivered in Barnet providing a nine month programme for the management of patients just below the diagnosable level of diabetes. The NHS Long Term Plan signals an intention to expand this provision. Locally, GPs have been incentivised to embed the annual review of patients identified at risk and assessment of motivation to change leading to brief advice and where appropriate referral to the NDPP.

A group consultation initiative is also underway in Barnet which aims to replace routine appointments with group based reviews and providing an opportunity for advice on self-care and peer support. At Millway Medical Practice, group consultations with prediabetics have demonstrated remarkable success with all patients recruited no longer demonstrating markers indicative of prediabetes after a few months.

Physical activity and healthy eating were also being promoted and Barnet has signed the Local Government Declaration on Sugar Reduction. A 'One You' Self-Help website incorporating resources to support behaviour change will be launched shortly.

Dr Lake noted that his report recommended a coordinated approach to diabetes to be overseen by the Quality Improvement Support Team (QIST). He qualified this recommendation, in that whilst greater impact could be delivered by coordinating actions on prevention, detection and management of diabetes, the organisation or service to lead on co-ordination still needed to be determined.

The Chairman noted that 90% of people with Diabetes have Type 2 which is "largely preventable and manageable by lifestyle changes" (page 14, 1.2 of the report). Given the high cost of the disease, as noted in the report and which continues to increase, she asked if more up-to-date figures on cost were available as the report cited data for 2015. Dr Lake responded that a comparable breakdown of costs had not been produced since 2015 but that it is generally accepted that around 10% of NHS expenditure is attributable to Diabetes.

A Member asked what could be done about the high incidence of diabetes in South Asian and Black populations. Dr Lake noted that this was partly due to genetic predisposition but also to aspects of dietary practices in certain communities. Healthy eating messages had not been specific to those communities so it was important to address this.

A Member asked what could be done to raise awareness and to reduce the prevalence of diabetes – she referred to page 14, 1.3 of the report - that there are likely to be over 8000 people with undiagnosed diabetes in the Borough". Dr Lake responded that programmes were in place with Barnet schools and some workplaces in an attempt to embed healthy lifestyles and various resources and support are available to support behaviour change. The Sugar Reduction Declaration is a positive step but more work was required to raise awareness. Childhood obesity in the UK is also a longstanding issue that needs to be tackled. He hoped that the QIST could help to start to embed prevention and detection of diabetes into Primary Care locally.

Ms Wakeling reported that Barnet had many workstreams in place involving schools and leisure services. The QIST would be working on reducing variation in detection and management of diabetes in Primary Care.

Ms Wood commented that the focus on diabetes which had been successful in the Burnt Oak CHIN, would be extended across the Borough. The CCG was looking at everything it could do from prevention to treatment to improve outcomes for patients in Barnet.

A Member mentioned that the Barnet Asian Women's Association had been promoting the message on healthy eating for some time so it would be helpful to have more focus on such groups in the future.

A Member asked when some Key Performance Indicators (KPIs) were likely to be available so that the impact of the interventions could be measured. Dr Lake responded that historically KPIs had focused on management after diagnosis but the culture was beginning to change with more focus beginning to be made on detection and prevention, so he hoped that KPIs would be developed around this soon.

A Member said that the mobile diabetes testing in Burnt Oak had found 25% of those tested to be diabetic or pre-diabetic. Often the poorest health indicators were found in residents with limited budgets. Could there be some collective intervention to help those residents?

Dr Lake responded that there is a wider programme of work promoting healthy eating, including trying to improve people's awareness of food options on limited budgets and their ability to cook. Ms Wakeling reported that the Public Health team had launched a Food Security Report and Action Plan for Barnet to ensure that residents have access to sufficient nutrition. She would circulate details to the Committee.

(Note: circulated on 25.04.19)

A Member asked how the impact of the programme would be measured since prevention could be difficult to measure. Dr Lake responded that its evaluation was ongoing nationally as part of the NDPP.

A Member referred to the figure of 8000 given in the report as the number of residents estimated to be undiagnosed diabetic or pre-diabetic. Given Barnet's population and age profile, is the true figure likely to be even higher? Dr Lake responded that the data was age adjusted so based on the best evidence to inform estimates.

A Member noted that previous work with Diabetes UK had revealed that they were aware of the Asian community in Barnet and the probable challenge for the Borough in tackling diabetes.

A Member commented that he was disappointed to see nothing in the report about child poverty since this was a major factor in poor health outcomes. Families with limited budgets were known to have diets high in white flour, potatoes, white pasta etc. leading to obesity and diabetes. The Member added that during half term the Rainbow Centre in Barnet had provided meals for 50 children daily. Poverty was a reality in Barnet and needed to be highlighted. Dr Lake responded that his report could have mentioned related pieces of work such as the Food Security Report which looked into this in greater detail.

A Member suggested that some of the information discussed be made available to the Children's Committee to help to raise awareness. The Chairman agreed, adding that a fifth of under five-year olds was known to be overweight or obese and this same group had a higher incidence of tooth decay. This had already been reported to the Children's Committee. She would speak with the Children's Committee Chairman.

Action: Chairman

The Chairman congratulated Dr Shaw and Barnet Hospital (BH) on the food made available to the staff and public in the canteen at BH and the changes that had been made to encourage healthier eating. She asked Dr Shaw to provide information on meals made available to patients. Dr Shaw agreed to provide this.

Action: Dr Shaw

Resolved that the Committee note the report.

9. ISS BARNET SCHOOLS - HEALTHY EATING (Agenda Item 9):

The Chairman invited to the table:

- Ms Linda Cregan - Food Service Director, ISS Barnet

- Ms Karin Hafner - Operations Manager, Barnet Education

Ms Cregan spoke to her presentation which was circulated and expanded on the presentation in the agenda. She also gave the Committee sample school menus, numerous leaflets and a list of schools where ISS provides catering services. She gave an overview of statistics on children's diet in England and work that was ongoing in Barnet to improve diet and exercise levels, as outlined in her presentation. This included a reduction in the amount of sugary foods available in schools, recipes for families to try at home, parents' taster events and school breakfasts and lunches.

ISS caters for a large number of schools and 90% of its food is local seasonal produce freshly prepared on-site every day. ISS was currently rolling out dessert free days by substituting fruit on four days of the week.

Ms Cregan reported that ISS runs food education days, pupil and parent cooking clubs, exercise workshops and gardening days in schools and works to help promote healthy eating messages. ISS also provides special diets for medical reasons and ensures its staff understand what ISS is trying to achieve. At lunch queues in schools 'snacking stations' were provided with healthy choices, as well as free hydration points with flavoured water, i.e. water with added cucumber and lemon slices – not sugar. ISS also continually seeks feedback from both Primary and Secondary school children.

A Member commented that some parents had fed back that pupils spend their lunch money on sugary snacks at break time and as a result could not afford lunch. Ms Cregan responded that ISS's strict guidelines were applied throughout the day, meaning that crisps, chocolate and fizzy drinks were never served in any of the schools that ISS cater for. However, some bread-type items were provided for break times. A price list was circulated at the meeting.

At the Council meeting on 29 January, a Member who is a School Governor reported that a parent had told her that the hot lunches were good but sandwich options provided by ISS were of poor quality. Ms Cregan said she would look into this and report back to the Committee.

Action: Ms Cregan

A parent at the same school had also reported that there were a lot of cakes and biscuits available and a teacher had commented that "the only way the Catering Company can make money is to increase the amount of sugar as that is where the profit margins are". Ms Cregan stated that cakes and biscuits were not permitted by ISS.

The Member also enquired about the sugary drink cartons that remained the same price despite a reduction in size. Ms Cregan responded that the Children's Food Trust had worked with manufacturers to reduce the cartons to 250ml. This related mostly to fruit juices. Ms Hafner thought this had happened prior to ISS becoming involved with the catering in some Barnet schools.

A Member asked how Years 5 and 6 could be encouraged to continue with healthy eating in light of the move to cafeteria-style lunches. Ms Cregan agreed that this was a challenge as free school meals stopped at this point. ISS was considering offering more choice at junior age and she hoped more information would be available on this by the end of 2019.

A Member asked about pressures on costs and how good quality food can be provided considering this. Ms Cregan responded that all ISS staff training focuses on efficiently providing the best quality healthy food within budget.

A Member asked what efforts were being made to help children to understand that they need to eat healthily. Ms Cregan responded that ISS nutritionists attend school assemblies to explain the impact of different foods in fun ways. Posters are supplied to schools and parent taster events are run twice a year with schools to explain what ISS is trying to achieve.

A Member enquired about food and allergies. Ms Cregan noted that ISS is extremely robust in this respect. Parents provide medical information so that a bespoke menu can be provided and all staff receive training in allergy management.

A Member, who was a School Governor at Totteridge Academy, reported that at a Health and Wellbeing event at the school it became known that none of the pupils had ever eaten porridge. The Member asked what could be done to address the issue of child hunger as this was part of the national picture. Ms Cregan responded that the Department of Health had introduced national programmes: it had provided £26 million for the Magic Breakfast campaign and was currently recruiting schools to this. The London Mayor was supporting the London Food Group which included school holiday time feeding programmes. Holiday feeding programmes tended to be charitable and more sporadic. The Department for Education would fund a series of national programmes in summer 2019. Funding could also be obtained via the London Food Board. Ms Cregan stated that ISS do not supply the catering at Totteridge Academy.

Resolved that the Committee noted the report.

10. EPR AND BARNET HOSPITAL PARKING (Agenda Item 10):

The Chairman invited to the table:

- Dr Steve Shaw - Chief Executive of Barnet Hospital, Royal Free London NHS Foundation Trust

Dr Shaw reported that the Royal Free London NHS Foundation Trust (RFL NHS Foundation Trust) had received funding from the Department of Health (DoH) for a new digital patient record system for BH and the RFH. Previous issues with the system had been resolved. Dr Shaw reported that he chairs two meetings per week with the Executive Team on progress of the project. The hospitals are now very paper-light with medical records in one place.

A Member asked whether any patients had raised any concerns about the new system. Dr Shaw responded that there had not been any concerns raised. The Chairman noted that a previous pathology issue had been quite serious. Dr Shaw reported that previously the laboratory's system had not interrelated well with the new system but this was now resolved. Any potential problems with the digital system are included in the Trust's Major Incident Training.

A Member asked whether handheld devices were being used in the Trust. Dr Shaw noted that this would be the way forward though it had only been introduced in relation to

renal services so far. The system had not reached the point that it was ready to roll out across the hospital.

Dr Shaw reported that efforts were being made to get staff to use a car-share app and that currently a procurement process was being carried out to supply a temporary two-storey modular car park at BH.

Dr Shaw added that he was committed to improving onsite parking capacity at BH and was also keen to collaborate with Barnet Council to ease the pressures on residential roads. Additional CPZs risked greater challenges for BH recruitment and retention. A planning application for the permanent car park and hospital extension would be submitted to Barnet around August 2019.

The Chairman advised the Committee that a review of the roads around the Hospital which are in a CPZ was being done. She informed the Committee that early last year the Environment Committee had voted to include BH in the Schools CPZ Scheme whereby staff in various Barnet Schools are able to buy permits allowing them to park in CPZs around their schools. The number of permits issued would be strictly controlled and would be calculated to allow for a maximum capacity of 80%. Cllr Edwards noted that he was not aware of this, even though BH was in his Ward.

Dr Shaw confirmed that BH received a large number of complaints from staff, patients and visitors about the lack of parking. He had met with Officers from the Highways Team to try to resolve some of the issues. Dr Shaw said he would be happy to meet with Cllr Edwards to discuss this matter further.

Resolved that the Committee noted the report.

11. WINTER PRESSURES ANALYSIS REPORT (Agenda Item 11):

The Chairman invited to the table:

- Dr Steve Shaw – Chief Executive of Barnet Hospital, Royal Free London NHS Foundation Trust
- Ruth Donaldson – Director of Commissioning, Barnet CCG
- Colette Wood – Programme Lead, CHINs, Barnet CCG

Ms Donaldson reported that much work had been done on delayed transfers of care and that Barnet now has one of the top performance indicators in London on ambulance turnaround times.

A weekend audit of Barnet's A&E would be carried out whereby patients would be asked why they had attended and whether they had tried other services first, such as their GP. Barnet stood 8th out of 18 in London for A&E performance.

Dr Shaw reported that the number of patients with 'Flu was down from the previous year. Dr Shaw noted that the 'Flu jab uptake for staff had been 50% lower than the previous year and it was important for the Trust to understand why this was the case.

Ms Donaldson reported that a strategy was in place for the GP Practices which had the most referrals to A&E. This involved developing Care Plans with GPs and looking at

reasons for repeat attendances. This had reduced 20% of attendances by the high-attending cohort.

Work is also ongoing with CHINs, particularly on trying to reduce variation in services.

Resolved that the Committee noted the report.

12. SUICIDE PREVENTION ANNUAL REPORT 2018-19 (Agenda Item 12):

The Chairman invited to the table:

- Dr Jeff Lake - Consultant in Public Health, LB Barnet

Dr Lake provided an update on actions from the 2018/19 report noting that council officers have been working with the police to explore ways of disseminating the *Help is at Hand* document for those who first meet a bereaved family after suicide. The Police had expressed an interest in 'Making Every Contact Count' training and this had been arranged from April 2019.

The Child Death Overview Panel's work had led to a useful understanding regarding safety planning at the point of discharge from hospital following self-harm or suicidal ideation. It had been found that patients and families were reluctant for information to be shared, so it may be helpful to develop some guidance for patients on how their data would be used.

Dr Lake reported that work was ongoing through Barnet's Schools Resilience Programme on building positive mental wellbeing and increasing capacity to respond to self-harm concerns.

A Member asked whether the increase in the incidence of self-harm over the past ten years could be attributed to social media sites. Dr Lake responded that there was a clear increasing trend and an increase in severity. The national attention to the role of social media recently was welcomed.

A Member noted that on page 49, 5.5.1 of the report, it states that "there is no statutory authority for Councils to require partners to take action" on suicide prevention. The Member asked if this was an impediment and whether there was a difference for minors. Dr Lake noted that where a safeguarding concern had been identified, the local Authority had a statutory role.

Dr Lake reported that Thrive London was shortly due to launch an information-sharing platform for partners on cases of suspected suicides. Also, coroners' data was being looked at in an attempt to create consistent reporting across London. A local audit of Barnet cases proved to be difficult to analyse due to the small number of cases suggesting that some trends might best be identified over wider geographical areas.

Ms Wakeling added that there is no statutory duty requiring other agencies to cooperate with the local Authority, in contrast to safeguarding issues for children or adults. She suggested that it would be helpful if the HOSC requested information directly from partners on the Suicide Prevention Working Group since it had the power to scrutinise this.

A Member suggested asking for information on the availability of counselling in the Borough and waiting times, since more funding had been provided for mental health recently.

Cllr Rawlings noted that he had had involvement with six suicide cases. The link between self-harm and a possible intention to commit suicide is not clear. Cllr Rawlings offered to speak to any relevant contact as he had had to deal with cases. Dr Lake would arrange this.

Action: Dr Lake

The Chairman noted that it would be useful to discuss suicide prevention at the July meeting and hopefully with some of the partners. It would be helpful to have some of the London-wide statistics.

Action: Governance Officer, Dr Lake

Resolved that the Committee noted the report.

13. SURPLUS LAND ADJACENT TO FINCHLEY MEMORIAL HOSPITAL OWNED BY COMMUNITY HEALTH PARTNERSHIPS (Agenda Item 13):

The Chairman invited to the table:

- Mr Eugene Prinsloo – Developments Director, Community Health Partnerships (CHP)

Mr Prinsloo reported that a meeting had been held on 20 February 2019 with Barnet's Planning Department. There was no firm recommendation for the land at this point. Work was ongoing on clarifying the final two options for the site, which will be either for NHS staff or general residential use, with some affordable housing.

The Chairman said that there is a lack of key worker housing and there is concern about this in relation to the site. A Member noted that there had been an opportunity to provide this at the Barnet Hospital site but this had been lost to an unpopular development that was unaffordable to most people. He urged Mr Prinsloo to seriously look into providing crucial affordable housing. Mr Prinsloo responded that as a company owned by the Department of Health this use was high on their agenda for the site given the problems with NHS workforce retention and recruitment.

A Member asked who owned the land at the northern corner which had a tree with a Protection Order on it. Mr Prinsloo responded that the freehold was owned by CHP and the entire site was let on a 25-year concession to the company that developed the hospital.

A Member urged Mr Prinsloo to consider service charges and other costs when considering housing that would be truly affordable to NHS staff as often key worker homes were too expensive. Mr Prinsloo noted that CHP would be working with the three Trusts in the area to consider which staff demographic needed this.

The Chairman asked Mr Prinsloo to attend a future meeting with an update. The clerk would add this to the Work Programme for an unspecific date.

Action: Governance Officer

Resolved that the Committee noted the report.

14. MID-YEAR QUALITY ACCOUNTS 2018-19 (Agenda Item 14):

Central London Community Healthcare NHS Trust, North London Hospice and Royal Free London NHS Foundation Trust

Resolved that the Committee noted the three reports.

15. HEALTH AND WELLBEING BOARD UPDATE (Agenda Item 15):

The Chairman invited to the table:

- Councillor Caroline Stock – Chairman, Barnet Health and Wellbeing Board

Cllr Stock informed the Committee about the following;

Nursery Schools in Barnet had also been included in the Sugar Reduction Declaration. Some schools have appointed ‘ambassadors’ to promote the consumption of healthy foods at breaks and lunch time.

Barnet Hospital has introduced a selection of meals with less than 500 calories and free water machines are now available.

There are going to be two Public Health Awareness days at Brent Cross Shopping Centre. The first is on 20 May and is an Awareness Day on Dementia and the second is on 11 June and is an Awareness Day about Diabetes.

The Samaritans have opened a new centre offering face-to-face support in Bounds Green.

The HWBB held their meeting on 17 January at Underhill School to listen to children’s views. There had been an interesting discussion on mental health and healthy eating.

Waitrose were raising money through their “Community Matters – Giving Back to the Community” scheme for Age UK’s Cookery for Widowers project.

Resolved that the Committee noted the verbal update.

16. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME (Agenda Item 16):

The Work Programme was agreed, subject to the amendments:

FMH to be discussed at a future meeting.

Suicide Prevention partners to be invited to the July meeting.

17. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 17):

None.

The meeting finished at 10.00 pm

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 18TH JANUARY, 2019** at 10.00 am in Committee Rooms 1 & 2, Haringey Civic Centre, High Road, London N22 8LE

AGENDA ITEM 7

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Tricia Clarke (Vice-Chair), Pippa Connor (Vice-Chair), Alison Cornelius, Lucia das Neves and Clare De Silva

MEMBERS OF THE COMMITTEE ABSENT

Councillors Huseyin Akpinar, Val Duschinsky, Julian Fulbrook and Osh Gantly

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 for absence were received from Councillors Huseyin Akpinar, Val Duschinsky and Osh Gantly.

Apologies for early departure were received from Councillor Clare de Silva.

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

There were no declarations of interest.

3. ANNOUNCEMENTS

There were no announcements.

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

There were no notifications of urgent business.

5. DEPUTATIONS (IF ANY)

There were no deputations.

6. MINUTES

Consideration was given to the minutes of the meeting held on 30th November 2018.

The Chair expressed concern of behalf of the Committee that they had not received figures on how capital receipts were being spent in North-Central London. She said she had been offered figures from the Royal Free but not any which were for the whole sub-region.

RESOLVED –

THAT the minutes of the meeting held on 30th November 2018 be approved and signed as a correct record.

7. NORTH LONDON PARTNERS MENTAL HEALTH PROGRAMME

Consideration was given to a report from North London Partners.

Chris Dzikiti (Mental Health Lead, NCL STP) and Will Huxter (Director of Strategy, NCL CCGs) presented the report to the Committee.

They highlighted that there was a significant unmet need for mental health services in the North Central London (NCL) area. They also mentioned the links that existed between mental illness and other forms of ill-health. There was a lower life expectancy among those with mental illness than in the general population; and individuals with mental health conditions were often frequent users of A & E services.

Officers were aiming for a model of care which was based around primary care in the community. They did not want hospitals to be seen as a 'home from home' for people with mental health conditions; they wanted them to receive the acute treatment they needed and then be able to return home. They wanted to see greater mental health awareness in primary care so that they could help individuals with mental health conditions and alleviate them in the way that they alleviated people's physical health conditions.

Mr Huxter and Mr Dzikiti said that perinatal mental health was a priority for the NCL mental health workstream. They had achieved a success with a Female Psychiatric Intensive Care Unit and had managed to eliminate out of area placements for that group.

Mr Dzikiti said that out of area placements remained a significant issue for patients in NCL. The sub-region had the 10th highest number of placements of young people out of area.

Members expressed disappointment that there was not data made clearly available in the report and presentation. They wanted to see data on matters such as out of area placements by borough and hospital and the costs incurred.

Members discussed the issue of people being taken to a place of safety under Section 136 of the Mental Health Act. Councillor Clarke said that she was aware of a constituent who had been injured by a patient who was mentally ill when they were visiting a relative in hospital. She felt that two mental health beds were not sufficient for S136 need.

Councillor das Neves raised the issue of the need for the Police to triage cases where individuals were displaying problematic behaviour but may have mental health difficulties and physical health problems too.

Mr Dzikiti informed the meeting that a 5-bed unit was being built at Highgate that could provide a place of safety for individuals who needed it when they were in a mental health crisis.

Members noted the importance of mental health services linking with other services in the community, such as housing, to help their service users.

A member from Islington raised the fact that Islington had one of the highest rates of suicide in the country and that she felt more suicide prevention work was required. Mr Dzikiti said that they were working on suicide prevention with the two mental health trusts and had a target to reduce it by 10%.

Members expressed concern about the differential occurrence of mental illness among various BME communities.

Councillor das Neves raised concerns about the links between poor mental health and crime. She noted that a study of 20 prolific young offenders had shown that there had been a high prevalence of mental health problems in their families.

Members also were concerned about the difficulty of young people accessing treatment. They mentioned cases they had come across where people had been told they were below the threshold for treatment; even though they had been through bad experiences and were displaying symptoms of mental illness.

Councillor Connor asked how the national plans to have 3000 mental health therapists co-located in primary care were progressing. She also highlighted that there was a loss of school counsellors due to budget cuts. She asked NCL partners to make contact with Network Learning Communities to ensure provision for schools.

Councillor Connor added that she did not want the opportunity to provide more beds on the St Ann's site to be missed.

Members wanted to see more mention of the voluntary and community sector in the documents. They felt that NCL partners could achieve more by working with them.

Members repeated their requests for more data. They wanted to see information on out of area placements, their costs and where the individuals being placed out of area came from and went to. They also asked for statistics on suicide, broken down by sex and age.

RESOLVED –

- (i) THAT the report and the comments above be noted.
- (ii) THAT the data requested by Committee members be provided.

8. NORTH LONDON PARTNERS MATERNITY PROGRAMME UPDATE

Consideration was given to a report from North London Partners.

Kaye Wilson (Head of Maternity Commissioning, NCL CCGs) and Rachel Lissauer (Director, Wellbeing Partnership, Haringey & Islington) addressed the Committee.

They explained that maternity services were provided on 4 hospital sites and 1 birth centre. There was a slightly decreasing but variable birth rate and the complexities of births were rising. They said that the number of 'complex' births were rising due to factors such as rising average maternal age and an increasing number of mothers with a high BMI.

The Chair said that there was a rumour that maternity units would be being consolidated because some of them dealt with too few births to be viable. Ms Wilson said that the Royal College did not recommend a set size for maternity units. However, continuity of care was important in delivering a good service and that was sometimes difficult in large units. She said that about 6000 births per year was probably an optimal size; beyond that level there would be likely to be more difficulties in continuity of care.

Ms Wilson noted that C-section rates were high. She explained that, if a woman had had one C-section, she would normally have to have one for her subsequent pregnancies. As such, effort was going in to preventing the need for women to have a first C-section.

The Chair noted the CQC maternity inspection data on page 69. She would like to have seen the figures from the Royal Free Group broken down by site. She asked what was being done for those aspects that were down as 'requires improvement'. Officers said that there was an action plan in place that was reviewed at regular quarterly clinical governance group meetings.

Ms Wilson and Ms Lissauer stated that NCL's aims were in line with the National Maternity Transformation Programme. They aimed to reduce stillbirths and neonatal deaths by 20% by 2020-21.

Officers highlighted that more women wanted to give birth in midwife-led units than actually did. They were aiming to ensure that they could facilitate this choice.

A member asked about home births and whether health providers were supporting the desire of some women to give birth at home. Ms Wilson said that, in the past, some organisations had been reluctant to facilitate home births but now that was an option that was open to women who were assessed as being 'low risk' deliveries.

Members asked about continuity of care and how it worked. Officers said that it was about continuity by a team, not just one midwife, as the workload would be too high if placed on one individual. They wanted staff to be able to 'follow' women to the relevant maternity unit or birth centre to provide this continuity.

There was a discussion about the need for a properly located bereavement room in the Royal Free. Councillor Cornelius commented that it needed to be near obstetric care while also not on the same ward as those who had recently given birth.

RESOLVED –

THAT the report and the comments above be noted.

9. UPDATE AND DISCUSSION TO PLAN FOR MOORFIELDS CONSULTATION

Consideration was given to a report on the planning for Moorfields' consultation.

Will Huxter (Director of Strategy, NCL CCGs), David Probert (Chief Executive, Moorfields) and Denise Tyrrell (Programme Director, NCL CCGs) addressed the Committee.

They explained that Moorfields' Eye Hospital served patients from a wide geographical area. They were coming to NCL JHOSC as their old premises and their proposed new St Pancras site were in the area of the JHOSC.

Members praised the report and welcomed the fact that it identified key risks and ways of mitigating them.

The Chair asked what the turnover of Moorfields was. She was informed it was £240m per year.

Members asked if the money from the sale of estates would be being used for revenue spend. They were assured it would not be. It would be spent on capital investment in the new site and, in addition, income from philanthropic sources would also go towards the capital spend.

Councillor Clarke asked about what would happen to the old City Road site. Mr Probert said that it would be sold on the open market. She said that there were some

concerns locally about the use of the site, and people would prefer that it was used for community benefit.

Members asked about liaison between Moorfields and local authorities. Mr Pobert said that they were building relationships with local MPs, leaders of the relevant councils, and the ward councillors.

Members asked about who would be leading on the consultation process. They were advised that Camden CCG would lead on it on behalf of Islington CCG.

Officers observed that, because of the wide dispersal of patients, a range of local authorities could be said to have a need to be consulted on the measures. It might be best to consult with the local JHOSCs for the areas that had the largest number of patients using the facility.

RESOLVED –

THAT the report and the comments above be noted.

10. ELECTRONIC PATIENT RECORDS

Members noted the report on Electronic Patient Records. They expressed concern that patient records were being held by a US-based firm which was owned by Google. They said authorities needed to ensure that this data was kept separate from other data which Google might hold.

Councillor Connor said she would like to hear whether patients and health staff had benefitted from this new system. Councillor Cornelius expressed disappointment that there was not more information in the report, and said that Barnet Health Scrutiny Committee had received a more detailed presentation on this topic.

Members asked that a report on the topic come back to a future meeting which identified the benefits from the scheme and measures being taken over data security. They added that they wanted to hear from officers involved and ask questions of them rather than simply receive an information report.

RESOLVED –

THAT a report on Electronic Patient Records come back to a future meeting of the JHOSC, with the information requested by members.

11. WORK PROGRAMME AND ACTION TRACKER

Consideration was given to the work programme report.

Members confirmed that they wanted to receive reports on Integrating Health and Social Care, Ambulance Service performance and Care Homes at their March

meeting. Members said they wanted the care homes report to say more about sharing best practice. The Chair also asked that there be a quarterly update report on NCL activities – starting in March.

Members agreed the following items for the June meeting:

- Estate Strategy
- Adult Orthopaedic Services
- Screening and immunisation
- Reducing A & E attendance

RESOLVED –

- (i) THAT the report be noted;
- (ii) THAT the proposed agenda for the March meeting be agreed;
- (iii) THAT the proposed agenda for the June meeting be agreed.

12. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no other items of business.

13. DATES OF FUTURE MEETINGS

It was agreed that the dates of future meetings would be:

- Friday, 15th March 2019 (Islington)
- Friday, 21st June 2019 (Barnet)
- Friday, 27th September 2019 (Camden)
- Friday, 29th November 2019 (Enfield)
- Friday, 31st January 2020 (Haringey)
- Friday, 13th March 2020 (Islington)

The meeting ended at 12:35pm.

CHAIR

Contact Officer: Vinothan Sangarapillai

Telephone No: 020 7974 4071

*North Central London Joint Health Overview and Scrutiny Committee - Friday, 18th
January, 2019*

E-Mail: **vinothan.sangarapillai@camden.gov.uk**

MINUTES END

Public Document Pack

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 15TH MARCH, 2019** 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), Tricia Clarke (Vice-Chair), Huseyin Akpinar, Alison Cornelius, Lucia das Neves, Val Duschinsky, Julian Fulbrook and Osh Gantly

MEMBERS OF THE COMMITTEE ABSENT

Councillors Pippa Connor and Clare De Silva

SUBSTITUTE MEMBERS PRESENT

Councillor Eldridge Culverwell

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 Councillors Pippa Connor and Clare De Silva. Councillor Eldridge Culverwell was attending as a substitute for Councillor Connor.

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

There were no declarations of interest.

3. ANNOUNCEMENTS (IF ANY)

The Chair announced that Item 8 (Ambulance Service Update) would be heard first.

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

There were no notifications of any items of urgent business.

5. DEPUTATIONS (IF ANY)

A deputation was received from Sue Richards and Vivien Giladi on the topic of Procedures of Limited Clinical Effectiveness (PoLCE).

They expressed concern about procedures being rationed via PoLCE. They did not feel that initiatives like “London Choosing Widely” had the standing to impose restrictions on whether certain procedures could be carried out.

The deputees were particularly concerned about the application of PoLCE to hip and knee replacements and cataract surgery. They expressed the view that these procedures were being cut back on funding grounds and that there should be a full consultation on the issue.

6. MINUTES

Consideration was given to the minutes of the meeting held on 18th January 2019.

Councillor Cornelius asked that the word ‘figures’ be added to the last sentence under Item 6 on page 2. She also asked that the name of the Barnet committee mentioned under Item 10 on page 6 be correctly recorded as ‘Barnet Health Overview & Scrutiny Committee’.

RESOLVED –

THAT the minutes be approved and signed as a correct record, subject to the amendments above.

7. NORTH CENTRAL LONDON PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS (POLCE) POLICY UPDATE - ENSURING EVIDENCE BASED CLINICAL POLICIES

Consideration was given to a report of North London Partners in Health and Care.

Dr Jo Sauvage, the Chair of Islington CCG and of the Health & Care Cabinet for North-Central London, addressed the Committee. She highlighted that there was huge variation in the approach that different practitioners took to similar conditions. The intention of North London Partners was to take an evidence-based approach to which treatments were effective and to improve the consistency of approach that doctors were taking.

In light of the comments made by the deputees, Dr Sauvage said she was open to meetings with councillors or with spokespeople from Keep Our NHS Public over specific issues they had concerns with the clinical guidance for.

Members said that they wanted consistency to be about offering consistent treatment to patients, not consistently refusing them. Members commented on cases where hip and knee replacements had been beneficial to their relatives.

Dr Sauvage said that the detail of the individual case was important with regard to discussions on hip replacement or cataract surgery. She said that there had been discussions with Moorfields about the criteria being used in PoLCE for cataract surgery and they have agreed with it.

She said that in some cases of PoLCE, there were alternatives such as physiotherapy which doctors should consider before going ahead with operations as surgery carried with it a risk. Members expressed the view that there might not be enough capacity to refer more people to physiotherapy and they might face long waiting lists.

Members expressed concerns that there could be a deterioration in people's quality of life if they had to wait longer for treatment. Pain might also hamper their ability to take measures like exercise which would improve their overall health.

Members expressed concern about decisions being budget-driven. Dr Sauvage responded that commissioners did have to manage health services within budget, but that the drive behind PoLCE was not about preventing people receiving care but ensuring that procedures which were not effective were not carried out – thus avoiding money being spent ineffectively.

Members were concerned that there might be negative equalities impacts from PoLCE, particularly as some of these procedures were mostly carried out on older patients. Will Huxter said that officers had offered to meet with Haringey Healthwatch to discuss their concerns about equalities impacts.

Deborah Fowler, Enfield Healthwatch, said that she felt consultation was not being fully undertaken. She also wanted patients to be clearly advised of their ability to obtain a second opinion.

The Chair commented that the governance process needed improvement. A PoLCE policy had been adopted without going out for consultation, and only after it had been adopted had people become aware of it.

Members asked that details be provided to a future meeting on the guidance for hip, knee and cataract operations and what had changed.

ACTION: North London Partners

Members also asked that this process not be repeated and that JHOSC and the public be consulted beforehand if similar issues of policy-making arose in future.

RESOLVED –

- (i) THAT the notes and the comments above be noted;

- (ii) THAT information be provided on the guidance for hip replacement, knee replacement and cataract surgery and on what had changed as a result of PoLCE;
- (iii) THAT governance processes be improved to ensure that the Committee and the public were consulted before measures such as PoLCE were introduced.

8. AMBULANCE SERVICE UPDATE - HOSPITAL HANDOVERS IN NORTH CENTRAL LONDON

Consideration was given to a report of the London Ambulance Service (LAS).

Peter Rhodes, the Assistant Director of Operations at the LAS, presented the report to the Committee.

He noted that the Committee had expressed concerns over handover times when it had previously discussed the issue. The LAS had been working with hospitals to tackle delays in being able to transfer patients, and had had a number of successes – notably at Barnet General and at the North Mid.

Mr Rhodes reported that the most serious call-outs (Category 1) were being dealt with within national target times. There were longer waits than the targets for lower priority (Categories 2 and 3) calls. He said that this was in part due to staff shortages. It was difficult to recruit enough skilled staff to meet service demand, and there was a limited capacity of training places to grow the service. Additionally, UK ambulance staff tended to want to work outside of London, and so there was recruitment from Australia by the LAS.

Members queried the seasonal variation in ambulance handover delays. Mr Rhodes said this was due to a greater number of people falling ill in January, due to the aftermath of Christmas and the cold weather. The health service did have plans to deal with the winter surge and so delays were smaller than in previous years.

Members queried whether there were more alternative means of hospital transport rather than ambulances which could be used for the lower priority call-outs.

RESOLVED –

THAT the report and the comments above be noted.

9. INTEGRATED CARE - WORKING WITH OUR COMMUNITIES

Consideration was given to a report of North London Partners in Health and Care.

Will Huxter, the Director of Strategy for the NCL CCGs, presented the item to the Committee. He said that some residents were currently receiving a good joined-up

service and he wanted this to be extended to others. This would require closer co-operation between Councils and NHS bodies.

Mr Huxter said that engagement with stakeholders on the integrated care strategy would begin shortly.

Members said that the strategy should start from resident experience. They also queried the question on page 55 of the agenda pack, which they thought was unclear.

Mr Huxter said that engagement would be mainly on the borough level, but that officers wanted to know if there were any specific ideas that members had which they felt should be done at the NCL sub-regional level.

The Chair said that the key issue for her was the identification of strategic risks and ways of mitigating them. Other members added that they would like more attention paid to the use of private providers. A member added that she was concerned about people receiving personal care packages and what would happen as funds ran out.

Doubt was expressed as to whether integration could be carried out at the speed that central government wished.

Members recommended that the focus of North London Partners be on how to ensure a positive resident experience from integration, and that strategic risks be identified and mitigated. They also asked that they investigate how governance and communications could be improved.

RESOLVED –

THAT the report and the comments above be noted.

10. CLINICAL PRIORITY WORK AREAS

Consideration was given to a report of North London Partners in Health and Care.

Will Huxter introduced the report. The Chair noted that page 67 of the report made reference to problems with maternity services. She said she was disappointed in the maternity paper and presentation that had come to the last JHOSC meeting as it had not mentioned these points, and so had given members a misleading impression.

Members discussed which workstreams they wished to focus on. They agreed that they would focus on:

- Maternity services
- Adult Social Care

- Mental Health
- Health & care closer to home

RESOLVED –

- (i) THAT the report and the comments above be noted;
- (ii) THAT the Committee focus on the maternity services, adult social care, mental health and health & care closer to home workstreams in its future work.

11. WORK PROGRAMME AND ACTION TRACKER

Consideration was given to the work programme, action tracker and to the information on capital disposals provided by hospitals.

Members agreed that items they wanted to consider at the June meeting were:

- Care homes
- Adult Orthopaedic Services
- An update on the estates strategy
- Reducing A & E attendance

They also indicated they would be interested in receiving an information paper on screening and immunisation.

With regard to the disposals information in Appendix 3, members said that they would like to see links to hospital accounts to understand the impact of the disposals revenue.

The Chair asked that the strategic risk register be appended to the work programme.

ACTION: North London Partners

Officers highlighted that there might need to be a special meeting of the JHOSC to consider the Moorfields' consultation on the reconfiguration of their service. With regard to this, the JHOSC agreed to invite members from other local authorities who had residents who were patients at Moorfields.

With regard to the Moorfields and St Pancras sites, members noted that Camden's own health scrutiny committee was focusing on the St Pancras site and Islington's was focusing on the Moorfields' site.

RESOLVED –

THAT the work programme be amended, as detailed above.

12. NORTH CENTRAL LONDON ADULT ELECTIVE ORTHOPAEDIC SERVICES REVIEW - UPDATE BRIEFING

The briefing was noted.

13. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There was no other business.

14. DATES OF FUTURE MEETINGS

It was noted that the dates of meetings in the municipal year 2019-20 would be:

- Friday, 21st June 2019 (Barnet)
- Friday, 27th September 2019 (Camden)
- Friday, 29th November 2019 (Enfield)
- Friday, 31st January 2020 (Haringey)
- Friday, 13th March 2020 (Islington)

The meeting ended at 12.10pm.

CHAIR

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MINUTES END

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Quality Accounts: a guide for Overview and Scrutiny Committees

DH INFORMATION READER BOX

Policy	Estates Commissioning IM & T Finance Social Care / Partnership Working
HR / Workforce Management Planning / Clinical	
Document Purpose	Best Practice Guidance
Gateway Reference	15794
Title	Quality Accounts: a guide for Overview and Scrutiny committees
Author	DH
Publication Date	16 Mar 2011
Target Audience	Local Authority CEs
Circulation List	Local Authority CEs
Description	Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.
Cross Ref	Quality Accounts Toolkit 2010/11
Superseded Docs	
Action Required	N/A
Timing	
Contact Details	Richard Owen NHS Medical Directorate Skipton House 80 London Road London SE1 6LH
For Recipient's Use	

Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs).

Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

This gives OSCs the opportunity to review the information contained in the report and provide a statement on their view of what is reported.

Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

Providers must send their Quality Account to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

This mini-guide has been produced specifically for OSCs and draws on relevant information already published in the Quality Accounts toolkit :

<http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/qualityaccounts/index.htm>

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers' publication of their financial accounts.

Who has to provide one?

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.

What is the purpose of a Quality Account?

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.

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.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

How will they be used?

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.

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.

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

Quality Accounts will be public-facing documents, published on NHS Choices

How will the process of producing a Quality Account benefit the provider?

The process of producing a Quality Account is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation.

It can also help with benchmarking against other organisations.

The process of producing a Quality Account also provides an opportunity for providers to engage their stakeholders, including PCTs, LINKs and the public, in the review of information relating to quality and decisions about priorities for improvement.

This sort of quality monitoring and improvement activity can have many purposes for the provider. For example it will help them to assess their risks and monitor the effectiveness of the services they provide; the information could also inform their internal monitoring of compliance with CQC registration requirements.

Why are OSCs being asked to get involved with Quality Accounts?

The Department of Health engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts.

A key message from our stakeholder engagement activity was that confidence in the accuracy of data and conclusions drawn on the quality of healthcare provided from these figures is key to maximising confidence in those reading Quality Accounts. Without some form of scrutiny, service users and members of the public may have no trust in what they are reading.

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

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

How can OSCs get involved in the development of Quality Accounts?

OSCs are ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

If an important local healthcare issue is missing from a provider's Quality Account then the OSC can use the opportunity in the form of a statement to be included in a provider's Quality Account to highlight this omission. Some of these issues might not directly relate to healthcare quality, so their omission by the provider might be unavoidable (given their legal obligation to report on healthcare only) and your commentary should acknowledge that.

Quality Accounts aim to encourage local quality improvements, OSCs can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

OSCs may also wish to comment on how well providers have engaged patients and the public, and how well they have promoted the Quality Account.

OSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and OSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the OSC are aware of each other's expectations in the process.

OSCs could therefore comment on the following:

- does a provider's priorities match those of the public;
- whether the provider has omitted any major issues;
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account; and
- any comment on issues the OSC is involved in locally.

What must providers do to give OSCs the opportunity to comment on their Quality Account?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located.

They must send it to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

The OSC then has the opportunity to provide a statement of no more than 1000 words indicating whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided.

The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report, which will include the statement, for publication.

If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

How does the review of Quality Accounts in April fit in with the other activities carried out by OSCs?

Quality Accounts do not replace any of the information sent to CQC by OSCs as part of CQC's regulatory activities.

Quality Accounts and statements made by commissioners, LINKs and OSCs will be an additional source of information for CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

It is recommended that discussions around the proposed content of a Quality Account and review of early drafts of the report is conducted during the reporting year in question so that by April each year OSCs will already have a good idea of what they expect to see in a provider's Quality Account and may have commented on earlier versions.

Where local elections are being held in April and OSCs will not have the opportunity to review Quality Accounts, it is advised that where possible, OSCs discuss plans and suggest content for Quality Accounts with providers when they reconvene in the summer.

Stakeholder engagement in the development of a Quality Account should be a year-long process – ideally starting at the beginning of the reporting year.

Which OSC should a provider send its Quality Account to?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located. This may be different from the geographical area of the lead commissioner. In these cases, liaison and co-operation will be the key to achieving a rounded view on the organisation for whose Quality Account you are providing feedback.

Does an OSC have to supply a statement for every Quality Account it is sent?

No. The role of OSCs in providing assurance over a provider's Quality Account is a voluntary one. Depending on the capacity and health scrutiny interests of the OSC, the committee may decide to prioritise and comment on those providers where members and the constituents they represent have a particular interest.

It would be helpful to let the provider know that you do not intend to supply a statement so that this does not hold up their publication.

Does the statement have to be 1000 words long?

No, this is a maximum set in the Regulations. We have increased the maximum limit for situations where LINKs and OSC wish to produce joint comments.

Working with commissioning PCTs, LINKs and other stakeholders

Existing DH guidance recommends that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee.

Joint committees may therefore wish to work together when considering Quality Accounts for organisations that provide services across multiple authority areas such as ambulance trusts. For instance, joint arrangements may already be in place for providing third party comments on providers to the CQC (for instance, to provide comments to CQC about a provider's compliance with registration requirements) and it would be appropriate to use these existing arrangements to discuss provider's Quality Accounts.

It should be noted however that the legal requirement is for a provider to send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located and to publish within their final Quality Account any statement that they have provided. It is important therefore that, when OSCs jointly consider a provider's Quality Account, it is the OSCs residing in the local authority area that sends the statement back to the provider. If the statement has been jointly written, it would be appropriate to state who has contributed to it.

How OSCs and other stakeholders work together is left for local discretion as there is variation across authority areas.

When OSCs jointly consider a provider's Quality Account, the OSC residing in the local authority area for the provider should send the statement back to the provider.

What should OSCs do if they receive a Quality Account from a provider with a national presence?

Some OSCs may receive Quality Accounts from multi-site providers. We do not expect an OSC to assure the quality of a national provider. Instead, we ask that the provider demonstrates how they nationally engage stakeholders day-to-day and in the production of the Quality Account.

How does Quality Accounts fit with the wider quality improvement agenda?

The objectives for Quality Accounts are 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, holding them accountable to stakeholders.

How do Quality Accounts relate to the work of regulators such as CQC and Monitor?

Quality Accounts do not replace any of the information sent to CQC as part of their regulatory activities. Quality Accounts and statements made by commissioners, LINKs and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

When providing comments on a Quality Account, OSCs should consider whether their reflections on the quality of healthcare provided should also be submitted to CQC.

Monitor's annual reporting guidance requires NHS foundation trusts to include a report on the quality of care they provide within their annual report. NHS foundation trusts also have to publish a separate Quality Account each year, as required by the NHS Act 2009, and in the terms set out in the Regulations. This Quality Account will then be uploaded onto NHS Choices.

Monitor's annual reporting guidance for the Quality Report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations, as well as additional reporting requirements set by Monitor. This is available from Monitor's website.

Quality Accounts for OSCs - Getting started

Before you receive a draft Quality Account:

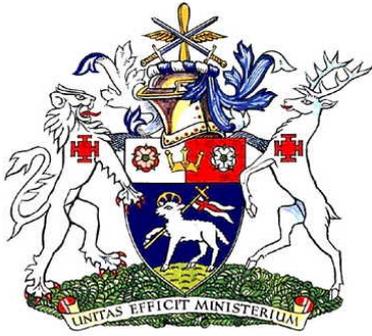
- Identify which providers will be sending their Quality Account to you and start discussions on proposed content early on in the reporting year.
- Providers have been encouraged in guidance to share early drafts of their Quality Account and useful background information on the content with stakeholders.
- Discuss the provider's proposed content of their Quality Account at an early stage to ensure that it includes areas that have been identified as being local priorities.

Once you have received a draft Quality Account (between 1 – 30 April):

- Before providing a statement on a provider's Quality Account, OSCs may wish to consult with other OSCs where substantial activity (for instance specialised services) is provided to patients outside their area.
- Write a statement (no more than 1000 words in length) for publication in a provider's Quality Account on whether or not they consider, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided. The statement could include comment on for instance, whether it is a representative account of the full range of services provided.

Sending the written statement back to the provider:

- Send the statement back to the provider within 30 days of the draft Quality Account being received. Your statement will be published in the provider's Quality Account.
- If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.



Title
**Health Overview and Scrutiny
Committee**

Date
21 February 2019

Title	NHS Trusts and North London Hospice Quality Accounts – Mid Year Review
Report of	Governance Service
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix A – Mid-year Quality Account Report CLCH and NLH Appendix B – Mid-year Quality Account Report Royal Free London NHS Trust Foundation
Officer Contact Details	Tracy Scollin – Governance Officer Barnet Tracy.Scollin@barnet.gov.uk

Summary

At its meeting in May 2018, the Committee considered the Quality Accounts from NHS Trusts and the North London Hospice for 2017/18. Health providers are required by legislation to submit their Quality Accounts to Health Scrutiny Committees for comment. NHS Trusts have a requirement to report their Quality Accounts to the Committee. At the meeting, the Committee was asked to scrutinise the Quality Accounts and to provide a

statement to be included in the Account of each health service provider.

The Committee have requested that the two NHS Trusts and the North London Hospice provide a response as to what action they have taken following the submission of its comments for inclusion within the final draft of their Quality Accounts last year.

The appendices contained within the report set out the comments made by the Committee to the Trust last year and the responses from the Trusts and the Hospice in respect of those comments.

Officers Recommendations

1. That the Committee notes the report.

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. The Committee has requested that the organisations that submitted their Quality Accounts last year provide an update on how they have actioned the comments made by the Committee.
- 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;

- 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;
 - How an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.
- 1.6 Commissioners and healthcare regulators, such as the Care Quality Commission, will use Quality Accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

2. REASONS FOR RECOMMENDATIONS

By receiving this update, the Committee will be able to see how NHS Trusts and the Hospice have responded to the comments that the Committee asked to be included within the Quality Accounts.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

Not applicable

4. POST DECISION IMPLEMENTATION

- 4.1 Once the Committee has scrutinised the report, it is able to consider if it would like to make any recommendations to the NHS Trusts and the North London Hospice.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

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

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

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

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

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

5.2.1 There are no financial implications for the Council

5.3 **Social Value**

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

5.4 **Legal and Constitutional References**

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

5.4.2 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.”

5.4.3 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.

5.5 **Risk Management**

5.5.1 Not receiving this report would present a risk to the Committee in that they would not have the opportunity to scrutinise the provision of Health Services in the Borough.

5.6 **Equalities and Diversity**

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.

5.6.4 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.

5.7 **Corporate Parenting**

5.7.1 N/A

5.8 **Consultation and Engagement**

5.8.1 Not applicable

5.8 **Insight**

5.8.1 N/A

6. **BACKGROUND PAPERS**

6.1 Agenda of the meeting of Health Overview and Scrutiny Committee 24 May 2018:
<https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=9506&Ver=4>

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Mid-year Quality Account comments

- The comments in blue are taken from the Health Overviews Quality Account comments 2018.
- Comments in black and the Responses provided by the Trust and Hospices.

Central London Community Healthcare NHS Trust

The Committee enquired as to which Boroughs the Trust was now serving and was concerned that previous expansion had brought challenges and that taking on more Boroughs could exacerbate the problems. The Trust said they were happy to circulate the list of Boroughs and that they are only taking on new services that were in their existing STP area and that this was in accordance with the overarching Trust strategy.

The Trust confirms their initial response that CLCH is only bidding for work in its existing STP areas. Attached for information is the Trust's strategy describing this – (please see page 5).

The Committee noted that improving the uptake of flu vaccines for frontline clinical staff had not been met. The Trust explained that there were reasons why staff had chosen not to take the vaccine. These included the belief that the vaccine had no value, that they had never had flu before, the belief that it could make the staff sick or lower their immunity and some even stated they did not want to be dictated to. The Trust said the plan going forward was to improve education on the vaccine and to emphasise its importance.

The Trust does not yet have an update on this year's vaccine uptake – its success or otherwise won't be known for a further few months. The Trust confirms they are currently promoting flu clinics and reminding staff of their chance to get vaccinated.

The Committee asked for an update on the increase in pressure ulcers. The Trust said it was disappointed that there was an increase, but there was an action plan and a team specifically investigating pressure ulcers. The Trust said it had identified that documentation on discharge and policy had not always been followed, but a root cause analysis after every pressure ulcer was conducted. The Trust said learning from each case was communicated to all staff and that every pressure ulcer was taken very seriously. The Trust highlighted the organisation had grown over the past year and so the greater numbers might not be proportional.

So far this year there have been 4 category 3 & 4 pressure ulcers in the bedded units. All of these have been subject to a root cause analysis. The number of pressure ulcers are closely monitored by clinical divisions and discussed by the patient safety managers and associate directors of quality. Where there has been a grade 3 or 4 pressure ulcer, these are discussed with both the Director of Nursing and Therapy and the Chief Nurse.

The Committee noted that the hand hygiene report had been lower than the Trust Board KPI of 97%. The Trust said it was disappointed with the audit and that it would be conducting investigations in order to improve this.

Recent audits have demonstrated that for quarter 1 and quarter 2, 2018/19, hand hygiene bedded services compliance is now 99.66%. So the Trust is now exceeding our KPI.

The Committee noted only 63% of the urinary catheter assessment forms had been completed. The Trust acknowledged this required improvement. In respect of the CQC recommendation regarding Children's Services, the Committee noted that the waiting time required improvement and asked what risk management strategy had been adopted. The Trust said that no 'must do' safeguarding issues had been identified by the CQC. The CQC however had commented on the need to provide different roles in Health Visiting Services and to improve the skillset across areas to fall in line with the CQC guidance.

This is currently being re-audited. Results won't be known until the end of January at the earliest.

In addition:

The Trust updated the Committee that the patient stories which were included in last year's Quality Account would now form part of the Annual Report

Please find attached patient stories annual report. Also please note that the Trust has the following page on their website which explains their approach to patient stories.

<https://www.clch.nhs.uk/get-involved/help-improve-services/patient-stories>

The Committee asked how a cost could be attributed to staff health improvement. The Trust explained that there was a small cost to run campaigns on health and wellbeing and run health schemes, however the expenditure was worth the gain.

No further comment.

The Committee noted that some Boroughs were particularly expensive to live in and queried whether this was influencing the staff retention rate. The Committee suggested that the Trust work with Housing Associations and other organisations to find affordable housing for their staff.

The Trust currently works with Network housing and Catalyst housing associations.

The Committee commented on the issues with staff retention and asked the Trust to explain how it would be approaching this. It said it would be looking to entice staff to stay by giving them new career pathways and supporting them to develop their careers. The Trust felt some staff had previously left due to a lack of awareness of the opportunities to progress. The Trust had established an

apprenticeship forum and retention and recruitment group in order to improve the retention of staff. The Trust also found the number of women returning after maternity leave had been disappointingly low, so the it was working on a programme of retraining and providing workshops for those returning. The Committee asked whether the high cost of child care played a part in women being unable to return and whether there was a crèche available. The Trust said this issue had not been identified, however it was considering providing affordable accommodation to attract young nurses.

Recruitment and retention issues are regularly reported to the Trust's workforce committee. At the most recent committee (held in November 2018) the Trust considered retention in detail. The committee was informed that the Trust:

*Uses the NHS Improvements toolkit on retaining clinical staff;
Is reviewing the retention strategy in the light of understanding the turnover data;
Looking at the reasons that staff leave and including looking at these reasons over time and whether they change.*

To address retention issues, a turnover plan is being put into place which includes (amongst other things) coaching and drop in sessions with associate directors of quality; ensuring the appropriate equipment is provided for given roles, looking at pay and opportunities for development and career progression; career clinics to be rebranded and relaunched.

The Committee noted only 63% of the urinary catheter assessment forms had been completed. The Trust acknowledged this required improvement.

This is currently being re-audited. Results won't be known until the end of January at the earliest.

In respect of the CQC recommendation regarding Children's Services, the Committee noted that the waiting time required improvement and asked what risk management strategy had been adopted.

The Children & Young People's Occupational Therapy service in Barnet has since transferred to a different NHS Trust and is no longer provided by CLCH.

The Trust said that no 'must do' safeguarding issues had been identified by the CQC. The CQC however had commented on the need to provide different roles in Health Visiting Services and to improve the skillset across areas to fall in line with the CQC guidance.

The health visiting service has a skill mix approach with Health Visitors and Nursery Nurses. Work is currently taking place to expand the approach further with the introduction of Community Paediatric Staff Nurses.

North London Hospice

The Committee noted the high turnover of staff detailed in the Quality Account again this year. The Hospice explained that although the data suggested there was an issue with high turnover of staff, many of those who had left were Bank staff. The Hospice explained that the HR department was working hard to devise imaginative and creative ways to recruit and retain staff. The Hospice had recently reviewed their appraisal system and was aiming to recruit more permanent staff.

The HR department has confirmed that of the 64 staff who were reported as having left the organisation last year, 30 were bank staff. These were people who had been on the books but were no longer undertaking bank work in the hospice and so were removed from the list. In the next years Quality Account we will distinguish between bank staff and permanent staff.

The Committee noted that the incidents of pressure ulcers was high again and queried the reasons behind this. The Hospice explained that they were extremely vigilant in checking patients and counting all pressure ulcers. They said that compared to some other organisations, they counted each ulcer rather than just counting each patient who had an ulcer. The Hospice also said they worked on the principle that there are six categories of pressure ulcers rather than four. The Hospice stressed that the recording of ulcers was taken very seriously and full route cause analysis was conducted for all pressure ulcers classified as Grade 3, Grade 4, Ungradeable or Deep Tissue Injury, to ensure that all ulcers were unavoidable. The Hospice had also been working with the Hospice UK Advisory Group to ensure a high standard of monitoring.

The Hospice has continued to report all pressure ulcers of all 6 categories (as is now recommended by NHS Improvement) and to undertake a Root Cause Analysis for all Category 3, 4, Ungradable Ulcers and Deep Tissue Injuries, finding all ulcers to have been Unavoidable. The Trust has continued to work with Hospice UK, benchmarking their practice against other hospices. In the first two quarters of this year, they have noted a slight reduction in the number of new ulcers and will report on this in full in next year's Quality Account.

The Committee asked for an update on how the Hospice was responding to staff members who had reported experiencing bullying and whether safeguarding practices had been put in place. The Committee also queried whether these incidents of bullying were potentially contributing to the difficulties in retaining staff. The Hospice said it was disappointed in the numbers of staff that reported experiencing bullying. The Hospice explained that because the data was anonymous and no staff had come forward and reported the incidents, it was difficult to understand the individual circumstances. The Hospice said that it was working with managers to try and resolve these issues. The Hospice also said it was trying to encourage more staff to fill in the survey next year in order to get a better idea of how staff could be better supported and empowered.

The figures from their most recent staff survey show fewer staff believe they have been bullied at work. The HR department have calculated this figure out to be 0.08% of the workforce. This number is in line with the average for all hospices. The

Hospice continues to have a robust safeguarding policy and staff training schedule as well as a Bullying and Harassment Policy and a Whistleblowing Policy (Raising Concerns about Poor Practice Policy).

The Committee noted there was an increase in the number of safety incidents reported. The Hospice explained that the system of reporting had changed with the introduction of an electronic reporting system over two years ago. The Hospice said lots of teaching and training had been developed in line with the implementation of the new system and the importance of reporting incidents had been regularly highlighted. The Hospice said that the increased resources had encouraged people to report incidents, rather than there being an increase in the actual number of incidents. The Hospice said the number of incidents reported last year and this year was similar and therefore consistent.

There was a reduction in the number of safety incidents reported in 2017 – 2018 (by 19). It was 2 years previously when there was a rise in reported incidents, thought to be related to the changes in reporting procedures, as explained above. So far consistent numbers of incidents have been reported for this year.

The Committee were concerned by the large increase in the number of days beds were closed as this had risen from 39 to 78 days. The Hospice explained that the closure of 3 rooms had been the result of issues with plumbing and there had been a long wait for a part needed to fix the issue. The Committee said it appeared that plumbing problems were a recurrent issue and was concerned that there was such a large impact on beds becoming unavailable. The Hospice said that, since this last incident, considerably fewer beds had been closed and the Facilities Manager was now present at triage meetings to ensure they had a good idea of why rooms are closed and to enable the Hospice to react to closures more quickly.

Since the actions mentioned above have been in place there have been considerably fewer days when beds were closed: Between 1st April 2018 and 30 November 2018 there have only been four closed bed days.

The Committee were concerned by the higher number of falls reported this year and asked the Hospice why these had increased. The Hospice said that there was a fine balance between allowing patients to be mobile but also avoiding falls. The Hospice explained that at the start of the Falls Project they had many patients who were mobile, but this inevitably came with a higher risk of falls. The Hospice said lessons had been learnt from the Falls Project and that sensory alarms for patients at risk of falling had been implemented. The Hospice was also about to purchase a low bed with crash mat. The Hospice felt the project had highlighted which patients were at risk and given staff more confidence in assessing and making decisions. User forums and practical sessions had been established to raise awareness and to help patients develop strengthening and balancing exercises.

The number of falls remains high, predominantly in the inpatient unit. This can partly be attributed to having a more mobile cohort of patients (evidenced by a small increase in number of patients discharged from the unit in the first two quarters of the year).

The Trust continues to strive to put everything in place to minimize the risk of patients falling and harm caused: the low bed is in use, more falls alarms have been purchased and the revised Falls paperwork is incorporated in to the staff moving and handling training. The Trust has revisited how often to review a patient's falls assessment (minimum weekly but also when patient condition changes). They aim to take a team approach to falls prevention. Patients who are at high risk of falls are identified in the ward office, raising awareness with all clinical staff, volunteers, admin staff and housekeepers of those at risk.

The Trust regularly reviews all the data captured regarding falls to analyse specifics e.g. time of fall, location of fall to ensure they are fully informed and can learn from the falls.

The Committee noted a Hard to Reach Programme was being established at the Hospice and asked how this was going to be done. The Hospice explained that it would be focusing on improving access to those with learning difficulties or suffering from substance abuse. The Hospice would be using external communication and ensuring services were accessible to all.

This Year (our 2nd for the project) they have prioritised improving access to people who are homeless, affected by substance misuse, as well those people who have a learning disability. In addition they wanted to understand and respond to specific cultural groups in each of our boroughs. They have worked on their website; they now have a new tab on the home page called 'Reaching our Communities'. For a time limited period, they now have in place Community Ambassadors in each borough. This has already made a significant difference to the amount of people and organisations they are seeing. There are four objectives they want to achieve from this: supporting Improving Access Priorities, Increasing the number of Compassionate Neighbours recruited and trained, as well as Community Members supported, increasing the number of people using Health & Wellbeing Service, as well as thinking of different 'Self-Management' resources to publicise.

The Committee asked how the 980 volunteers at the Hospice were supported in their work. The Hospice explained there is an extensive training programme in place which has been developed over the last few years. The Hospice said there were different levels of training dependant on the specific role of the individual, with a focus on the emotional development and support of those working face to face with patients. The Hospice also provides regular meetings with staff to ensure there is feedback and support.

The Trusts continues to train and support their volunteers. During the first two quarters of this year they reviewed their volunteer data base; updating records and ensuring accuracy. This has resulted in them now having just over 700 volunteers actively volunteering for the hospice.

They have been piloting annual reviews with volunteers in one of our service areas and will review that in early 2019 with a view to expanding in to other areas.

The Committee asked for an update on whether the Hospice had sourced alternative pressure- relieving mattresses. The Hospice explained that the existing mattresses

were not received well by some of the patients, so they had campaigned for money to buy an alternative. The Hospice said that, so far, the patients with these mattresses seemed happy. The Hospice were monitoring any decrease in the number of pressure ulcers as a result.

Patients continue to be happy with the new mattresses purchased in March 2018. As reported above they have noticed a slight reduction in the number of new pressure ulcers in the first two quarters of this year. This will be reported on in full in next year's Quality Account.

The Committee queried how many people used the Bereavement Service and how many had to turn to private services. The Hospice said it was not able to give an exact answer, but explained assessments were made by phone in order to establish what follow up support a bereaved individual required.

A review of the bereavement service and how data is collected has been undertaken. More information on numbers of people receiving bereavement counselling will be provided in next year's Quality Account. There are no waiting lists for bereavement support, although the Trust would never know if anyone accessed support privately.

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**Update on progress made to achieve the quality account priorities:
Mid-year report**

Report to: Barnet Health and Overview Scrutiny Committee

Meeting date: December 2018

Report from: Dr Chris Streater: Chief medical officer

Author/s: Dawn Atkinson: Deputy director of clinical
governance and performance

Karen Gordon: Head of clinical governance
and performance

This report provides an update on progress made to achieve the quality account priorities for 2018/19 and feedback on the points raised in the statement issued by Barnet HOSC.

Part One: Update on progress to achieve the Update on quality account priorities during quarter two (July to September 2018)

The eight chosen priorities remain within the three domains of quality (patient experience, clinical effectiveness and patient safety) and continue to have an executive sponsor, a designated lead and an associated committee where progress is monitored and assurance provided. Five out of the eight priorities were carried forward from 2017/18 and the remaining three priorities were new areas that were identified for improvement across the trust as outlined in table 1 below.

Table 1: Overview of priorities for 2018/19 and associated committees.

Quality domain		Priorities for 2018/19	Continued from 2017/18	Associated committees
Patient experience	1	To achieve certification for The Information Standard.	✓	Clinical Standards and Innovation Committee (CSIC)
	2	To further enhance and support dementia care.	✓	
	3	To improve our involvement with our patients and carers.	✗ new priority	
Clinical effectiveness/ quality improvement	4	To build capability in the workforce and have an online project tracker tool.	✓	People and Population Health Committee (PPHC)
	5	To develop a superior change-management capability putting clinicians in charge of their clinical pathway.	✓	
Patient safety	6	To improve safer surgery and invasive procedures	✓	Clinical Standards and Innovation Committee (CSIC)
	7	To improve our learning from deaths	✗ new priority	
	8	To improve infection prevention and control	✗ new priority	

The key below is used to summarise the level of progress made during quarter two.

Key:

Status	Progress as expected for mid-year point	★
	Progress below expectation for mid-year point	★

Priority one: Improving patient experience:

As a major provider of healthcare services in London, the trust aims to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences.

1. Achieving ‘The Information Standard’

Executive Sponsor: Emma Kearney, director for public affairs and communications. Trust Lead: Yovna Lachanan, patient information manager			
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
To achieve trust certification for ‘The Information Standard’.	To work with Clinical Pathway Groups (CPGs) to embed the patient information approval process and ensure information produced via these channels are in line with the Information Standard requirements.	<p>Progress includes meeting with CPG programme manager for women’s and children’s division to ensure the trust’s patient information approval process is embedded. Support is also provided to all staff producing patient information relating to other CPG pathways in development, for example Acute Kidney Injury (AKI) information.</p> <p>Next steps are to meet with the full CPG team to ensure understanding of patient information requirements, the approval process and to identify KPIs to support this.</p> <p>Progress is on-going and CPG teams continue to be supported in the production of their patient information.</p>	★
	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.	<p>Application process has been scoped out and amendments to patient information policy to be made based on a self-gap analysis before application is made.</p> <p>Work with key stakeholders within the radiotherapy department already established and the next steps will include working with the new quality and assurance manager for radiotherapy to undertake a scoping exercise for the department. This will ensure effective communication to the wider team of the plans to apply for the Information Standard for the department.</p> <p>Radiotherapy patient information is all currently up to date, but will need to be reviewed in the next quarter in line with their review date.</p>	★

2. Enhancing dementia care

Executive sponsor: Debbie Sanders, group chief nurse.		Trust Lead: Danielle Wilde, group dementia lead	
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy	Improve dementia services for patients admitted to RFL and their carers	<p>Action plan for the national audit of dementia has been completed. Audit currently in progress on the 3 reporting sites (8 West, 10 North and 6 South). Data collection closed on September 21 with results available in July 2019.</p> <p>Dementia key worker scheme implemented on 4 wards, providing specialist input and support for patients and families.</p> <p>Publication of RFL Guide to Dementia now available on all wards across the trust. Regular carer support sessions held on Hampstead and Barnet sites and 5 new “Sundown Sessions” currently in production.</p>	★
	Improve staff experience in caring for people with dementia	<p>8 important things about me document updated and new process implemented.</p> <p>“High Bay” project to launch in 2019 with an emphasis on resourcing and training NAs to facilitate group activities sessions for patients who are being cared for in an enhanced bay.</p> <p>Innovative ChickenShed theatre training to take place on January 30 for CAPER Anchors looking to further their training in communication and care for patients living with dementia.</p> <p>Music therapy training planned for interested staff complemented by an improved roster of musicians visiting the organisation under the RF Charity.</p> <p>Delirium pathway documentation continues to be piloted across the trust and the Dementia Implementation Group (DIG) will now be reviewing all PALS / incidents reported that relate to dementia or delirium which will help us to identify hotspots.</p>	★
	To design new dementia strategy for 2019 – 21 period	Strategic event planned for end of the year inviting the public, carers, patients and interested staff to feed into our new strategy.	★

3. Improving involvement with our patients and carers

Executive sponsor: Debbie Sanders, group chief nurse. Trust Lead: Richard Chester, deputy director for patient experience			
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
To improve our involvement with our patients and carers	<p>Following feedback from staff and patients a broader approach is being taken to ensure that we improve our involvement with our patients and carers.</p> <p>Building on previous involvement with our patient partners in CPGs, QI projects, hospital based committees/ groups and with task and finish groups</p>	<p>The trust continues its approach to embedding experience and involvement in its services and development.</p> <p>The trust has adopted the patient experience framework published by NHS England.</p> <p>The framework brings together the characteristics of organisations that consistently improve patient experience and enables boards to carry out an organisational diagnostic against a set of indicators</p> <p>Key themes for rating organisations as outstanding or inadequate were found to be: Leadership, Organisational Culture, Compassionate Care, Safe Staffing Levels, Consistent incident reporting and learning lessons. There are 23 areas to assess against, with each one being broken down into various sub-categories.</p> <p>The patient experience has a role to play in a number of questions and the collation as a whole, and the document has been reviewed by the patient experience team. However, information will be required from quality improvement, HR, organisational development, Group, boards, medical directors and directors of nursing. Therefore the suggestion is that the document be taken to each Local Executive Committee (LEC) who can delegate across the hospital site ownership of parts of the assessment and from there we could collate to a group level score.</p> <p>In addition the patient experience team have strengthened their relationship with CPG team so that they can become more involved with the CPG work streams.</p> <p>Patient representatives have been appointed to the patient experience committees at both Barnet and Royal Free sites. Work has begun on updating and improving the information on the patient experience section of the website for both patients and staff.</p>	★

Priority two: 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.

Quality Improvement (QI) priority:

4. Building capability within our workforce

Executive sponsor: Chris Streater, Chief medical officer.		Trust Lead: James Mountford, director for quality	
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
To build capability in the workforce and have an online project tracker tool.	<p>Ability to prioritise QI projects based on local/Group need.</p> <p>Local ownership, at service, divisional and hospital unit level.</p> <p>To provide access to site-based QI help and support, site-based learning and access to expert QI knowledge.</p> <p>To create opportunities to share learning across the site and Group.</p>	<p>A key element of developing our infrastructure is creating an integrated quality improvement management system by which we can register, track and report on QI activity.</p> <p>A working group has been set up and a service specification has been developed to reflect the organisations and progress has been made with the introduction of <i>Leading for Improvement</i> with our senior leaders being trained as QI sponsors.</p> <p>In order to support local ownership we need to provide transparency of Quality Improvement projects through having an online system to register, track and report on QI progress. Life QI has been chosen as the system to do this and we aim to launch this in Q4 2018-19.</p> <p>Together with the leadership team we continue to look for effective ways to share learning across each site and the group.</p> <p>In November we hosted a QI showcasing event where 34 posters were displayed and presented, over 100 staff attended this event. Additionally, on Royal Free Hospital site we are including a QI presentation at the chief executives briefing. Next steps are to introduce similar events and learning opportunities at each site.</p>	★

Clinical Pathway Group (CPG) priority:

Variation in clinical practice and process leads to worse patient outcomes and these results in higher costs. Therefore the goal of the program is to reduce unwarranted variation in clinical practice and process. Clinical pathway groups are clinically-led ways of working across several hospital sites aimed at reducing variation and ensuring patients receive the best standard of care, wherever they are treated.

5. Digitise clinical pathways

Executive sponsor: Chris Streater, Chief medical officer. Trust lead: John Connolly, CPG program director			
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
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.	<p>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 roll out of Millennium Model Content and opening of the new Chase Farm Hospital.</p> <p>Our measure for success for 2018/19 is to have seven digitised clinical pathways.</p>	<p>Work has remained in support of the digital transformation at the RFL. The trust has embarked on a journey which to become one of the most digitally advanced trust in the UK by 2020.</p> <p>Multidisciplinary teams are working together to design the clinical pathways; ensuring that the diagnostic and treatment decisions are consistent and based on the latest evidence to deliver the best possible outcome. All the pathways are being co-designed with patients; their experiences are being taken into account, which will in turn improve outcomes.</p> <p>The new Chase Farm Hospital has opened and likewise six pathways have been fully digitised. These include:</p> <ol style="list-style-type: none"> 1. Preoperative Assessment 2. Elective Hip 3. Elective Knee 4. Right Upper Quadrant Pain (RUQP) 5. Induction of Labour 6. Admissions to Neonatal Unit ("Keeping mothers and babies together) 	★

Priority three: Patient safety priorities

For 2018/19 we chose to focus on safer surgery, learning from deaths and infection prevention and control.

6. Safer surgery

Executive sponsor: Debbie Sanders, group chief nurse Trust lead: Hester Wain, deputy director for patient experience																						
Priority for 2018/19	Key measures for success	Update for mid-year point	Status																			
Safer surgery and invasive procedures	To achieve zero Never Events by the end of March 2019	<p>We have reported a total nine never events during 2018/19 (6 in Q1 and 3 in Q2). The never events were in the following descriptions:</p> <table border="1"> <thead> <tr> <th></th> <th>Description of never event</th> <th>number</th> </tr> </thead> <tbody> <tr> <td rowspan="4">Q1</td> <td>• unintentional connections of a patient requiring oxygen to an air flow meter,</td> <td>2</td> </tr> <tr> <td>• wrong site procedures which resulted in no/low harm to the patient.</td> <td>2</td> </tr> <tr> <td>• wrong eye injection</td> <td>1</td> </tr> <tr> <td>• retained swab</td> <td>1</td> </tr> <tr> <td rowspan="3">Q2</td> <td>• wrong knee prosthesis</td> <td>1</td> </tr> <tr> <td>• retained needle post episiotomy,</td> <td>1</td> </tr> <tr> <td>• wrong side transforaminal epidural injection</td> <td>1</td> </tr> </tbody> </table>		Description of never event	number	Q1	• unintentional connections of a patient requiring oxygen to an air flow meter,	2	• wrong site procedures which resulted in no/low harm to the patient.	2	• wrong eye injection	1	• retained swab	1	Q2	• wrong knee prosthesis	1	• retained needle post episiotomy,	1	• wrong side transforaminal epidural injection	1	★
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	• retained needle post episiotomy,	1																				
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To increase by 75% the number of Local Safety Standards for Invasive Procedures (LocSSIPs) in place by the end of March 2019	<p>The Patient Safety CPG was established on 1 April 2018 and has prioritised the 'Invasive Procedures Pathway' as the first initiative to deliver eighteen Local Safety Standards for Invasive Procedures (LocSSIPs) across the trust.</p> <p>The Patient Safety CPG is initially focusing on three pathways: cardiology, radiology and endoscopy and meetings have been held with these services. The emphasis has been on redesigning and testing LoCCSIPs within these services. A Gantt chart had been compiled to track progress.</p>	★																				

7. Learning from deaths

Executive sponsor: Debbie Sanders, group chief nurse. Trust lead: Hester Wain, deputy director for patient experience			
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
To improve our Learning from deaths (Lfd)	To increase by 10% the percentage of reviews of patient deaths recorded centrally by the end of March 2019	<p>11% patient deaths were recorded centrally for review in 2017/18.</p> <p>Therefore, the aim is to increase this to 21%. Data on the numbers of patient deaths reviewed during 2018/19 will be available from October 2018.</p> <p>We have increased the numbers of deaths reviewed in 2018/19 Q1 to 15%.</p>	★
	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	<p>The 2017 NHS staff Survey showed that 68% of RFL staff agreed/strongly agreed that “When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.”</p> <p>We are working to use more dynamic survey data to show how we improve this metric.</p> <p>We are now publishing: Safety needs and incident learning (SNAIL), weekly update on key areas of learning from incidents and near misses using SBAR.</p> <p>Plus, Free Way to Safety (FWTS) monthly newsletter (key safety learning from serious incidents, emailed to incident managers); and Health and safety monthly newsletter (key Health and safety information, emailed to Health and safety champions);</p>	★

8. Improving infection control

Executive sponsor: Debbie Sanders, group chief nurse			
Trust lead: Yvonne Carter, head of infection prevention and control nursing			
Priority for 2018/19	Key measures for success	Update for mid-year point	Status
To improve infection prevention and control	To achieve 10% reduction by year of meticillin-resistant <i>Staphylococcus aureus</i> (MRSA).	MRSA bacteraemias – currently two attributed cases, one attributed to RFH and one to BH. Reduction in Gram negative bacteraemias remains on going – 10% reduction achieved last year. The current rate fluctuates but remains within process limits. Measures for reduction are driven through the monthly IPC Divisional Leads group.	★
	To achieve Trust-attributed zero <i>Clostridium difficile</i> (C.diff) infections due to lapses in care by end of March 2019	Currently no lapses in care for C.diff cases. Total cases are two above threshold. All cases have an RCA, with learning fed back through the monthly IPC Divisional Leads group	★

Conclusion

It was disappointing to report further never events, however the trust is ensuring that we learn from our never events. Weekly executive-led cross-site safety meetings are held to share immediate learning and identified risks.

During the next reporting period, the trust will carry on building on measures to achieve the set quality account priorities in support of our commitment to provide our patients with world class expertise and local care.

Part two: Feedback on points raised in the quality account 2017/18

The second part of this report provides feedback on the comments raised by Barnet HOSC as recorded in the quality account 2017/18.

	Comment from committee	Response from Trust																																																																														
1	<p>The Committee asked the Trust to clarify the total number of C.Diff cases, as it was noted they did not meet their target last year.</p> <p>The Committee commented that the tables in the Quality Account were not particularly clear and asked that the target for the year be included.</p> <p>The Trust explained that the two graphs explaining C.Diff were measuring different things, which is why the numbers were different.</p>	<p>The trust continues to report on the number of C.difficile cases and the attributable reason (lapse in care) as well as the C.difficile infection rate per 100,00 occupied bed days (which provides a national benchmark for the trust).</p> <p>For 2018/19 the C.difficile target is 65 and at the end of November the trust had reported 43 cases.</p> <div data-bbox="936 619 2123 1401"> <p style="text-align: center;">RFLNHSFT 2018/19 C. difficile cases and "lapses in care" versus Trust objective trajectory and 2017/18</p> <table border="1" data-bbox="958 1203 2107 1378"> <thead> <tr> <th></th> <th>Apr-18</th> <th>May-18</th> <th>Jun-18</th> <th>Jul-18</th> <th>Aug-18</th> <th>Sep-18</th> <th>Oct-18</th> <th>Nov-18</th> <th>Dec-18</th> <th>Jan-19</th> <th>Feb-19</th> <th>Mar-19</th> </tr> </thead> <tbody> <tr> <td>RFLNHSFT cumulative "lapse in care" cases</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>2</td> <td>2</td> <td>2</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RFLNHSFT 2017/18 "lapse in care" cases</td> <td>0</td> <td>1</td> <td>1</td> <td>2</td> <td>2</td> <td>3</td> <td>3</td> <td>5</td> <td>5</td> <td>6</td> <td>7</td> <td>7</td> </tr> <tr> <td>RFLNHSFT 2018/19 cumulative cases</td> <td>4</td> <td>8</td> <td>14</td> <td>21</td> <td>28</td> <td>35</td> <td>39</td> <td>43</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RFLNHSFT 2018/19 cumulative objective</td> <td>6</td> <td>12</td> <td>17</td> <td>23</td> <td>28</td> <td>33</td> <td>39</td> <td>44</td> <td>49</td> <td>55</td> <td>60</td> <td>65</td> </tr> <tr> <td>RFLNHSFT 2017/18 cumulative cases</td> <td>4</td> <td>9</td> <td>18</td> <td>27</td> <td>32</td> <td>40</td> <td>47</td> <td>54</td> <td>62</td> <td>66</td> <td>74</td> <td>82</td> </tr> </tbody> </table> </div>		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	RFLNHSFT cumulative "lapse in care" cases	0	0	0	0	0	2	2	2					RFLNHSFT 2017/18 "lapse in care" cases	0	1	1	2	2	3	3	5	5	6	7	7	RFLNHSFT 2018/19 cumulative cases	4	8	14	21	28	35	39	43					RFLNHSFT 2018/19 cumulative objective	6	12	17	23	28	33	39	44	49	55	60	65	RFLNHSFT 2017/18 cumulative cases	4	9	18	27	32	40	47	54	62	66	74	82
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<p>2</p>	<p>The Committee noted A&E targets had not been met. The Trust said Barnet Hospital was improving having hit 90% last week, but there had been a big variation during the winter which had been particularly challenging.</p> <p>The Trust said that currently the Royal Free was around 85% and that a big focus was being put into increasing this to 90% by September 2018 and 95% by February 2019.</p> <p>The Trust said the Emergency Department (ED) at the Royal Free was now fully open and colleagues were working towards improving performance targets.</p>	<p>The Royal Free Hospital has been above year on year performance since April 2018 and is currently on trajectory. Barnet Hospital has been above both trajectory and year on year performance until October 2018.</p> <p>There are a number of improvements planned and in progress. Full details will be presented in the quality account 2018/19.</p> <p>Improvement initiatives at Barnet Hospital includes:</p> <ol style="list-style-type: none"> 1. Workforce profile is being reviewed. Performance of attendance avoidance schemes flagged to the CCG 2. Focus on full capacity protocol and supporting flow of patients out of ED 3. Daily and weekly reviews. ECIST to provide additional support to long stay patient work 4. Workforce plan in place and reviewed weekly by the divisional team. <p>Improvement initiatives at Royal Free Hospital:</p> <p>Reducing Length of Stay (LoS):</p> <ol style="list-style-type: none"> 1. Implement a system-wide weekly escalation meeting 2. Account manage the top 8 longest staying patients in the trust (2 per Exec) 3. Continue with divisional weekly stranded patient review meetings <p>Discharge to access:</p> <ol style="list-style-type: none"> 4. Establish non-weight bearing Pathway 1/2 5. Increase utilisation of existing pathways <p>Increasing ambulatory emergency care:</p> <ol style="list-style-type: none"> 6. Set up additional hot clinics for specialties 7. Set up a hot clinic for dressing changes & suture removal 8. Move chiropody out of AAU 9. Embed OT in RAT to ensure a 'home first' culture 10. Create a blocked catheter ambulatory care pathway
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3	<p>The Committee was concerned that the issues surrounding parking at Barnet Hospital which had been raised for many years, were still outstanding. The Committee stressed that patients had raised concerns about the lack of parking and that this often led to them missing appointments. The Committee stressed that the car park was inadequate and that this issue urgently needs addressing.</p>	<p>Detailed separate report sent to the committee. Highlights include:</p> <ul style="list-style-type: none"> • Car parking survey (August 2018) to engage and understand issues. Nearly 800 responses in total with around 600 from Barnet Hospital staff. • Survey information used to inform a new Parking Policy, recently shared with Group Joint Negotiating and Consultative Committee and Group Policy Committee for approval and adoption. • Incentives for car sharing, out of hours permits, simplified qualification criteria. • New permit batches will be released during December to maximise utilisation of current staff parking. • Additional short-term parking capacity options are being considered, these include; <ul style="list-style-type: none"> • Modular car park (as used in supermarkets and railway stations) • Rental of local offsite car parking facility (within walking distance) • Discussions with Barnet Council are planned to try to delay the extension of Controlled Parking Zone until one of the above solutions can be implemented.
4	<p>The Committee was concerned that the targets for Referral to Treatment (RTT) had not been met and that the Trust's performance in February 2018 was only 83.4%, compared to the national target of 92% waiting 18 weeks or less for access to Consultant-led services. The Trust said this was a concern and that it was a big focus for improvement. The Trust said they investigated all cases where patients had waited longer than the target for care to ensure no harm had been caused. The Trust also said the figures were partly a result of improvements to the way in which it tracks patient pathways.</p>	<p>Current focus is on finalising the validation approach to the new Patient Tracking List (PTL) now that this has been released by MBI. A paper has been submitted to the December Trust board for a decision on how to proceed. Additional validators have already been recruited and we are also offering overtime for existing staff.</p> <p>However, we are maintaining a small amount of business as usual validation as operations are still using the current PTL and we are using it to report as a trust. We are maintaining a large operational focus on reducing the number of tip-ins to the >52 week backlog including man-marking patients and reporting via weekly sitreps.</p> <p>We do have two strands of Clinical Harm Review (CHR) assessment for patients waiting longer than 52 weeks. There is clinical harm component in the RCA form completed when the patient breaches 52 weeks which requires the clinician to identify if harm has been caused or will be caused if the patient continues to wait. There is then a full and formal central clinical harm review that is undertaken for all patients treated after 52 weeks (whether this is an active RTT pathway or not).</p>
5	<p>The Committee was also concerned with the delay in first definitive treatment with only 83.1% of patients receiving treatment within the 62 days.</p>	<p>The trust continues to identify methods to make improvements to our 62 week cancer target. This has included the roll out an expanded STT service for Lower GI patients on the Barnet and Chase Farm sites in mid-September and the trust now consistently see ~75% of patients enter this</p>

	<p>Although this figure was an improvement on last year, it still is below the 92% standard. The Trust said currently the 62 week target was not being met due to the large volume of referrals of patients with low GI cancer, which was an increasing issue. The Trust assured the Committee that work was being done to make the necessary improvements.</p>	<p>pathway.</p> <p>Since implementation, the trust has also seen the overall backlog and number of tip-ins to the backlog reduce</p>
6	<p>The Committee enquired as to how the Trust dealt with mental health patients that turn up at the A&E. The Trust said it was working on better engagement with service providers to place them into the right care. The Trust acknowledge A&E was not the right environment for many of them, but was sometimes the only safe place the police could bring them. The Committee were also informed that the police do receive training on how to deal with mental health incidents.</p>	<p>Barnet CCG presented a review of mental health provision at the October BH UEC Transformation Board and the following milestones have been incorporated into the Transformation programme plan:</p> <ul style="list-style-type: none"> • NELCSU Smart System to be utilised to capture mental health capacity across NCL and demonstrate where capacity is available for emergency patients • BCCG review of MHLS against core 24 standards • New NEL CSU MH escalation protocol to be implemented and actioned by Trust • Roll-out further training to improve capability of RFH staff in managing mental health patients.
7	<p>The Committee queried how the Trust was working with other service providers to encourage people to use alternative services rather than A&E, where appropriate. The Trust said it was working to improve the communication around Out of Hours Services. The Trust is holding conversations about having an Out of Hours Hub at the front of the hospital to assess whether patients can be treated away from A&E. The Trust acknowledged that there was confusion among people about what services are available and this required improvement. The Trust said it would bring a report to a future meeting on how this was progressing.</p>	<p>Streaming guidance has been developed and implemented along with piloting a GP streaming model to review opportunities to redirect patients from ED. Streaming to AAL and AEC increased from October. Joint nursing and primary/ secondary care streaming currently being explored and working with CCGs to increase MiDOS utilisation.</p>

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Barnet Health Overview and Scrutiny Committee

15 May 2019



Title	NHS Trust Quality Accounts 2018/19
Report of	Head of Governance
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	<p>Appendix 1 – Committee’s Comments on 2017/18 Quality Accounts – May 2018</p> <p>Appendix 2 –North London Hospice Quality Account 2018/19</p> <p>Appendix 3 – Community London Healthcare NHS Trust Quality Account 2018/19</p> <p>Appendix 4 – Royal Free Hospital NHS Foundation Trust Quality Accounts 2018/19</p>
Officer Contact Details	<p>Tracy Scollin, Governance Officer</p> <p>Tracy.scollin@barnet.gov.uk Tel 020 8359 2315</p>

Summary

This report presents the Quality Accounts from NHS Health Service providers 2018/19. 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 2018/19, 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.”

5.5 Risk Management

5.5.1 There are no risks.

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 Corporate Parenting

5.7.1 None in the context of this report.

5.8 Consultation and Engagement

5.8.1 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).

5.8.2

5.8 Insight

5.8.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1.1 Health Overview and Scrutiny Committee – 24 May 2018 – The Committee provided their comments on each of the Trusts'/Hospice's Quality Accounts:

<http://barnet.moderngov.co.uk/documents/g9506/Printed%20minutes%2024th-May-2018%2019.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=1>

Appendix 1:

Minute Extract from the Meeting of the Barnet Health Overview and Scrutiny Committee on 24 May 2018

9. QUALITY ACCOUNTS 2017-18

North London Hospice

The Chairman invited the following to the table:

- Miranda Fairhurst - Assistant Director, North London Hospice
- Giselle Martin-Dominguez – Assistant Director, North London Hospice

The Committee scrutinised the Draft Quality Account of the North London Hospice for the year 2017-18 and wish to put on record the following comments:

- The Committee commended the five week course for carers at the end of life which is run by the Hospice. The Committee noted the compliments from those who had attended the course, saying it had been excellent and very beneficial. The Hospice said this course had been developed via the Health and Wellbeing Centre and would be an ongoing course.
- The Committee commented on the activities and groups being run by the Hospice to support patients such as the Catching the Light group and the Death Café. The Committee said it was wonderful to hear such good feedback from patients on how these groups had helped them cope with their illnesses.
- The Committee praised the Hospice on their Service User Experience Key Performance Indicators (KPIs), noting all but one were higher than the previous year. The Committee also acknowledged there were no reported incidents of C.Diff at the Hospice, which is an excellent achievement; the Committee hoped to see this continue.
- Although the Committee noted that the number of pressure ulcers was high, they were pleased that all incidents were classified as unavoidable, which suggested that a good standard of monitoring was in place.
- The Committee was pleased to see that a part-time pharmacist had been employed to review the medication every patient takes on admission to the Inpatient Unit to ensure the medication given was correct.
- The Committee commented on how good the One Page Patient Profile for the Dementia Steering Group is, as it assisted staff with familiarising themselves with each patient. The Committee thought this was an excellent idea and should continue.
- The Committee was also pleased to see the incorporation of a Safeguarding Key Worker to take responsibility for each incident and chase down the issue to resolution. The Hospice said this was working well and the Safeguarding Key Worker meets with each team to discuss and resolve cases and this had really improved communication.
- The Committee complimented the Hospice on the wonderful service it provides in Barnet and expressed how appreciated it was. The Committee also commended the amazing volunteers and wonderful staff for all their hard work.

However:

- The Committee noted the high turnover of staff detailed in the Quality Account again this year. The Hospice explained that although the data suggested there was an issue with high turnover of staff, many of those who had left were Bank staff. The Hospice explained that the HR department was working hard to devise imaginative and creative ways to recruit and retain staff. The Hospice had recently reviewed their appraisal system and was aiming to recruit more permanent staff.
- The Committee noted that the incidents of pressure ulcers was high again and queried the reasons behind this. The Hospice explained that they were extremely vigilant in checking patients and counting all pressure ulcers. They said that compared to some other organisations, they counted each ulcer rather than just counting each patient who had an ulcer. The Hospice also said they worked on the principle that there are six categories of pressure ulcers rather than four. The Hospice stressed that the recording of ulcers was taken very seriously and full route cause analysis was conducted for all pressure ulcers classified as Grade 3, Grade 4, Ungradeable or Deep Tissue Injury, to ensure that all ulcers were unavoidable. The Hospice had also been working with the Hospice UK Advisory Group to ensure a high standard of monitoring.
- The Committee asked for an update on how the Hospice was responding to staff members who had reported experiencing bullying and whether safeguarding practices had been put in place. The Committee also queried whether these incidents of bullying were potentially contributing to the difficulties in retaining staff. The Hospice said it was disappointed in the numbers of staff that reported experiencing bullying. The Hospice explained that because the data was anonymous and no staff had come forward and reported the incidents, it was difficult to understand the individual circumstances. The Hospice said that it was working with managers to try and resolve these issues. The Hospice also said it was trying to encourage more staff to fill in the survey next year in order to get a better idea of how staff could be better supported and empowered.
- The Committee noted there was an increase in the number of safety incidents reported. The Hospice explained that the system of reporting had changed with the introduction of an electronic reporting system over two years ago. The Hospice said lots of teaching and training had been developed in line with the implementation of the new system and the importance of reporting incidents had been regularly highlighted. The Hospice said that the increased resources had encouraged people to report incidents, rather than there being an increase in the actual number of incidents. The Hospice said the number of incidents reported last year and this year was similar and therefore consistent.
- The Committee were concerned by the large increase in the number of days beds were closed as this had risen from 39 to 78 days. The Hospice explained that the closure of 3 rooms had been the result of issues with plumbing and there had been a long wait for a part needed to fix the issue. The Committee said it appeared that plumbing problems were a recurrent issue and was concerned that there was such a large impact on beds becoming unavailable. The Hospice said that, since this last incident, considerably fewer beds had been closed and the Facilities Manager was now

present at triage meetings to ensure they had a good idea of why rooms are closed and to enable the Hospice to react to closures more quickly.

- The Committee were concerned by the higher number of falls reported this year and asked the Hospice why these had increased. The Hospice said that there was a fine balance between allowing patients to be mobile but also avoiding falls. The Hospice explained that at the start of the Falls Project they had many patients who were mobile, but this inevitably came with a higher risk of falls. The Hospice said lessons had been learnt from the Falls Project and that sensory alarms for patients at risk of falling had been implemented. The Hospice was also about to purchase a low bed with crash mat. The Hospice felt the project had highlighted which patients were at risk and given staff more confidence in assessing and making decisions. User forums and practical sessions had been established to raise awareness and to help patients develop strengthening and balancing exercises.

In Addition:

- The Committee noted a Hard to Reach Programme was being established at the Hospice and asked how this was going to be done. The Hospice explained that it would be focusing on improving access to those with learning difficulties or suffering from substance abuse. The Hospice would be using external communication and ensuring services were accessible to all.
- The Committee asked how the 980 volunteers at the Hospice were supported in their work. The Hospice explained there is an extensive training programme in place which has been developed over the last few years. The Hospice said there were different levels of training dependant on the specific role of the individual, with a focus on the emotional development and support of those working face to face with patients. The Hospice also provides regular meetings with staff to ensure there is feedback and support.
- The Committee asked for an update on whether the Hospice had sourced alternative pressure- relieving mattresses. The Hospice explained that the existing mattresses were not received well by some of the patients, so they had campaigned for money to buy an alternative. The Hospice said that, so far, the patients with these mattresses seemed happy. The Hospice were monitoring any decrease in the number of pressure ulcers as a result.
- The Committee queried how many people used the Bereavement Service and how many had to turn to private services. The Hospice said it was not able to give an exact answer, but explained assessments were made by phone in order to establish what follow up support a bereaved individual required. The Committee noted there was an error on page 18 which should read 2017, rather than 2018.

Central London Community Healthcare NHS Trust (CLCH)

The Chairman invited the following to the table:

- Kate Wilkins – Interim Assistant Lead of Quality, CLCH

The Committee scrutinised the Draft Quality Account of the CLCH NHS Trust for the year 2017-18 and wish to put on record the following comments: CLCH

- The Committee was pleased to see the success of the Shared Governance

Quality Councils. The Trust said that the Quality Councils ensured the organisation had a voice from the shop floor. The Quality Councils are chaired by lower paid workers and supported by the Assistant Director of Equality, enabling them to feel empowered and to work towards identifying and resolving issues. The Trust said that this had been running for its second year and the feedback had been positive.

▣ The Committee commented on the success of the Care Homes Inreach Team which was run in 7 Care / Nursing Homes in Wandsworth. The Committee were keen to see this established in Barnet as there are many Care Homes in the Borough. The Trust said it is a Wandsworth commissioned scheme but it would discuss with Barnet CCG about implementation in Barnet. The Trust said it is an excellent scheme.

▣ The Committee was pleased to note that the number of patients reporting that they had been treated with dignity and respect had increased, as this is an important aspect of quality care.

However:

▣ The Committee enquired as to which Boroughs the Trust was now serving and was concerned that previous expansion had brought challenges and that taking on more Boroughs could exacerbate the problems. The Trust said they were happy to circulate the list of Boroughs and that they are only taking on new services that were in their existing STP area and that this was in accordance with the overarching Trust strategy.

▣ The Committee noted that improving the uptake of flu vaccines for frontline clinical staff had not been met. The Trust explained that there were reasons why staff had chosen not to take the vaccine. These included the belief that the vaccine had no value, that they had never had flu before, the belief that it could make the staff sick or lower their immunity and some even stated they did not want to be dictated to. The Trust said the plan going forward was to improve education on the vaccine and to emphasise its importance.

▣ The Committee asked for an update on the increase in pressure ulcers. The Trust said it was disappointed that there was an increase, but there was a action plan and a team specifically investigating pressure ulcers. The Trust said it had identified that documentation on discharge and policy had not always been followed, but a root cause analysis after every pressure ulcer was conducted. The Trust said learning from each case was communicated to all staff and that every pressure ulcer was taken very seriously. The Trust highlighted the organisation had grown over the past year and so the greater numbers might not be proportional.

▣ The Committee noted that the hand hygiene report had been lower than the Trust Board KPI of 97%. The Trust said it was disappointed with the audit and that it would be conducting investigations in order to improve this.

▣ The Committee noted only 63% of the urinary catheter assessment forms had been completed. The Trust acknowledged this required improvement.

☐ In respect of the CQC recommendation regarding Children's Services, the Committee noted that the waiting time required improvement and asked what risk management strategy had been adopted. The Trust said that no 'must do' safeguarding issues had been identified by the CQC. The CQC however had commented on the need to provide different roles in Health Visiting Services and to improve the skillset across areas to fall in line with the CQC guidance.

In addition:

☐ The Trust updated the Committee that the patient stories which were included in last year's Quality Account would now form part of the Annual Report

☐ The Committee asked how a cost could be attributed to staff health improvement. The Trust explained that there was a small cost to run campaigns on health and wellbeing and run health schemes, however the expenditure was worth the gain.

☐ The Committee noted that some Boroughs were particularly expensive to live in and queried whether this was influencing the staff retention rate. The Committee suggested that the Trust work with Housing Associations and other organisations to find affordable housing for their staff.

☐ The Committee commented on the issues with staff retention and asked the Trust to explain how it would be approaching this. It said it would be looking to entice staff to stay by giving them new career pathways and supporting them to develop their careers. The Trust felt some staff had previously left due to a lack of awareness of the opportunities to progress. The Trust had established an apprenticeship forum and retention and recruitment group in order to improve the retention of staff. The Trust also found the number of women returning after maternity leave had been disappointingly low, so the it was working on a programme of retraining and providing workshops for those returning. The Committee asked whether the high cost of child care played a part in women being unable to return and whether there was a crèche available. The Trust said this issue had not been identified, however it was considering providing affordable accommodation to attract young nurses.

Royal Free London NHS Foundation Trust

The Chairman invited the following to the table:

- Dr Mike Greenberg - Medical Director for Barnet Hospital

The Committee scrutinised the Draft Royal Free London NHS Foundation Trust Quality Account 2017-18 and wish to put on record the following comments:

☐ The Committee asked for an update on the diabetic alerting system that was mentioned in the previous Quality Account. The Trust did not have the information to hand but would update the Committee later.

☐ The Committee acknowledged that Barnet Hospital had been held up as a model for ambulance turnaround times and that great strides had been made in this area. The Trust said the focus for the winter was to improve the flow of beds throughout the hospital as this would have a positive impact on the A&E targets, enabling them to meet the national

target of 95%. The Trust said the summer came with different challenges as the activity and volume of patients in A&E increases, but the severity of the illness decreases.

☐ The Committee praised the Trust on Barnet Hospital Stroke Unit being awarded an “A” and said that was an excellent achievement.

☐ The Committee commended the Trust on its refurbishment of Ward 10N, the Dementia Ward, which helped make patients with dementia or Alzheimer’s feel at home.

☐ The Committee was pleased to read that Clinical Practice Groups and “huddles” had been set up. The Trust said that these groups were an example of the way in which it was working to reduce any unwanted variation between the different hospitals. The Trust explained that new digital systems would be put in place and rolled out to ensure every site has the same equipment. The Trust said the improved equipment would allow them to prompt all sites to give the same treatment, tests and feedback as well as tailor care to individuals when required.

☐ The Committee was pleased to see there was an increased focus on safety, however they suggested a target number of falls be included in the future to make it easier to assess improvement.

However:

☐ The Committee asked the Trust to clarify the total number of C.Diff cases, as it was noted they did not meet their target last year. The Committee commented that the tables in the Quality Account were not particularly clear and asked that the target for the year be included. The Trust explained that the two graphs explaining C.Diff were measuring different things, which is why the numbers were different.

☐ The Committee noted A&E targets had not been met. The Trust said Barnet Hospital was improving having hit 90% last week, but there had been a big variation during the winter which had been particularly challenging. The Trust said that currently the Royal Free was around 85% and that a big focus was being put into increasing this to 90% by September 2018 and 95% by February 2019. The Trust said the Emergency Department at the Royal Free was now fully open and colleagues were working towards improving performance targets.

☐ The Committee was concerned that the issues surrounding parking at Barnet Hospital which had been raised for many years, were still outstanding. The Committee stressed that patients had raised concerns about the lack of parking and that this often led to them missing appointments. The Committee stressed that the car park was inadequate and that this issue urgently needs addressing.

☐ The Trust updated the Committee on the parking situation and explained that Barnet Hospital was in early discussion about building a multi-storey car park on-site. The Trust agreed to bring a report on the plans and progress of the development to a future meeting. The Committee requested that Ward Councillors be consulted on the plans as early as possible to engage with residents. The Committee also suggested advertising bus routes that travel to the hospital to encourage more people to use public transport.

☐ The Committee noted that only three of the comments from the Committee on the 2016-2017 Quality Account had been published. The Chairman stressed that it was a requirement for all the comments to be included in full.

☐ The Committee was concerned that the targets for Referral to Treatment (RTT) had not been met and that the Trust's performance in February 2018 was only 83.4%, compared to the national target of 92% waiting 18 weeks or less for access to Consultant-led services. The Trust said this was a concern and that it was a big focus for improvement. The Trust said they investigated all cases where patients had waited longer than the target for care to ensure no harm had been caused. The Trust also said the figures were partly a result of improvements to the way in which it tracks patient pathways.

☐ The Committee was also concerned with the delay in first definitive treatment with only 83.1% of patients receiving treatment within the 62 days. Although this figure was an improvement on last year, it still is below the 92% standard. The Trust said currently the 62 week target was not being met due to the large volume of referrals of patients with low GI cancer, which was an increasing issue. The Trust assured the Committee that work was being done to make the necessary improvements.

In addition:

☐ The Committee enquired as to how the Trust dealt with mental health patients that turn up at the A&E. The Trust said it was working on better engagement with service providers to place them into the right care. The Trust acknowledge A&E was not the right environment for many of them, but was sometimes the only safe place the police could bring them. The Committee were also informed that the police do receive training on how to deal with mental health incidents.

☐ The Committee queried how the Trust was working with other service providers to encourage people to use alternative services rather than A&E, where appropriate. The Trust said it was working to improve the communication around Out of Hours Services. The Trust is holding conversations about having an Out of Hours Hub at the front of the hospital to assess whether patients can be treated away from A&E. The Trust acknowledged that there was confusion among people about what services are available and this required improvement. The Trust said it would bring a report to a future meeting on how this was progressing at the Royal Free Hospital.

☐ The Committee queried whether statistics were available regarding the waiting time at A&E in comparison to alternative services and suggested this could be used as a persuasive campaign to encourage people to use other services more. The Committee asked whether nurses advise patients that they can go elsewhere to be seen more quickly. The Trust said this does take place, however nurses were only able to advise patients to do this in very low- risk cases.

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**NORTH LONDON HOSPICE
QUALITY ACCOUNT
2018-19
DRAFT**



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Executive Summary

Patient Story **Peter's Story**

"Watching this wonderful man slowly die away in front of our eyes over the nine months of his illness was deeply painful. But the amazing support of North London Hospice enabled him to die with such dignity, in the home he loved, surrounded by all four generations of the family"

These words from Peter Dyer's daughter, Louise Hodgkinson, show the impact our community nursing team can have on a family facing a journey with a terminally ill loved one.

Peter had many passions. He was a wedding photographer, musician, dog trainer, father-of-three, grandfather, great-grandfather and husband to Pam for 53 years.

In late 2017 Peter was diagnosed with a malignant brain tumour at the age of 75.

While he remained Peter was mobile, Peter and Pam utilised the facilities at NLH's Health & Wellbeing Centre in Winchmore Hill. Peter would attend the exercise classes and lunches and if the pianist was there he would often provide the vocals.

"As a carer, I received much needed support from the Hospice," explained Pam. "I did the carers course, had massages and tried reiki."

In his final months, Peter decided he wanted to remain at home so a care team was arranged.

The hospice developed a care plan with Peter and supported him with his symptom management. A Community Palliative Clinical Nursing Specialist visited Peter and Pam every week and they received regular visits and support from a Social Worker and the Palliative Consultant.

"They were all excellent," added Pam. "They helped us prepare and gave us all the time we needed as we tried to ready ourselves for what would happen next."

Louise added: "The hospice played a big part in us being able to keep dad at home. During the last couple of weeks the house was full of family.....grandkids, great-grandkids....sometimes we'd have 18 for dinner. We'd all float in and out of his room to chat or read to him. We created some wonderful memories in those last few months, including celebrating his 76th birthday.

"Having dad cared for at home enabled us to be with him and for the children to be more prepared for his passing. On the day he died he received a kiss from one of his grandchildren and two minutes later, he was gone."

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

It is with great pleasure that I introduce you to North London Hospice's (NLH) 2018 - 2019 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 has seen a number of significant service developments. There has been investment in our community services as part of the NHS Sustainable and Transformation Plan (STP) to provide end of life care to more people within our three boroughs. This funding will see additional Nurses, Doctors and Allied Health Professionals joining services. The development will see the Community Services extending hours of operation to 8am-8pm.

We have also increased our service provision Out of Hours. In addition to the telephone advice service, we now have a clinical nurse specialist and healthcare assistant available to visit patients where necessary between 8pm and 8am. Recruitment is well underway to enable the service to operate seven days a week.

The First Contact Service is up and running and will provide a simpler approach to clinical calls from patients and professionals.

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 Patient and Family Feedback Group for their comments and suggestions. We have five projects this year:

- Development of a carer's strategy
- Organisational review of the integration of User Involvement, Co-production and Community Engagement
- Year 2 of the implementation of the Productive Ward on the Inpatient Unit
- Implementation of a new clinical database EMIS
- Development of non-medical prescribing within the community teams

In March we held our second North London Hospice staff conference. Departments presented on a wide variety of topics focused on Leadership, sharing practice to enable a greater understanding and learning across the organisation. It was a successful day, positively evaluated by attendees. Plans are already underway for our next conference in 2020.

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

Pam McClinton
Chief Executive of North London Hospice
April 2019

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.

This 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 are available to read in the reception areas at the Finchley and Winchmore Hill sites. Paper copies are also available on request via our Assistant Director of Quality.

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. Overnight Clinical Nurse Specialist Service
3. Health & Wellbeing Service (H&W)
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. First Contact Service

For a full description of our services please see Appendix One

Part 2: PRIORITIES FOR IMPROVEMENT 2018-19

The following priorities for improvement for 2018-2019 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:

Improving Access: Addressing inequalities in service provision (Year 2)

What we planned

This was the second year of a priority for improvement project to address inequalities in accessing our hospice services.

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

- People with learning disabilities
- Homeless people
- Improving our working with the significant cultural groups across the three boroughs we service - Barnet, Enfield and Haringey.

Progress against the Plan

Progress was very much aided by the appointment of two Hospice Community Ambassadors.

People with learning disabilities

- Learning Disability champions were identified by our services
- The Ambassadors connected with many borough stakeholders to profile NLH services, explored different ways to refer and to gain commitment for closer partnership working
- A Learning Disability Stakeholder event is being held in May 2019 and will bring together internal and external members to explore partnership working

Homeless People

The Ambassadors met with key stakeholders in the three boroughs to promote the Hospice, particularly the Health & Wellbeing Centre, and to explore partnership working. One referral for a homeless person was reviewed in depth to ensure needs were met.

Working with significant cultural groups

The Ambassadors have met with several cultural groups and continue to build relationships with them. For example: attendance at the interfaith forum, Enfield, and building relationships with the North London Mosque (having been given a monthly slot at the mosque to raise awareness of NLH).

Going forward

During the Priority for Improvement period it was acknowledged that NLH needed to invest resources in community development. The Board approved investment for two years and part of this is to identify new and different groups to assist improvement of access. Community Ambassadors are now in post across our three boroughs with the aim to expand our Compassionate Neighbours initiative and continuing to develop our partnerships.

Work that commenced during this priority for improvement will be addressed as part of the Patient Experience Priority for Improvement in 2019 – 2020. See page

Priority Two: Patient Experience:

Introduction of a “One Page Patient Profile” (now called “Things to know about me”)

What we planned to do

We planned to introduce a One Page Patient Profile across our services, as a simple, concise way of communicating information about an individual patient (includes anything important to them; what they like and how they want to be supported) on a single sheet of paper, completed by the patient or a family member. It is particularly supportive for patients who are not able to tell the staff this information for themselves, for example if they have dementia.

Progress against the plan

The Hospice Dementia Steering Group designed the initial One Page Patient Profile and decided to call it “things to know about me”. The draft was reviewed by members of the Hospice Patient and Family Feedback Group and minor changes were made.

It was piloted on the Inpatient Unit (IPU) and then rolled out throughout the Hospice. It is now used regularly, mainly in IPU, for patients with dementia, or with other patients who are unable to sufficiently communicate.

Staff have found using the document helpful, as have families and patients. Examples where staff have found it supportive in improving patient care include knowing that a patient like to:

- Have his headphones in for long periods
- Have a handkerchief in his top pocket of his pyjamas
- Have her door kept open.

Staff report that families have said that they felt re-assured knowing that this important information was recorded.

This is a copy of the document:

Things to know about me

Routines I like to follow

-
-
-

People important to me

-
-
-

How I communicate

-
-
-

Hobbies / interests / jobs

-
-
-

**THIS IS ME
I like to be called:**

Things that worry or upset me

-
-
-

I would also like you to know:

-
-
-

Things that help me feel better

-
-
-

Dementia Steering Group NLH July 18 v.2

Care Number:

Going Forward

The use of 'things to know about me' has become established practice in the IPU. It is a regular agenda item at the Dementia Steering Group in order to continue to review its use and to remind staff that it can be used for Community and Health & Wellbeing centre with patients who could benefit from it.

Priority Three: Patient Safety:

Establishing a falls group for community patients

What we planned

We planned to set up a group that was both educational and practical for our Health & Wellbeing patients, community patients and any inpatients waiting to be discharged home. We planned for a questionnaire to be given to patients before and after they attend the groups to ascertain if the aims as outlined below have been achieved.

For patients to have:

- Increased awareness of why falls happen and know what they can do to reduce them at home
- Better knowledge of what to do if they do fall

Progress against the plan

A pilot group was run in October 2017 with the feedback from the questionnaire showing that participants had been positive about the group and that the goals had been met. Following the pilot a second group ran at the start of 2019.

Handouts were provided, and we will continue to develop these as we refine what we do to ensure we meet the needs of our patients.

Going Forward

A falls group will consist of three, one and half hour long sessions, and will run four times a year.

Each services' multidisciplinary team meeting will identify who would benefit from the group and place the patient directly onto the waiting list for the group.

The group will combine both patients and carers and continue to have a multidisciplinary approach by including a physiotherapist, occupational therapist and a nurse.

Steering group meetings will ensure discussions continue around our falls pathway, ongoing developments and to keep falls awareness at the forefront of priorities at North London Hospice.

Priority Four: Clinical Effectiveness:

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

What we planned to do

We planned to implement the first three core modules of the Productive Ward.

- The Well-organised Ward
- Knowing how we are doing
- Patient Status at a Glance

(The Productive Ward is an initiative developed by the NHS to improve ways of working that leads to "Releasing Time to Care", enabling staff to spend more time with their patients).

Progress against the plan

Elements of all three modules have been introduced leading to meaningful change within the IPU. Some examples of where successful changes were made include:

The well-organised ward:

- Process changes in how medicines were ordered
- Changes to stock being kept in patient rooms to save time by having items to hand
- Improved labelling of stores cupboards so we could easily see contents

Knowing how we are doing:

A board in the ward office was dedicated to providing clear easy to read information on how the unit is doing.

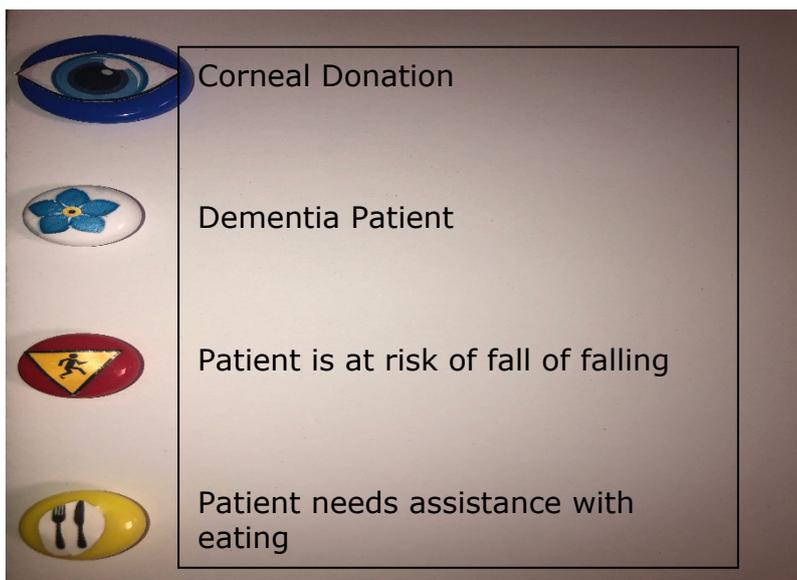
Two examples of information include: a colourful graph to demonstrate to staff the reduction in pressure ulcers over a two-year period and copies of the compliments received from relatives.

This helps to keep staff informed and remind them of the difference they are making to patient care.

Patient Status at a Glance

Magnets were made by our ward clerk to put against patient names on the board in the ward office. For example, to indicate patients who had dementia, who were at risk of falling and who needed help with eating and drinking.

This helps staff and volunteers to identify "at a glance" important patient needs and whilst it does not replace the handover, it releases time to care as it reduces the need to remind staff and volunteers about patient care risks and needs.



Examples of magnets used to identify patient needs at a glance.

The introduction of all three modules has enabled time to be saved in different ways, enabling staff to spend more time with their patients.

Going Forward

Whilst continuing to re-enforce the changes introduced through the three core modules, we are going to work on implementing change associated with four further modules, and we will do this as a Priority for Improvement for 2019 – 2020.

LOOKING FORWARD: PRIORITIES FOR IMPROVEMENT 2019-20

The following Priority for Improvement Projects for 2019-20 have been identified by the clinical teams and endorsed by the Quality, Safety and Risk Committee.

All projects were discussed at the Hospice Patient and Family Feedback Group, their comments were 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:

Developing a Carers Strategy

How we identified this project

NLH aims to look after not just the patient but to also provide support for the people who care for them. It is our intention to formulate a Carers Strategy to set out how we do this:

By carer we mean the significant family members, friends, children and neighbours that make each day possible for someone living with a progressive and terminal illness. Within our communities they are key people, supporting patients at home and often preventing admission/readmission into hospitals. In addition, within NLH we have extended this definition of carer to include kinship carers. By which we identify those individuals providing care to children, before and after the death of one or both parents. This includes adult siblings, grandparents and other family members as well as friends.

Being a carer of someone who is terminally ill brings particular and specific challenges – not least the fact that these individuals will often fail to recognise themselves as a carer. Our professional behaviour can often reinforce that lack of identification – as we may often see carers only as family members; as individuals who may need bereavement support, without acknowledging also that they could benefit from engagement and support around their carer role specifically.

Our strategy must attend to the identification of carers, as well as attending to our relationship with them, and any additional help they need to enable them to remain resilient and effective in this role.

What we plan to do:

We plan to produce a Carers Strategy to:

- Increase our understanding of need and the work we are doing with carers
- Raise the profile and understanding of needs and work undertaken with carers across NLH
- Provide a wider range and type of support to carers by staff and volunteers – informal to formal involvement

What the outcomes will be:

That a strategy will be in place in order to achieve the above

Patient Experience - Project 2:

Organisational review of the integration of User Involvement, Co-production and Community Engagement

How we identified this project

Over recent years NLH has undertaken a number of initiatives to engage further with both its users and the public. For example, by establishing user forums, Compassionate Neighbours, development of Health & Wellbeing services through co-production and improving access as a Priority for Improvement.

A review is now needed to identify how we integrate user involvement, co-production and community engagement moving forward

What we plan to do

Initially to hold a workshop with internal stakeholders from across the organisation. This meeting will be key to developing and agreeing the scope of the project, objectives and timeframes and in defining the organisations strategic and operational response. This is to ensure the organisation continues to respond appropriately to both user and engagement agendas.

What the outcomes will be

A consolidated and defined organisational approach to user involvement, co-production and community engagement

Patient Safety - Project 3:

Non-medical prescribing - independent prescribing for

Community Teams

Non-Medical Prescribing (NMP) is the prescribing of medicines, dressings and appliances by health professionals who are not doctors.

How we identified this project

NLH acknowledges the benefits to patient care of its nurses being non-medical prescribers. The priority for improvement supports the organisation to expand the number of non-medical prescribers across the community teams.

What we plan to do

We plan to develop and implement a professional development programme for non-medical prescribing. This is a two to three year project.

What the outcomes will be

- Existing Band 7 Community Nurses (excluding those within three years of retirement) to be trained as NMP by March 2022.
- New Band 7 Community Nurses to be trained as NMP within three years of appointment.
- Inclusion of NMP targets. Pay award following successful completion and implementation in practice
- Clinical outcomes:- improved patient outcomes and quicker symptom control through the prescribing of medications including injectable end of life care medications

Clinical Effectiveness - Project 4:

Implementation of the Productive Ward in the Inpatient Unit (Year 2)

How we identified this project

This is part of a two year project. Last year a steering group was set up to undertake work on the three core modules of the Productive Ward.

What we plan to do

This year we plan to address four further modules:

- Meals

- Medicines
- Admissions and Planned Discharges
- Shift handovers

Our intention is for the steering group to review each module in turn and identify areas where practice could be improved following the suggestions outlined in the Productive Ward toolkit.

What the outcomes will be

Elements from the Productive Ward toolkit for each module relevant to our care in the IPU will be implemented so that change occurs, releasing time for our staff to spend with their patients.

Clinical Effectiveness - Project 5:

To introduce a new organisational clinical records database, EMIS

How we identified this project

NLH current clinical records database no longer meets the needs of the organisation.

What we plan to do

Development and deployment of the new database that has been built to meet both the clinical and data reporting requirements of the organisation.

Improve the sharing of information between NLH and patients GPs

Ensure efficient management of processes related to triage and transfer of patient information

What the outcomes will be

To have a clear, standardised, safe and efficient electronic pathway in place to transfer, store, record and use clinical information to communicate both internally and externally.

STATEMENTS OF ASSURANCE FROM THE BOARD

The NLH Quality Account is required to report on a series of mandatory statements. Where they are not applicable to our service, they can be found in Appendix 4.

Review of services

During 2018-19, NLH provided and/or sub-contracted two services where the direct care was NHS funded and three 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 2018-19 represents 34% per cent of the total operational income generated by NLH for the reporting period.

Participation in Audit

The following audits were undertaken during the previous year to ensure that NLH provides a consistently high quality service.

Infection Prevention and Control Audits

Audits have been completed for IPU, Health & Wellbeing Centre and the George Marsh premises with levels of compliance of 95%, 95% and 98% respectively. Areas of non-compliance included the need for improved treatment of lime scale, consistent completion of decontamination checklists and the correct labeling of sharps bins.

Hand Hygiene Audits

The Hospice receives specialist Infection Prevention and Control support from an external specialist. This year we undertook the Hand Hygiene audit provided by the specialists which considered both the handwashing facilities and observation of clinical staff. The audit was completed for IPU, Health & Wellbeing Centre and the George Marsh premises with levels of compliance of 100%, 94% and 100% respectively. The corrective action required was the removal of items that were obstructing the round to the clinical hand wash basin.

Audit of Waste Management

This audit was undertaken to ascertain compliance to Hospice policy and relevant legislation regarding management of waste. The initial audit found several areas of non-compliance. However, two subsequent follow-up audits have found that all identified non-conformance were actioned and completed. A further re-audit is to take place next year.

Medication 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. This year has seen the introduction of a new Controlled Drug Register on the Inpatient Unit and policies have been updated to address issues such as handling of controlled drugs in the community and destruction of patients own medication.

Audit of use of bedrail risk assessment tool in IPU

This was a patient safety audit repeated from last year to ascertain compliance to the use of bedrail policy. The audit showed an improvement in completion of the bedrail risk assessment, and some improvement in the frequency of review (re-assessment). However, not all reviews were completed weekly in accordance with the policy. The outcome of the audit following discussion with the relevant clinicians, led to the policy being updated stating that the review is to be undertaken when the patient's condition changes rather than weekly.

Audit of fall paperwork in IPU

This was a re-audit following the introduction and subsequent audit of the new falls paperwork last year. This audit showed improvement in all standards regarding completion of falls paperwork. Of particular note was that 100% of reviews were fully completed (33% improvement from last time). A further re-audit is planned for January 2020.

Audit of the Dementia-Friendly Environment – Health & Wellbeing Centre

This was also a re-audit from last year. The findings were good. They were discussed at the operational meeting in March 2019: signage is going to be improved (of exit and toilets) and the compilation of a resource box for dementia patients to be held on site will be considered.

Audit of compliance to the Care Quality Commission Standards

Internal audits were carried out in all clinical services throughout the Hospice over a four month period. Practice was audited against the Care Quality Commission (CQC) regulatory standards, and the findings were generally good.

An action plan was put in place for improvements to be made, monitored by the Quality and Risk group. Examples of actions:

- Introduce a policy for the use of chaperones.
This has been written and is currently progressing through NLH governance systems.
- Nutrition care plans updated to include information about culture / religion requirements.
- Ensure high level dusting is routinely undertaken in patient rooms.
This has been actioned and is being regularly monitored.

The internal audits will be repeated next year.

Audit of admissions to the Inpatient Unit (IPU)

The minimum target for IPU occupancy is 80%. On occasion this is not reached as patients are not able to be admitted from the IPU waiting list. An audit was undertaken to determine the reasons for not admitting a patient on a given day. The audit found that the primary cause of non-admissions cited over the two month period (Oct-Nov 18), was due to a lack of nurses or doctors. The Hospice was already aware of the nursing staffing issues and ongoing work has been undertaken to recruit more IPU nurses, with some recent success. In addition, a rota of doctor availability is going to be available to assist in planning for admissions.

Record-Keeping Audit (IPU)

This was a re-audit looking at how well the paper records used in IPU comply with the record-keeping standards set out in the policy. The audit found improvements in all areas particularly with regards to the use of abbreviations in records. However, further improvement is still required for staff to print their names the first time they make an entry in patient record. The education team will deliver a record keeping update for staff and a further re-audit will take place.

Audit of compliance to the blood transfusion standards (IPU)

This audit looked at the extent to which the documentation pertaining to all blood transfusions undertaken in the IPU over the past year complied with the Blood Transfusion Policy. The findings showed that compliance was good with a few minor improvements to be made. For example ensuring that a full set of patient observations is recorded in the patient records post transfusion. Staff have been made aware of this.

Audit of consent practices throughout hospice services

This audit looked at the records from patient services throughout the Hospice to ascertain the extent to which they complied with the Hospice Consent Policy. Minor areas for improvement were noted that have been discussed at the Information Governance Steering Group and will be addressed with the introduction of the clinical database EMIS.

Use of the new referral form for Patient and Family Support Service Quality, Innovation, Productivity and Prevention Project (QIPP)

This project involved reviewing a new process for referrals from the Inpatient Unit to the Patient and Family Support service. The process was reviewed by a Social Work Manager at quarterly intervals, and included consultation and feedback from those making referrals. Appropriate changes were made to the documentation and process, which is now fully integrated into the IPU. The final review indicated that all referrals contained the required information and staff had become more confident in identifying appropriate issues to refer to the service and their level of urgency. This has resulted in a timelier, effective response from the Patient and Family Support Service.

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'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.



NLH is required to register with the Care Quality Commission and its current registration status is unconditional.

DATA QUALITY

Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner.

The Data Security and Protection Toolkit was introduced for 2018/19 and is an online self-assessment tool that must be completed by all organisations that has access to NHS patient data and systems. It enables these organisations to measure their performance against the National Data Guardian's 10 data security standards and to provide assurance that they are practicing good data security and that personal information is handled correctly.

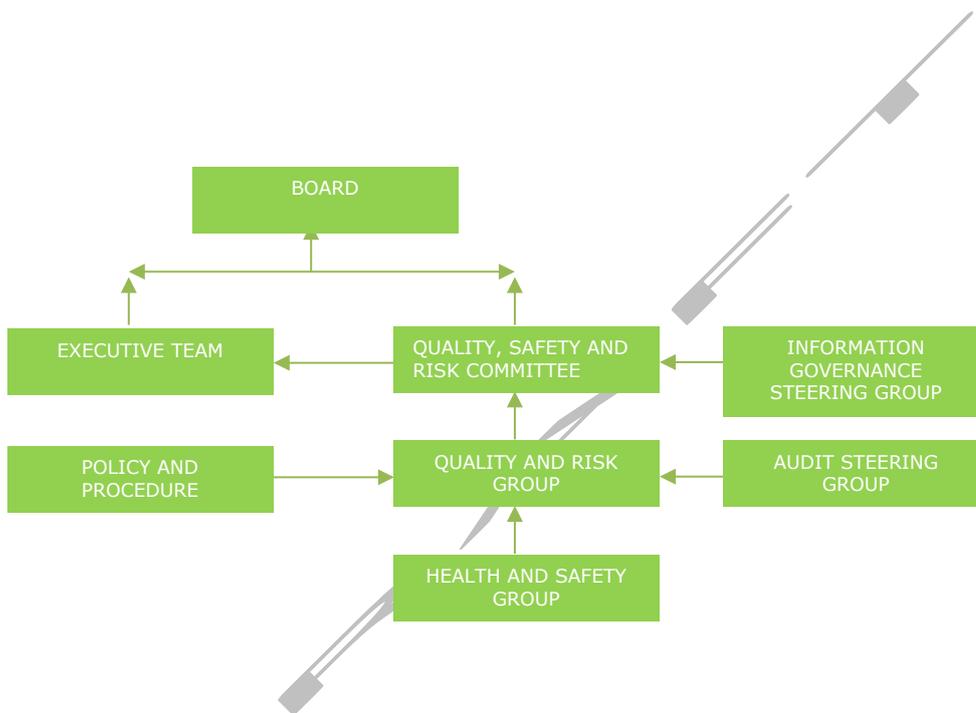
The Hospice completed this toolkit in March 2019, completing all mandatory assessments.

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 2



KEY SERVICE DEVELOPMENTS OF 2018-19:

Health & Wellbeing Service Highlights 2018-2019

Following the launch of The Health & Wellbeing service in March 2018 the service has continued to evolve and develop. The team has consolidated regular courses and workshops which continue to run throughout the year providing rehabilitation and self-management skills, emotional and psychological support, social and companionship opportunities and one to one clinic appointments to support symptom management.

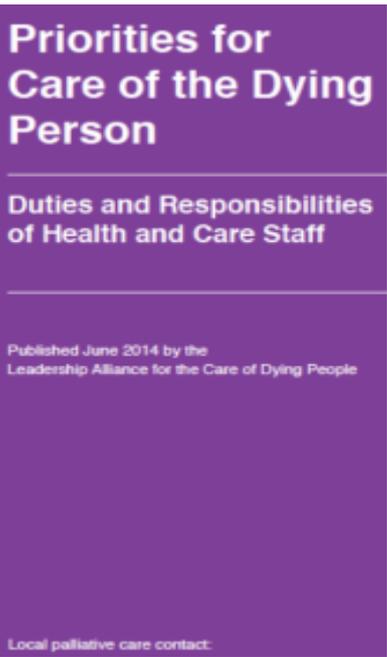
Highlights and new initiatives this year include:

- Working in collaboration with the charity Look Good, Feel Better to provide regular workshops to help women combat the visible side effects of cancer treatment
- After providing the training for the Hospice Biographers last year, we now have trained volunteers to interview and record oral life stories, part of some of the legacy work we undertake
- Following training, our Health Care Assistant has set up a Namaste group for those with impaired cognition, focusing on the senses (Namaste Care is a structured programme of sensory activities that aims to improve end-of-life care for people who have advanced dementia by giving them pleasure and helping them connect with others)
- The *Catching the Light* photography group has gone from strength to strength and exhibited and sold some of their work at the Affordable Arts Fair on Hampstead Heath as well as learning about photography, setting up monthly photography walks and exploring issues such as self-identity through photography
- We have been fortunate to have a drama therapy student and an art therapy student – both have contributed hugely to the psychological wellbeing services. We have also been able to run a weekly Life Matter group for men.
- The drama therapist worked alongside the physiotherapist to co-produce a group for those with a neurological condition exploring functional and expressive movement
- Following feedback from patients we now run a three session course to understand common sleep problems and strategies to improve sleeping patterns

Community Services

The Community team's **rapid response service** has been running for over a year. The rapid response Clinical Nurse Specialists (CNSs) see approximately five urgent cases per week across the three borough teams. This service helps to ensure we are responsive to urgent need and is supported by the teams Associate CNSs, Social Workers and Health Care Assistants enabling patients to die at home, with support for their family/friends. It also promotes joint working with General Practitioners (GPs) and District Nurses (DNs) and strengthens the development of end of life care practice.

The Community Team have delivered training to GPs and DN's on the **5 Priorities of Care** document:



If anyone, or the dying person or those important to them raise concerns, a senior clinician must review the person and the goals and plan of care. The titles above are intended as memory prompts and attention should be paid to the whole description for each section. Expanded explanations are included overleaf.

This is a national document aimed at supporting staff in delivering compassionate care for people and their next of kin at the end of life. The document is now in use as a care plan, with additional information booklets - one with all professionals contact details and pharmacy opening times (borough specific) and a second with vital information to support relatives and friends caring for their loved one.

The community nurses are leading on the implementation of the use of **Coordinate My Care (CMC)**. Coordinate My Care is an innovative NHS service that builds medical care around the wishes of each patient. A shared care plan is created and updated that can be seen by all the healthcare professionals who might be involved in providing care: - GPs, community nurses, hospital team, out-of-hours doctors, specialist nurses, London Ambulance Service and NHS 111, enabling them to have information on patient's preferred place of care and current care plan, helping to prevent unnecessary / unwanted admissions to hospitals.

The **overnight CNS service** started in November, building on the existing Out of Hours telephone advice service. This is a three year project where care is provided by a CNS and a Healthcare Assistant between 20.00 and 08.00. It includes giving patients and professionals access to advice on the telephone, and coordination of other services, and where indicated face to face visits to manage a crisis and prevent unwanted /unnecessary admissions to hospital. The service has received 821 calls since November 2018.

Under the **Sustainability and Transformation Plans (STP)** - see page X and investment from the Clinical Commissioning Groups (CCGs) in Barnet, Enfield and Haringey we have recruited extra nursing staff of all grades to the Community teams. This means we can extend our reach to more people, supporting them and their loved ones in their preferred place of care and ensuring comfort through effective pain and symptom management and promoting their optimum level of independence.

On the 1st April 2019 we set up a **First Contact Service**. This was where the triage service and the switchboard merged in to one service to ensure all calls into the Hospice are dealt

with promptly and by the right person.

Patient and Family Support Services

Community Development (Compassionate Neighbours)

Projected demographic changes relating to end of life; an ageing population and increase of people living for longer with a number of conditions (multiple morbidities), means that what 'Hospice Care' is will change. Our communities will increasingly need to be more involved in the solution to care as well as engaging with us differently.

Our Board of Trustees have invested in development posts to improve our capacity to make essential contacts and develop resources to promote ourselves. We hope that by building relationships with our communities we understand each other better; so they are more likely to use our services, support us and each other.

This development has three main strands to:

- Increase take up of our Health & Wellbeing Services,
- Continue to target specific groups to improve access. E.g. people who are homeless, to identify more ways for patients and families to support themselves ('Self-Management' resources)
- Further increase Compassionate Neighbours who support each other and Community Members who are socially isolated; particularly challenging when facing a life limiting illness. 96 people have been trained as Compassionate Neighbours so far, and they have supported 61 individuals.

Kinship Support

We are proud to be one of two hospices in the UK to have gained funding from St James' Place Charitable Trust, to be the first to have a designated kinship support coordinator. Kinship support is support provided to Grandparents and other kin, as well as unrelated 'friends' of the family, where one or both of a child's parents have died.

The post, which started in January 2019, will be able to scope the range of needs and through working collaboratively, will explore the most relevant and effective service response. For example, providing information, informal support networks (WhatsApp groups), designated volunteer support and signposting to other organisations. This one-year development will raise the profile of kinship supporters and their protective role for children, as well as raise awareness and upskill NLH staff and volunteers via a training programme. This will also link in with a new Priority for Improvement (2019/20) to develop a Carers Strategy.

Outcome Star Development – Working Title 'Preparation Star'

This NLH initiated development with other collaborators (St Joseph's Hospice, Macmillan Cancer Support, Jewish Care and the London Association of Directors of Adult Social Services)

will have completed the pilot phase by May 2019. The intention was to develop a collaborative assessment tool. As with all such initiatives we have begun to understand what is useful. The time taken for our nurses and social workers to complete it seems too long. However, for more well patients who attend Come & Connect, it has proved really useful, as a way of opening up conversations. For this reason a 'Self-Completion' version is now part of the pilot. This could become something available to everyone with a life limiting illness to help plan and assist conversations with loved ones, professionals and agencies. (See Appendix 3 for further details on Outcomes Stars).

Bereavement Support Development

In response to service need a targeted volunteer recruitment campaign took place in early 2019. We were delighted with the response and level of interest and have been able to recruit and deliver initial training to 25 additional bereavement support volunteers. This will enable us to continue to develop the options of support available.

Our Bereavement Information Leaflet has been reviewed, updated and now better reflects the service we provide. We have also created several resources to enable people who have received support to provide feedback about their experience and contribute to further development of the service.

Work with children and young people

In response to feedback from staff and service users, we have developed our resources for children and young people. Following consultation with staff we now have a number of books, workbooks and resources that families can borrow to support younger family members themselves. They can also be used by staff and volunteers in our work with families. These have been utilised and well received. Our next stage of development is to further understand need, review current provision and raise the profile of Children and Young People within the organisation.

Dementia Steering Group

The Dementia Steering Group has continued to meet regularly throughout the year and has grown in size.

Highlights and achievements of the year being:

- Successful implementation of the **Things to Know About Me** document (Priority for Improvement for 2018).
- The introduction of clear guidance for Inpatient Unit and Community staff on when and how to use PAINAD (**a pain assessment tool** specially designed to be used with patients who have dementia) as a means to monitor patient pain and response to pain relief.
- A **dementia chest** for the Inpatient Unit containing dementia friendly signs and equipment to set up in a patient's room if they have dementia. This was a

recommendation from the Kings Fund audit of the dementia friendly environment which we undertook last year.

- A day long **education** session given by an expert in dementia care and attended by the majority of the Dementia Steering Group – demonstrating our multi-disciplinary team approach to dementia care.

Patient and Family Feedback Groups

Our Patient and Family Feedback Group has continued to take place every 6-8 weeks alternating between our two sites. It is currently open to patients and carers attending the Health & Wellbeing Service and Inpatient Services.

Topics discussed this year:

- 2018-2021 Hospice Strategic Plan highlighting funding issues and additional services NLH will provide
- One page profile – group gave their views on how to present this to good effect and suggested it would be useful for home patients
- NLH website – views on the current website sought and how to improve for the future
- Compassionate Neighbours project – group thought this project was very worthwhile
- Sustainability & Transformation Partnership – all thought it was a good idea to extend Community Services.
- Overnight service – group were pleased that we will be able to offer this service and that the overnight nurse follows up calls in the morning, to check on the situation

Nutrition

International Dysphagia Diet Standardisation Initiative:

NLH have been working collaboratively with Valeside and St Joseph's Hospice catering team to implement the standards on the IPU.

Schwartz Rounds

Schwartz Rounds were introduced in the hospice as a Priority for Improvement in 2016-2017. Since this time they have continued to be run and have become fully embedded in the Hospice.

Attendance is good and they have been well evaluated with comments such as:

"Excellent Schwartz Round. Made me appreciate and value other colleagues more"

"Today's Schwartz round reaffirmed my belief that everyone who works here for whatever reason all want to help or make a difference in some way. I work with some amazing people"

"Good insight into colleagues on an emotional level, and to hear shared experience from audience. Impressed with effort and turnout".

"As usual very insightful. I feel lucky to work for an organisation that is so supportive"

"Safe environment to share personal stories and reflect on own feelings and memories"

Schwartz round topics have included

- "Why I do what I do"
- "I tried my best"
- "Going the extra mile"
-

Journal Club

The multidisciplinary journal club was implemented as a Priority for Improvement in 2017-2018.

Six papers have been presented over the past year on a range of topics including:

- End of life care for homeless people
- Morphine or Oxycodone for cancer-related pain
- Understanding compassion in palliative care workers

Attendees have found the meetings interesting and useful:

- "it has made me consider a broader view of a physical symptom"
- "increased awareness of issues"
- "good to know we are adhering to practice"

PARTNERSHIP WORKING

Sustainability and Transformation Plan (STP)

NLH continues to be actively involved with North London Partners in Health and Care as members of the North Central London (NCL) STP Last Phase of Life Steering Group. This group is overseeing the implementation of a new Service Specification for Community Palliative Care across the North Central London Clinical Commissioning Groups (CCGs).

This is one of four projects under the NCL STP Urgent and Emergency Care Programme.

The Service Specification is now being implemented across Barnet, Haringey, Enfield, Camden and Islington Community Palliative Care Teams following increased investment by the Clinical Commissioning Groups in the services.

The project has been supported short term (6 months) by a Project Consultant and Project officer working with all providers and based at NLH.

This has resulted in:

- The recruitment of a significant number of new staff across professional disciplines in Barnet, Haringey and Enfield to deliver specialist community palliative care to an increased reach of patients across the borough.
- The implementation of the same referral and triage process across all five boroughs of the STP.
- The completion of baseline data reporting and mechanisms to report Key Performance Indicators for the project until project completion in 2021.
- The adoption of *Coordinate My Care (CMC)* in routine practice across all five boroughs of the STP.
- Recording educational and training activities to support and develop knowledge and skills of health and social care staff in stakeholder groups across the five boroughs.

This has included Steering Group meetings, service planning meetings and regular teleconferences both with providers and commissioners in addition to working with staff internally to adopt Quality Improvement approaches in implementing change.

EDUCATION AND TRAINING

The NLH education team have continued to provide a quality learning experience and develop new projects over the year.

Within the Hospice, mentorship and individual support was provided to IPU by a Practice Educator on a weekly basis with very positive feedback. The Single Nurse Administration Training (SNAT) was revised and tailored to individual service needs and work is currently underway to provide a robust preceptorship framework.

Following successful accreditation of our two day Palliative Care course for healthcare professionals to a Regulated Qualifications Framework (RQF) Level 5, two courses were delivered. All learners who submitted workbooks were successful in reaching the required standard to pass and the feedback from the external moderator was very positive. "This is very good work and I fully agree with all assessment decisions. The students demonstrate an in depth understanding of the subject, which is a clear reflection of your teaching, learning and assessment strategies. Well done."

Additional courses offered in the Hospice Education prospectus, such as the RQF Level 2 Award in awareness of end of life care, Namaste, Advanced Communication Skills and Summer and Autumn School were all delivered with positive evaluations.

We continued to offer a variety of training to care homes in palliative and end of life care. As part of the Enfield Care Home Project, training focusing on symptom management at the end of life and a Human Rights approach to end of life care has been delivered to over 400 staff in 29 care homes. Bespoke study days were also run in partnership with Barnet Community Education Provider Network (CEPN) to provide end of life care training for Registered Nurses and Healthcare Assistants in Barnet Care Homes.

We continued to welcome nursing and social work students to the Hospice and this year extended placements to physiotherapy students. We were successfully audited by Hertfordshire University for placement quality. In addition, undergraduate and post graduate doctors have had placements and training opportunities at the Hospice. We also welcomed a number of overseas visitors to the Hospice this year, from as far afield as the USA, Japan and Myanmar.

It was a successful year for Apprentices. Three NLH staff commenced a level 2 Team Leading apprenticeship, our first apprentice successfully completed their Health and Social Care course and we were nominated for 'Apprenticeship Provider of the Year' by Barnet and Southgate College for the quality and support offered to our learners by the Hospice team.

The Hospice successfully held its second staff conference this year, focusing on the theme of leadership. Breda Athan MBE, led the way as keynote speaker sharing her experience of nursing leadership during the Ebola outbreak in 2015. This was supported by some outstanding presentations from NLH teams on the leadership involved in their everyday work.



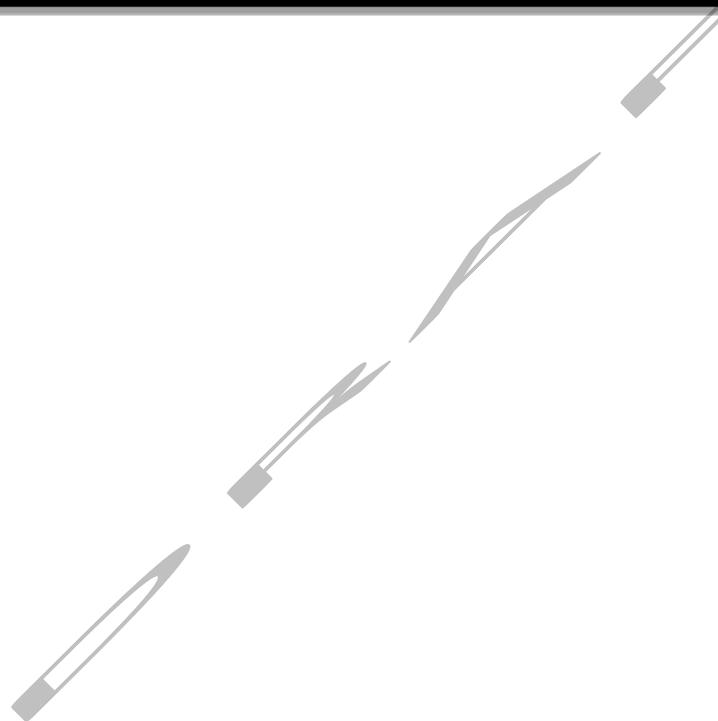
A total of 1569 learners attended our training



Over 700 hours of training and mentoring provided



We have worked with 43 external organisations



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)



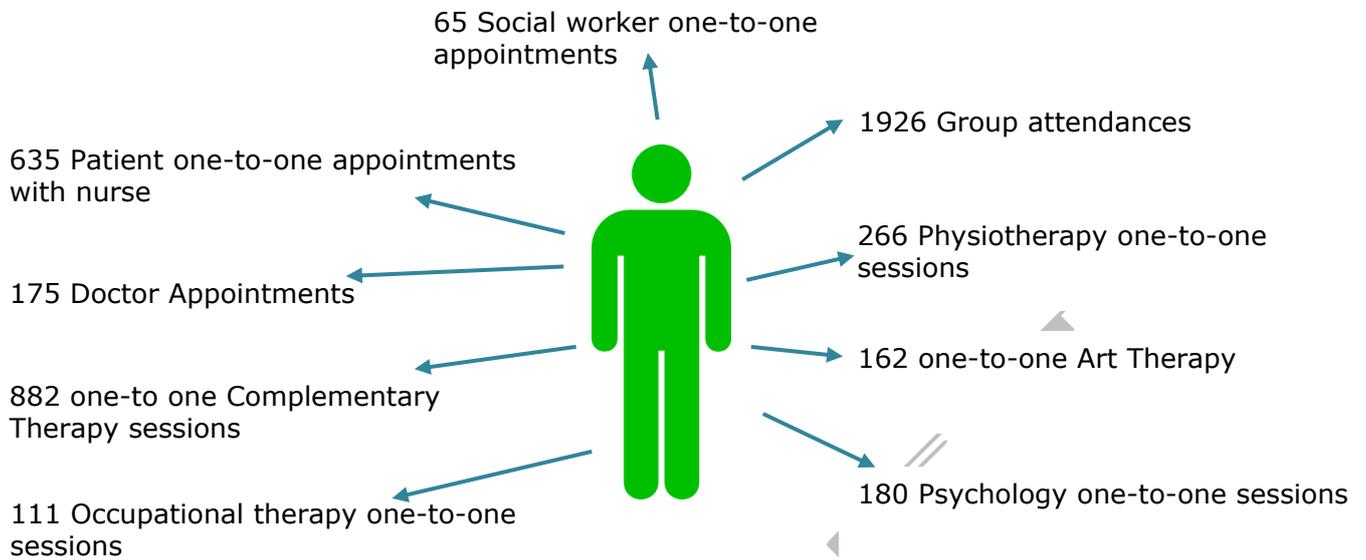
Analysis:

This year there has been an increase in admissions to the unit from 304 in 2017/18 to 348 patients this year, with a similar split between patients who were discharged and patients who died in the unit, as last year.

The percentage of cancer versus non cancer diagnosis has remained consistent (85%), despite NLH referral criteria being inclusive of all life-limiting conditions. The average length of stay has decreased this year from 16.5 to 14.4 days; we have seen 14 patients with stays of over 40 days prior to their death, and 7 patients with 40+ day stays prior to their discharge from the unit. This reflects the complexity of patients' needs.

There were only 12 days when beds were closed (compared to 78 in 2017/18) following the successful implementation of measures to address the problem.

Health & Wellbeing Service

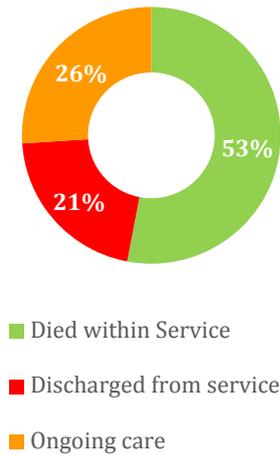


Analysis

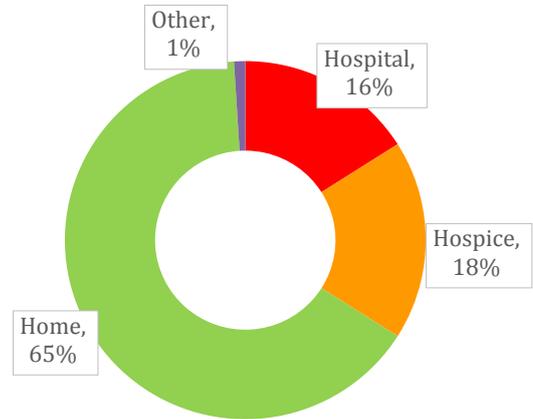
Variations in numbers of appointments undertaken by different healthcare professionals this year to last reflect responding to demand and also posts being vacant at times over the year. For example, group attendances increased by almost 500 and physiotherapy sessions by approximately 50. However, there were fewer social work appointments and fewer one to one appointments with a nurse.

Community Teams

OUTCOME FOR COMMUNITY TEAM PATIENTS 2018/2019



PLACE OF DEATH

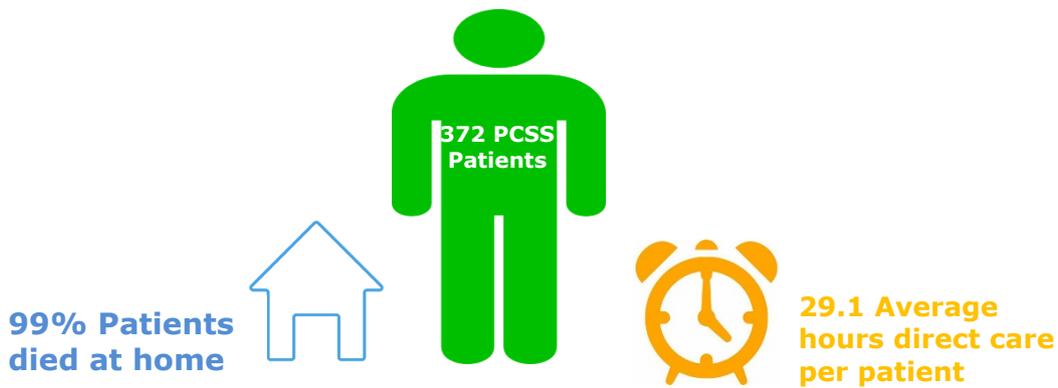


The Community teams have supported 2244 patients in their homes this year which is a 4.5% increase from last year's activity.

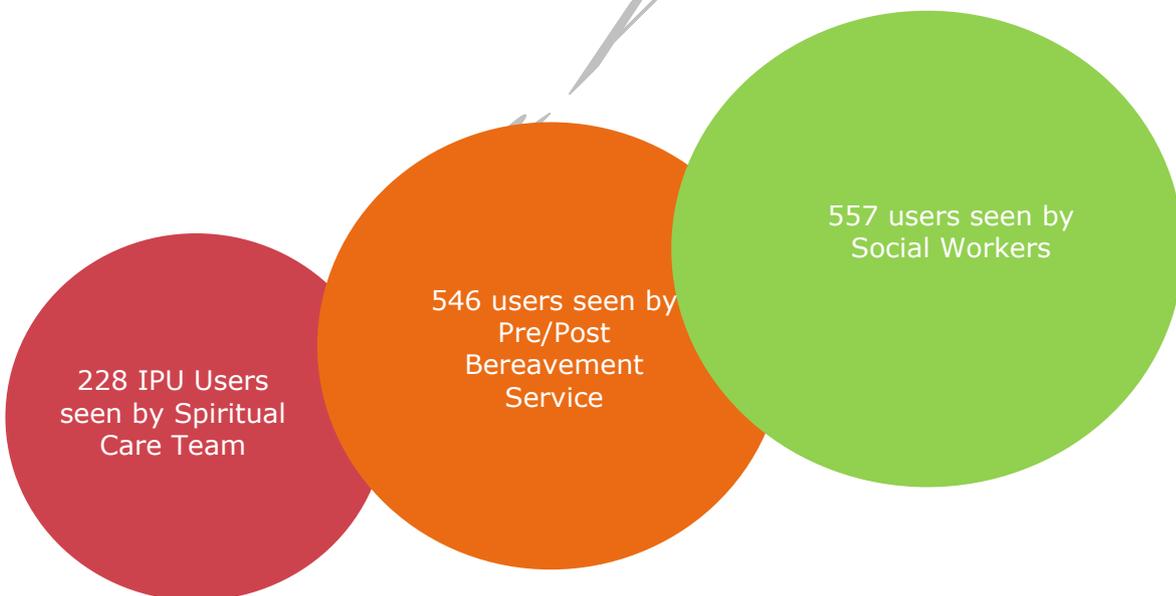
Of these community patients, 21% were discharged when they no longer required specialist support, 53% were supported by the service until their death, with 26% remaining on the caseload.

Of the 1209 patients who died whilst under the care of the community team, 65% patients were supported to die in their own homes (including care homes), an increase from 61% last year. Hospital deaths have reduced from 19% last year to 16%.

Palliative Care Support Service (PCSS)



Patient and Family Support Services



This year has seen an increase in all three teams within the Patient and Family Support Service. Of particular note is the increase in amount of people who accessed our pre and post bereavement service from 343 last year to 546 this year. This is a reflection of the changes we made over the last year to reach more people.

SERVICE USER EXPERIENCE

User feedback is gathered from a variety of channels: 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 to identify improvements or changes required to endeavour to meet our users' needs.

2018 User Surveys

The annual service-specific surveys in 2018 have been collected by paper surveys and using a tablet device.

Paper surveys were sent from May-October 2018 to:

- Community Team patients as they start to use the service
- Relatives/Carers of Barnet, Enfield & Haringey Community Team patients, 3 months after death
- Relatives/Carers of Inpatient Unit patients, 3 months after death
- Palliative Care Support Service (PCSS) families, 3 months after death
- Health & Wellbeing patients after the first visit

A total of 880 surveys were sent out, 305 returned (35%).

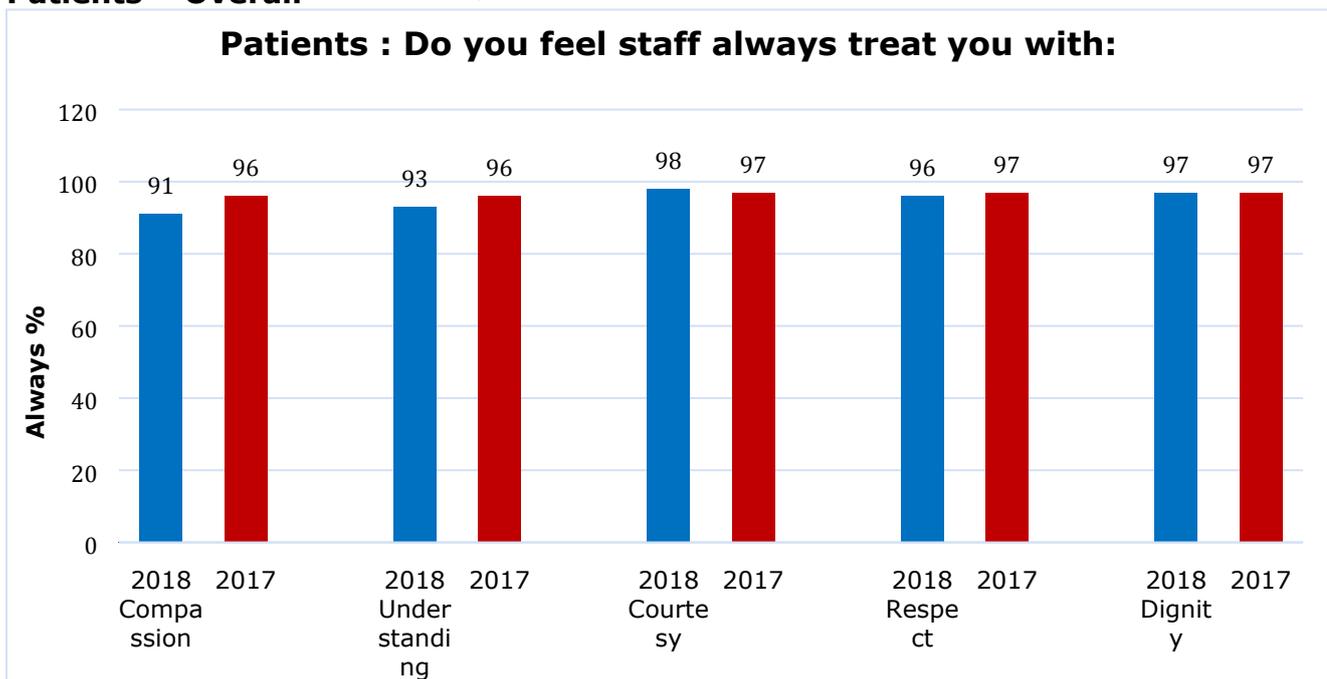
Tablet surveys (43) were completed by Inpatient Unit patients from December 2017 – October 2018. The aim of the tablet surveys is to be able to provide "realtime" feedback so any issues can be dealt with promptly. Positive feedback was received from IPU patients that issues reported during the realtime survey were acted on immediately.

Key Performance Indicators

Key Performance Indicator 1

"Are you/was the patient treated with compassion, understanding, courtesy, respect and dignity?"

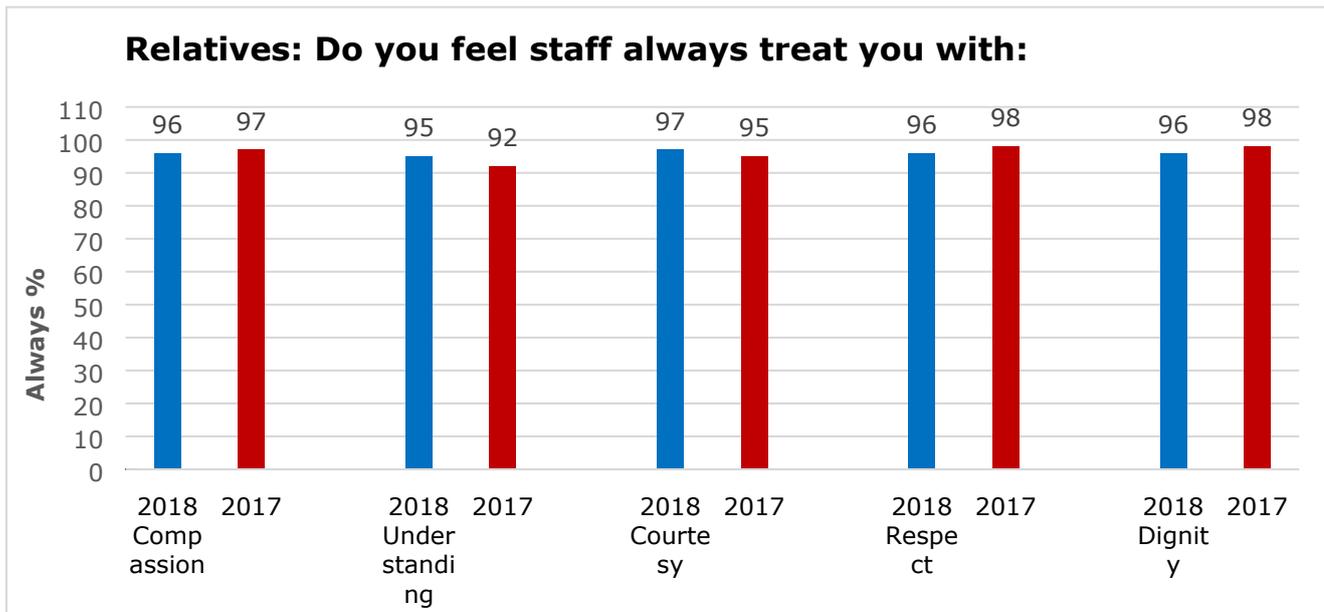
Patients – Overall



These results are the averages of the patients' experience for Inpatient Unit, Community Teams and Health & Wellbeing services.

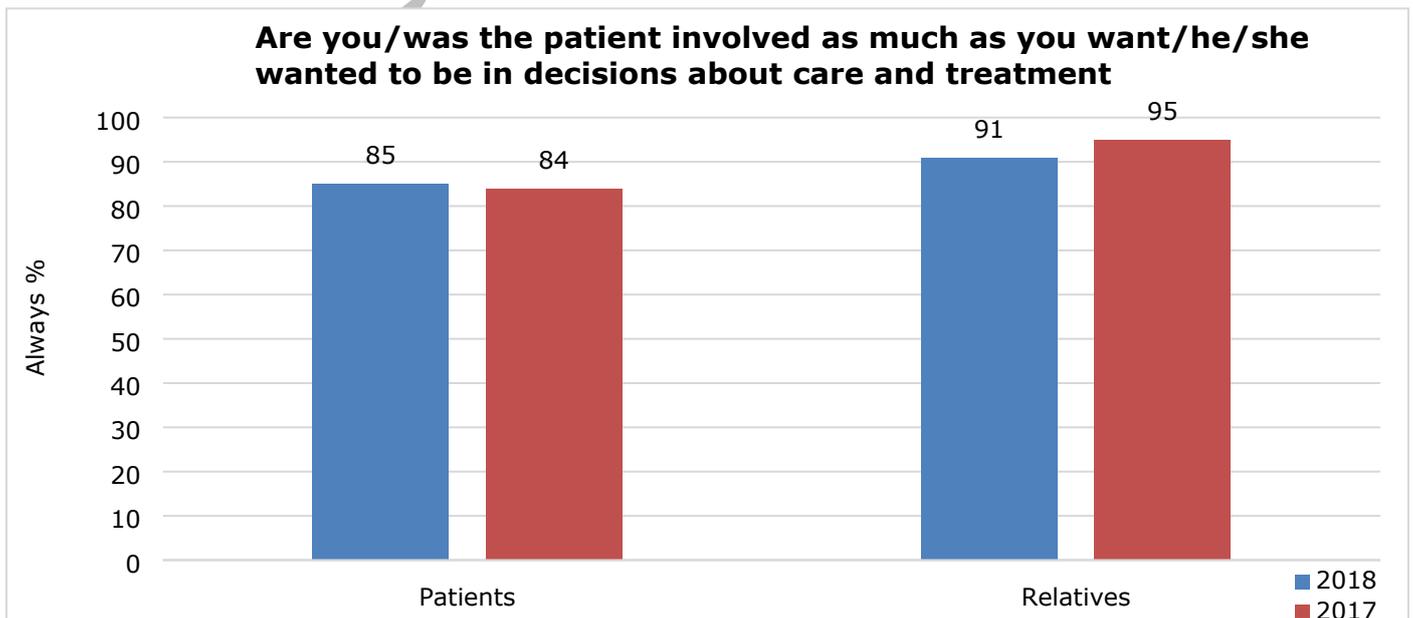
Overall extremely good scores, just a small decrease in compassion and understanding.

Relatives – Overall



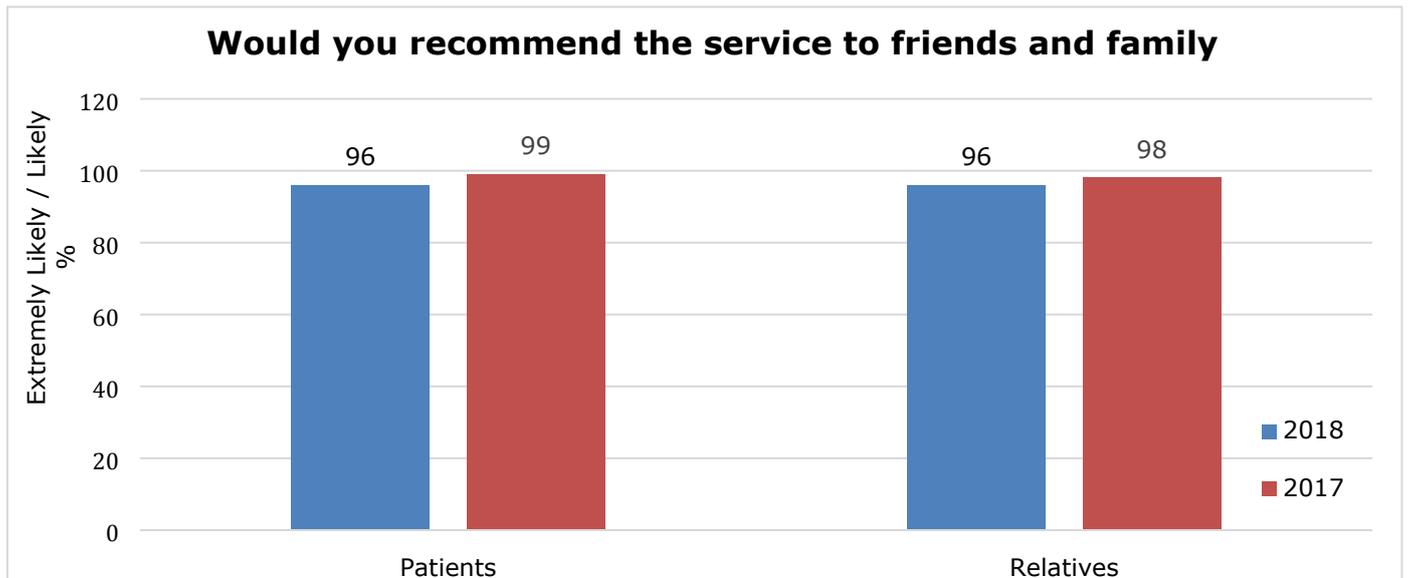
These results are the averages of the "Always" results from Inpatient, Community Teams and Palliative Care Support Service relatives. A comparable result to 2017.

Key Performance Indicator 2



These results show a very good improvement from Health & Wellbeing patients, however a decrease in the number of patients responding 'Always' on the Inpatient Unit. This question has been identified as an area for improvement for 2019 for the Inpatient Unit to try to understand what areas patients felt that they have not been involved with.

Key Performance Indicator 3 - Family and Friends test



All have decreased this year. Both the Inpatient Unit and the Community Teams had two responses of Unlikely to recommend.

This year, the average of the responses, 'Extremely likely' and 'Likely' across the services is 96%.

COMPLAINTS

Quality Performance Indicator	2016-2017	2017-2018	2018-2019
Number of Complaints (NLH target less than 30)	10	15	12

Quality Performance Indicator	2016-17	2017-18	2018-19
Investigations completed, complaint upheld/partially	9	12	11
Investigations completed, complaint not upheld	1	2	0
Multi Agency complaint		1	0
In progress			1

Analysis:

NLH receives complaints about clinical and non-clinical (charity shops) aspects of its business.

This year a total of 12 complaints were received:

11 were clinical (patient service) complaints.

5 involved Community Services, 4 Inpatient Unit and 2 our Triage service (now First Contact).

This correlates with 0.43% of patients and families supported by NLH this year made a complaint.

Of the completed investigations 11 complaints were upheld or partially upheld.

One complaints investigation is still in progress.

The predominant theme concerned service delivery relating to care given or gaps in service provision.

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

- For staff to plan the early initiation of syringe driver medication prescription for patients at home/care home
- For Inpatient Unit to ensure that the actual time is recorded when staff reviewed a dying patients.

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

Concerns:

This year we received 23 concerns from our users. 21 related to clinical care. The following are some examples of concerns raised this year:

- Visitors too noisy for other patients/visitors
- Relative wants to know sequence of events of day patient died

Compliments:

This year a total of 237 written compliments were received and recorded on NLH Compliments Log. Below is a selection of compliments received:

Community Team Barnet:

"We wish to thank you and all those from the Hospice who made it possible for our beloved wife and mum to end her days in comfort and peace at own home and for your kind and helpful care provided for her."

Community Team Enfield:

"Many thanks for all the care, love and compassion you showed to our family during last few weeks. You made what seemed an impossible task, possible."

Community Team Haringey:

"A very belated thank you is in order for you and your team. We will never forget all the support and advice you gave. Please thank the rest of your team."

Inpatient Unit:

"To all at North London Hospice. Every single one of the team was excellent, showing compassion in the care of our mum. Also thank you for looking out for the entire family and friends."

PCSS:

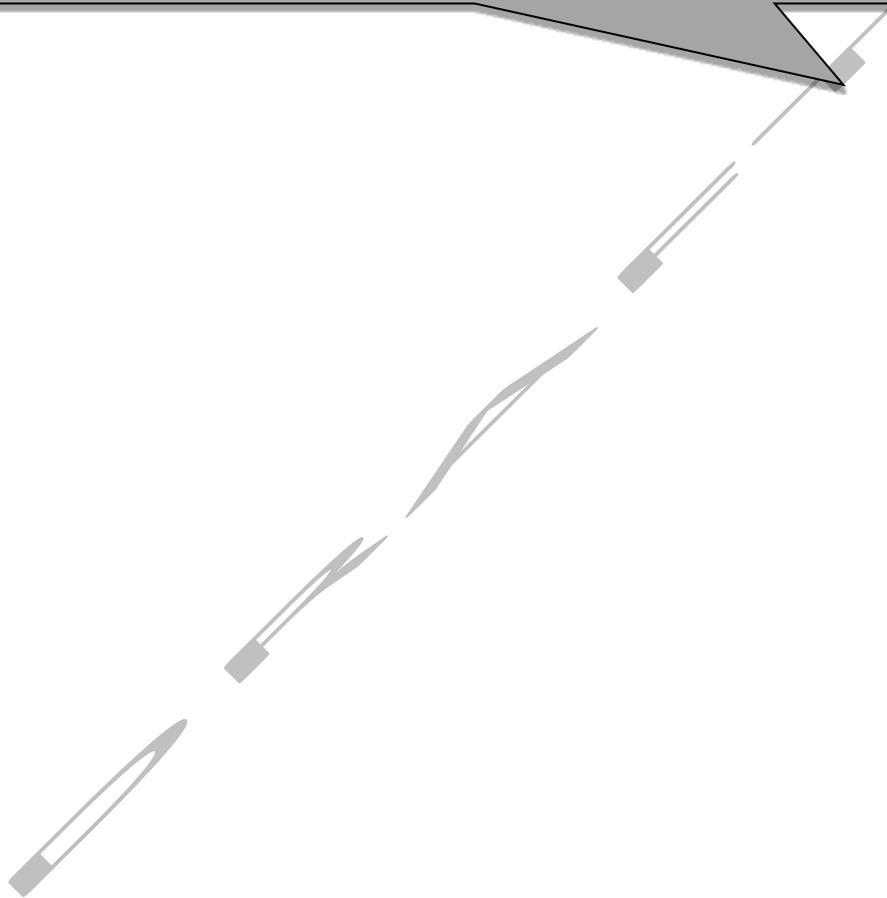
"At the most terrible time of our lives, the PCSS staff made an awful situation a lot more bearable with their love, care and kindness. As a family we want to say a huge thank you to everyone who helped our mum, but also us. We were made to feel extremely safe and knowledgeable with what was going on. This is something we will never forget and we just don't know what we would have done without PCSS help."

Health & Wellbeing Service:

"I cannot thank you enough for the wonderful services you provide. The support you have given me this past year has been invaluable and I am forever grateful to each and every one of you."

Supportive Care:

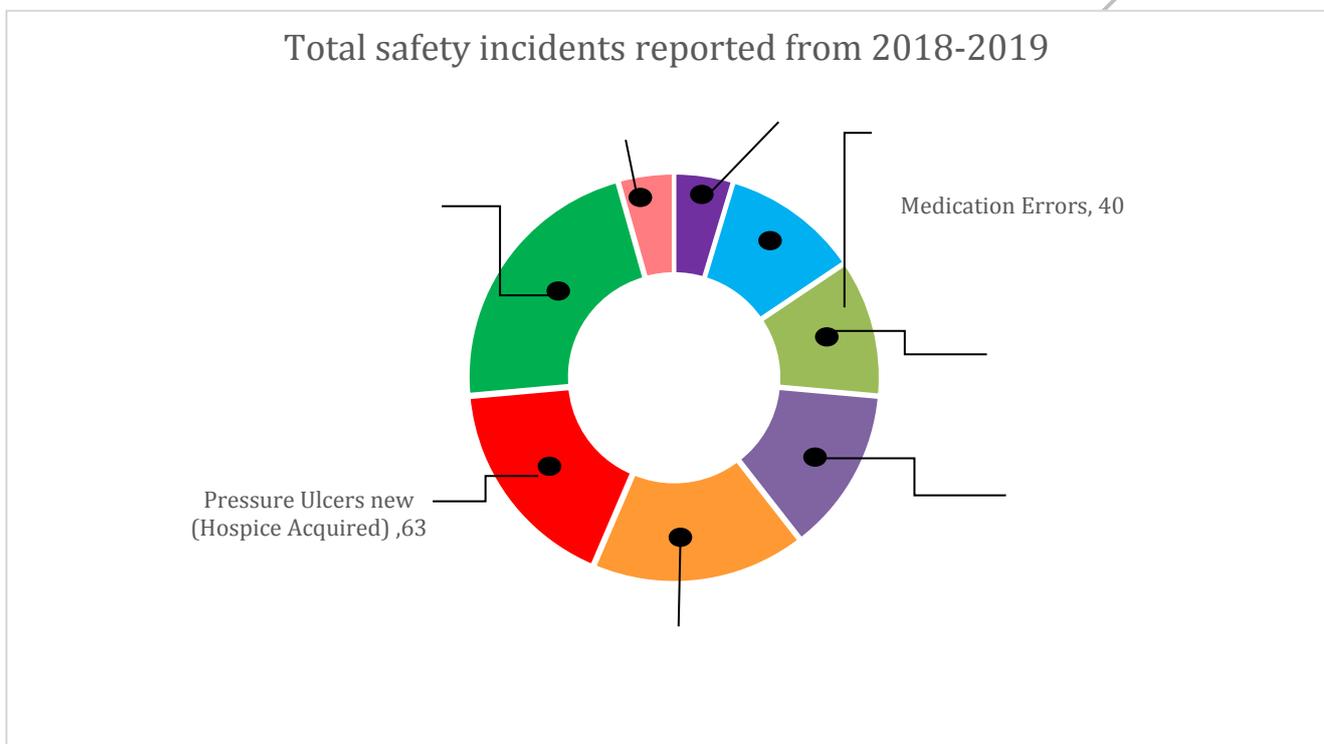
"Just a line to say a BIG thank you for your time and support you have given me over the past months, it really has been appreciated. When I started to come to you I really did not know where I was heading and our meetings have helped me get through that. I also thank you for leaving our meetings open in the event I may need to talk again, I find that reassuring. Once again many thanks for everything."



PATIENT SAFETY

Reported incidents

	2016-17	2017-18	2018-19
Total number of Incidents (clinical and non-clinical)	371	352	367



This table shows the various categories of incidents reported in the hospice over the year

Analysis

A similar amount of incidents were reported this year as for the previous two years.

Pressure Ulcers

This year saw a reduction in new pressure ulcers (hospice acquired) and also in pressure ulcers present on admission.

The number of new pressure ulcers reported decreased from 78 to 63. We believe this is partly attributed to the new mattresses purchased in March / April 2018.

We continue to carry out a full Root Cause Analysis on all new Category 3, 4, Unstageable Pressure Ulcers and Deep Tissue Injuries and have concluded that no harm was caused.

Medication incidents

This year saw an increase in medication errors (although comparison with other hospices shows we are still below the average for a hospice of this size). We now separate medication incidents from those that were not patient-related (missing medication, pharmacy dispensing issue etc.) and those that directly affected a patient. Of those that affected patients directly 12.5 % were classed as "near misses". None of the other patient-related medication incidents caused any patient harm. All medication incidents are monitored closely for identification of themes / trends. None have been identified.

Patient Falls

There was an increase in the number of patient falls this year (from 53 to 62) despite the introduction of patient alarms and the purchase of the low bed in IPU, along with the Falls Documentation Audit showing an improvement in record keeping. One fall was categorized as a Duty of Candour incident. Of the other falls, 39% resulted in no harm and 60% resulted in a low level of harm. All falls are reviewed, and monitored for trends and themes.

Benchmarking with other hospices (This covers IPU incidents only):

Falls

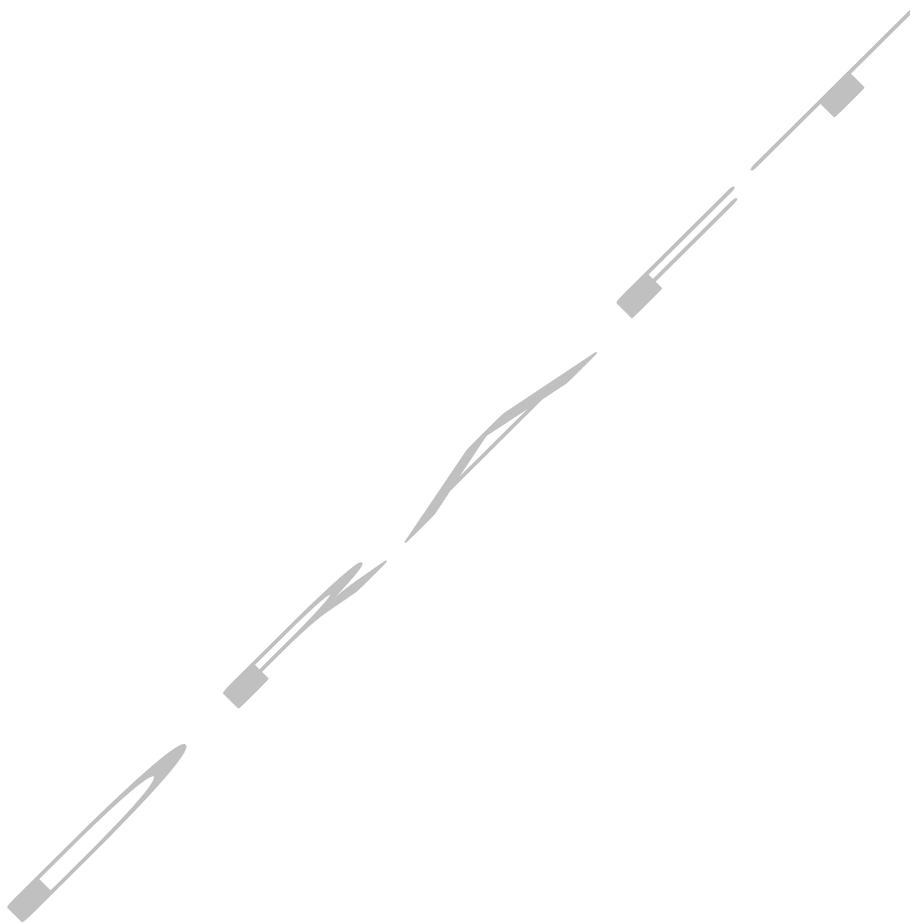
	2016 - 2017	2017-18	2018-2019
Number of patient related slips, trips and falls	27	53	62
Falls per 1,000 occupied bed days	5.74	10.5	12.36
Hospice UK Benchmarking Falls per 1000 occupied bed days (for Hospices of the size of NLH)	10.8	10.3	10.1

Medicine Incidents

	2016 - 2017	2017 -2018	2018-2019
Number of medicine incidents	28	17	40
Medicine incidents per 1000 occupied bed days	5.74	3.35	7.97
Hospice UK Benchmarking Medicine incidents per 1000 occupied bed days	10.4	11.5	13.0

Infection Prevention and Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2016-17	NUMBER 2017-18	NUMBER 2018-19
Patients who contracted Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia whilst on the IPU (NLH target 0)	0	0	0



NLH STAFFING

NLH employs a total of 214 permanent staff and 40 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.

	2016-17	2017-18	2018-19	
			Clinical	Non-clinical
Staff joined	74	34	23	19
Staff left	59	64	16	15

In 2017 we commented that of the 64 staff who had left during the year 30 were bank staff, who had been on the books although no longer undertaking bank work in the hospice and had been removed from the list accordingly. We said that in this year's Quality Account we would distinguish between bank staff and permanent staff; the above figures relate only to permanent staff.

Although recruitment of Band 5 and Band 7 nurses remains problematic, a continuing overall increase in establishment has been met with considerable success in recruitment and improved retention of staff in general. We continue to seek and pursue potential recruitment and retention incentives, and are currently considering a group life insurance provision; where there is recognised difficulty in attracting appropriately skilled applicants we now advertise one-off financial incentives to successful applicants and to staff for successful introduction of candidates. The staff Information & Communication Forum has been developed to exercise its role more effectively as a platform for issues and concerns to be raised, discussed and addressed as necessary.

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

NLH use the Hospice UK-sponsored staff survey where some questions relate to the indicators above. Below are the questions asked and responses in both 2017 and 2018:

2017	In the last year I have not been bullied at work %			Diversity is welcomed at the Hospice %		
	Staff N=88	Vols N=131	UK hospices completing survey	Staff N=88	Vols N=131	UK hospices completing survey

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

2018	In the last year I have not been bullied at work %			Diversity is welcomed at the Hospice %		
	Staff N=144	Vols N=190	UK hospices completing survey	Staff N=144	Vols N=190	UK hospices completing survey
Strongly disagree	4	2	3	2	1	2
Disagree	8	2	7	5	3	4
Neither agree nor disagree	8	7	9	18	16	20
Agree	42	25	32	49	49	47
Strongly agree	38	64	50	26	31	27

As demonstrated above, our most recent staff survey shows a considerably lower percentage of staff believe they have been bullied at work than in 2017, and the latter results were drawn from a significantly larger survey population. The HR department have calculated this figure to be 0.048% of the workforce. The figures are in line with the average for all hospices, as they are in respect of diversity.

We continue to have a robust safeguarding policy and staff training schedule as well as a Bullying and Harassment Policy, a Whistleblowing (Freedom to Speak Up) Policy and an Equal Opportunities Policy.

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

NLH Board of Trustees Quality Account Comment

The Board of Trustees has been impressed by the progress made over the years 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 first year as Chair of the North London Hospice, I am delighted to 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 encouraged to see how the investment in the Community Ambassadors has supported the progress of the Priorities for Improvement for improving access to Hospice services for disadvantaged groups and supports the organisation to increase collaborative partnerships both internally and externally. In addition, the introduction of the 'things to know about me' patient profile ensures that we keep the patient and what is important to them at the heart of our work.

For 2019/20, the Priority for Improvements continue to build on the success of previous achievements in relation to user involvement, co-production and improving access. The development of a Carers Strategy recognises the holistic nature of the work of the hospice, we look after those who care for our patients as well as the patients themselves. The introduction of the new clinical database will support our communication with General Practitioners across our three boroughs and support the organisation as it continues to develop the First Contact Service and the expansion of the community services.

The Board welcomes the improvements illustrated in this year's Quality Account and fully supports the Priorities for Improvement identified for 2019/20, recognising that they build on much of the excellent work already being undertaken.

It is 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.

Lis Burgess Jones
Chair
North London Hospice Board of Trustees

STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

APPENDIX ONE: NLH 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 (including friends and family network) 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 operates 7 days a week from 9am-5pm

The service emphasis is based on:-

- *Care closer to home
- *The Facilitation of timely and high quality palliative care

This is achieved by providing:-

- *Specialist advice to patients and health care professionals on symptom control issues
- *Specialist advice and support on the physical, psychological, emotional and financial needs of the patients and their carers.

2. Overnight CNS Service / 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 by a clinical nurse specialist/senior nurse on the IPU 7 days a week between 17.00 – 09.00 If indicated the CNS and HCA can visit patients. At weekends and bank holidays, a community Clinical Nurse Specialist deals with calls between 0900-1700 hours.

3. Health & Wellbeing Service

The Health & Wellbeing Service comprises 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 Inpatient Unit has 18 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons such as for symptom control and 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 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/psycho spiritual 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 & Wellbeing Service to develop group work, which help create opportunities for peer support and informal networks developing beyond the hospice.

7. First Contact Service

First Contact comprises a team of Specialist Nurses and administrators and is the first point of access for all referrals to NLH and for all telephone enquiries from patients, families and healthcare professionals.

First Contact 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. It acts as a signposting service for patients in the last year of life.

APPENDIX TWO: 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 NLH's 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 risks and to develop the concept of residual risk and ensure that all services take an active role in risk management, including 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)

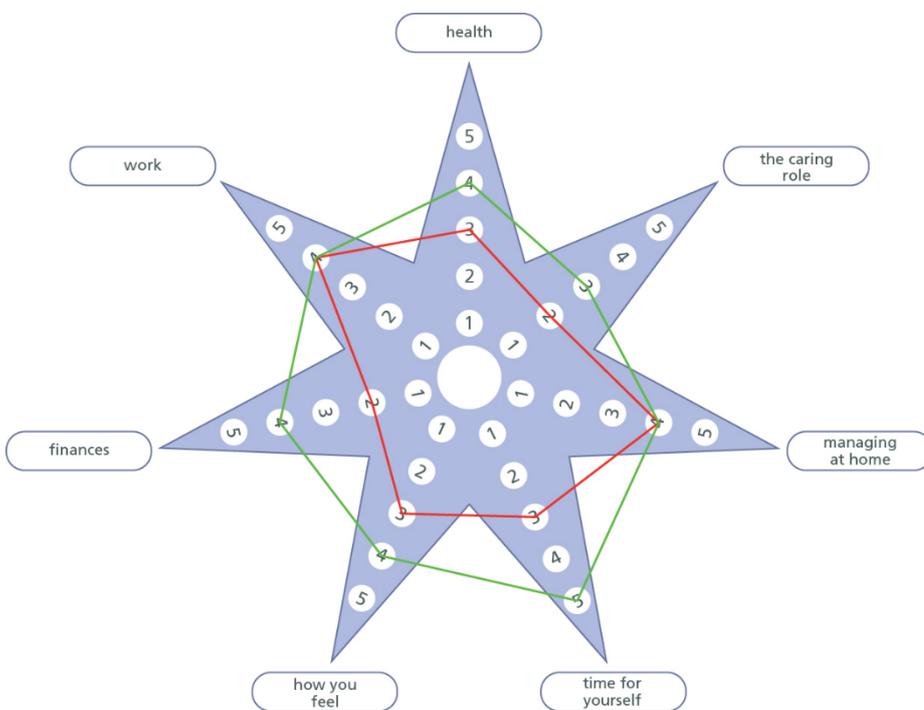
The PPG group ensures the review of all NLH policies and procedures. It reports to the Q&R and QSR.

Health and Safety Group

The Health and Safety group ensures the review and monitor of all aspects of Health and Safety that affect the organisation. It reports to the Q&R and QSR.

APPENDIX Three – 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.



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

APPENDIX FOUR: MANDATORY STATEMENTS

The North London Hospice Quality Account is required to include the following mandatory statements despite not being applicable to the work we do.:

Participation in clinical audits and research

During 2018-19, 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 2018-19 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2018-19, 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 2018-19 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2018-19, 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 2018-19 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

Care Quality Commission

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 2018-19 as of the 31st March 2019.

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

DATA QUALITY

NLH did not submit records during 2018-19 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.

NLH was not subject to the payments by results clinical coding audit during 2018-19 by the Audit Commission. This is not applicable to independent hospices

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:

Fran Deane
Director of Clinical Services

North London
Hospice 47
Woodside Avenue
London N12 8TT

Tel: 020 8343 8841

Email: nlh@northlondonhospice.co.uk

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CLCH QUALITY ACCOUNT 2018-19

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About CLCH		
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Statement of the Chair of the Quality Committee		
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OUR QUALITY PRIORITIES FOR 2019-2020		
Whom did we involve		
STATEMENTS OF ASSURANCE FROM THE BOARD		
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Secondary use services; data security protection DSP (previously information governance toolkit), clinical coding error rate		
Clinical audits		
Research		
Freedom to speak up		
CQUINS		
Care Quality Commission (CQC)		
Data Quality		
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PART 3 – OTHER INFORMATION		
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Statement of directors' responsibilities for the quality report		
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PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2018-2019

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 seventh 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 describes our six quality campaigns namely; Positive patient experience; Preventing Harm; Smart Effective care; Modelling the Way; Here, Happy, Heard and Healthy and Value Added Care. Key outcomes, along with their associated measures of success are listed for each campaign. The strategy also explains how our Quality Account priorities are aligned with the six campaigns.

Performance against these are continuously monitored and reported via the Quality Committee and Trust Board. In accordance with the strategy, we have collected information about our performance against the measures of success. We will use this information to look at how well we have performed over the past year and we will also identify where we could improve over the next and future years.

The strategy also 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.

In March 2019 we took the opportunity to refresh the quality strategy. The quality priorities remained the same but we made some minor changes to the measures of success for 2019-2020. The updated strategy can be found here:

<https://www.clch.nhs.uk/application/files/5815/5264/8619/FinalQS.pdf>

How can I get involved now and in future?

At the end of this document you will find details of how to let us know what you think of our Quality Account, what we can improve on and how you can be involved in developing the report for next year. If you would like to receive a printed copy of the CLCH Quality Account, please contact us via e-mail communications@clch.nhs.uk or telephone 020 7798 1420.

ABOUT CLCH

We provide community based NHS health services across Greater London and Hertfordshire. We care for more than two million people with over 10 million patient contacts per year. Every day, our professionals provide high quality healthcare in people's homes and local clinics, helping them to stay well, manage their own health with the right support and avoid unnecessary trips to, or long stays in hospital. We support our patients at every stage of their lives; providing health visiting for new-born babies through to community nursing, stroke rehabilitation and palliative care for people towards the end of their lives.

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

- Adult community nursing, including 24 hour district nursing, community matrons and case management.
- Specialist nursing including; continence; respiratory, heart failure; tissue viability and diabetes.
- 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.

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>

Vision mission and values:

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/1715/3747/5337/CLCH_Annual_Report_2017_-_18.pdf

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the Quality Account for the year ending March 2019. During another busy year for CLCH we have welcomed new services to the Trust, including 0-19 services in Ealing and school nursing in Wandsworth, and also moved our South London Sexual Health Service into new premises in Clapham Junction. I would like to thank all the staff involved in the design and re-location of services; moving a service is always challenging and our staff went the extra mile to make this happen.

Last year when I introduced the Quality Account I reported that that we were finalists for the Health Service Journal (HSJ) Patient Safety Award in the category of **Organization of the Year**. This was for our work on our Quality Strategy, *Simply the Best, Every Time* and I am delighted to report that the Trust subsequently won this award.

Learning from when things go wrong is always one of the most difficult, and important, areas of our practice. In the last year we have continued to make sure we learn from incidents, to improve our practice and to reduce, and prevent harm, to the people in our care.

Looking ahead to 2019/20 we look forward to welcoming new colleagues joining us, as the Trust takes on responsibility for providing adult community services in Hertfordshire, and also opening our CLCH Academy. The Academy will provide education and training opportunities enabling community and primary care professionals to learn together. We will also support new roles and ways of working such as Apprentice Nursing Associates as well as rotations across community and primary care.

Finally my thanks to all our staff for their continued commitment to providing excellent care.

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.

Andrew Ridley - Chief Executive Officer

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

Our aim is simple: to ensure CLCH provides outstanding care. We want our services to be as safe, effective and patient-focussed as possible. To achieve this, the Trust's Quality Committee has continued to monitor progress against our Quality Strategy *Simply the Best, Every Time*, its six quality campaigns and the associated quality priorities described within the strategy. The committee, as well as receiving monthly updates and a quality dashboard, also reviewed in-depth reports on our progress towards achieving our quality objectives.

The committee continued to invite staff to give quality presentations. This enables us to hear the voice of staff and service users first-hand, focussing our attention on areas where we have got things right and those where we need to do better. Additionally, as part of our Board Commitment to undertaking '15 Step Challenges', committee members visited a range of clinical areas in order to see and hear for themselves how the Trust is delivering services. This has been a powerful source of information and feedback for committee members and has translated into tangible improvements in how the Trust delivers its services.

During the year, as part of our continuing journey to recognise quality and learn from each other, we have embedded 18 quality councils across the Trust. This is an impressive achievement. I would like to extend my thanks to our users, members of the public and staff who play such a significant role in making these a success.

I am delighted to say that this year we awarded Quality Development Unit (QDU) status to:

- Barnet muscular skeletal (MSK) team
- Inner London paediatric dietetics
- Merton holistic and rapid investigation services (HARI)
- Hertfordshire respiratory service
- Harrow podiatry service
- Colville health visiting team
- Hammersmith & Fulham speech and language therapy education team

QDU status is only awarded after a team has achieved excellent results in their self-assessments, quality indicators and quality inspection team visits and has applied to the Quality Panel to become a QDU. Units that achieve this status receive support to invest in their service and become a resource for other teams seeking to improve.

I am pleased that during the year we saw a significant reduction in falls on our bedded rehabilitation units and also an improved friends and family test score which exceeded the national target for both December and January.

Looking ahead, in 2019-20 the Quality Committee will continue to monitor progress against the objectives set out in the final year of our current, updated Quality Strategy and will be working closely with the Chief Nurse and his team as we develop our CLCH new quality strategy to support our aspirations to provide the best service we can.

Dr Carol Cole - Chair of Quality Committee

PRIORITIES FOR IMPROVEMENT 2019-2020

Our quality priorities for 2019 – 2020 are the same as laid out in our updated 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 2019-2020 are as follows:

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

KEY OUTCOMES	MEASURES OF SUCCESS 2019-2020
Service developments and plans of care co-designed with patients and service users	<p>95% or above of proportion of patients whose care was explained in an understandable way</p> <p>92% or above proportion of patients who were involved in planning their care</p> <p>All service improvement projects will be supported through co-design</p> <p>Patients will be members of the Quality Councils in each division</p>
Patient stories and diaries used across pathways to identify touch points and 'Always events'	<p>Always Events to become integral to Quality Councils as a method used to improve patient experience</p> <p>Evaluation of Always Events* and their impact on patient experience</p> <p>Thematic analysis of previous year's stories with shared learning.</p> <p>Continued use of patient stories shared at Divisional and Trust forums.</p> <p>Evaluation of the use of patient diaries/innovative approaches to patient stories and their impact on patient experience</p>
Patient feedback used to inform staff training	<p>Patient feedback will be integral to the review and development of education and training</p> <p>Evaluate the use of patient stories as part of learning from serious incident reviews. Patient stories and feedback will be integral to the learning from serious incident reviews</p>
Divisional Quality Council Objectives	Three objectives with outcome measures

* **Always Events:** 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 five criteria: important; evidence- based; measurable; affordable and sustainable.

CAMPAIGN TWO: PREVENTING HARM

KEY OUTCOMES	MEASURES OF SUCCESS 2019-2020
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 pressure ulcers (PU) and falls will continue to fall (5%) Maintain high levels of reporting and low levels of harm. 0 % PU in bedded areas 100% Root Cause Analysis (RCA)* completed on time 0% falls with moderate or above harm in bedded areas
Safety culture and activities signed up to in ALL services	No outstanding actions from serious incidents. All risk register actions are met by identified completion date.
Variations in practice identified and acted upon	All staff using repository* in practice
Divisional Quality Council Objectives	Three objectives with outcome measures

Repository: the lessons identified from pressure ulcer learning are placed in a 'repository'. This allows staff to reflect on their practice and modify future actions as appropriate.

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.

CAMPAIGN THREE: SMART, EFFECTIVE CARE

KEY OUTCOMES	MEASURES OF SUCCESS 2019-2020
Clinical staff use the most up to date clinical practices	<p>Central alerting system (CAS)* alerts (including Patient Safety Alerts (PSAs))</p> <p>Monthly Board KPI target for timely alert closure $\geq 90\%$</p> <p>NICE 90% of services complete a Baseline Assessment Form for NICE* Guidance within the agreed timeframe.</p>
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	Three objectives with outcome measures

* **CAS:** 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.

* **PSAs:** These alerts rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death

***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.

CAMPAIGN FOUR: MODELLING THE WAY – PROVIDING WORLD CLASS MODELS OF CARE, EDUCATION AND PROFESSIONAL PRACTICE

KEY OUTCOMES	MEASURES OF SUCCESS 2019-2020
New roles and career pathways are in place which support the needs of patients/service users.	<p>Review of career pathway frameworks to include integrated roles and primary care.</p> <p>The continued implementation of clinical apprenticeship roles</p> <p>The implementation and evaluation of the Nursing Associate role across the Trust</p> <p>Rotation programmes implemented across the Trust</p> <p>Continued improvement in Staff survey results in relation to education and learning</p> <p>Evaluation of fast track programmes</p>
Each clinical profession has a clear and successful model of professional practice which includes their role in improving population health as health champions.	<p>Evaluate the model of professional practice</p> <p>Staff survey results</p>
The Implementation of the CLCH Community and Primary Care Nursing Academy	Evaluation of the year one successes of the Academy
Processes in place to enable statutory mandatory training compliance to meet Trust target	<p>Undertake service audits to identify gaps in training</p> <p>Training linked to incidents and risk assessments</p> <p>95% training compliance</p>
Divisional Quality Council Objectives	Three objectives with outcome measures

CAMPAIGN FIVE: HERE, HAPPY, HEARD AND HEALTHY – RECRUITING AND RETAINING AN OUTSTANDING WORKFORCE

KEY OUTCOMES	MEASURES OF SUCCESS 2019-2020
Staff are fully engaged and involved in the model of shared governance	Six Quality Councils are established per division and well attended. Shared governance becomes part of “the way we do things” at CLCH
Voluntary staff turnover below 10% by 2020 Staff vacancies below 10% by 2020	Voluntary staff turnover below 8% Staff vacancy rate below 8% by March 2020
Staff surveys are undertaken which demonstrate improving levels of staff engagement	Above 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 4% reduction in the number of staff who report feeling unwell as a result of work related stress in the 201 Staff Survey. Sickness absence remains below target of 3%
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 20%
Divisional Quality Council Objectives	Three objectives with outcome measures

CAMPAIGN SIX: VALUE ADDED CARE – USING ENHANCED TOOLS, TECHNOLOGY AND LEAN METHODOLOGIES TO MANAGE RESOURCES WELL INCLUDING TIME, EQUIPMENT AND REFERRALS.

KEY OUTCOMES	MEASURES OF SUCCESS 2019-2020
The user experience across CLCH, primary care, specialist services and social care is as seamless as possible	Continued assessment of patient pathway is embedded in divisional planning Patient involvement is the norm
Clinical staff use the latest technology to improve care delivery	Each division has used improvement tools to improve 15 % of services
Front line staff lead new lean ways of working	25 % staff to have been trained to basic level in improvement skills , including lean
There will be demonstrable culture of clinical enquiry and continuous improvement across the Trust	80% staff able to contribute to improvements at work 80% staff reporting they have access to improvement analytics when required
Divisional Quality Council Objectives	Three 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*.

In January 2019 we refreshed our *Quality Strategy* and sent it to all our external stakeholders. We confirmed that the quality priorities described in the strategy would be the quality priorities for our *Quality Account* and asked for comments on this.

Furthermore we consulted on our quality priorities and their associated measures of success between 1st February and 5th April 2019. Information was provided for staff via internal communications and our *Spotlight on Quality*. Our external website also allowed people to comment on our quality priorities and we also wrote to our shadow members asking for their comments.

The issues raised in response to the consultation are listed below and were all individually responded to. There were no objections to any of the proposed priorities. Where appropriate the feedback will be used to inform the next update of our quality strategy.

- More consideration to be given to community engagement
- Support for openness and transparency
- Support for engagement with patients as described in campaign one
- Request for further information about no blame culture
- Podiatry appointments waiting times

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2018-2019 CLCH provided 79 NHS services.

CLCH has reviewed all the data available to them on the quality of care in 100% of services. The income generated by the NHS services reviewed in 2018-2019 represents 100% of the total income generated from the provision of NHS services by CLCH for 2018-2019

Secondary use services

CLCH submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data which included the patient's valid NHS number was 93.5% and which included the patient's valid General Medical Practice Code was 92.9%.

All (100%) of this information related to records for patients admitted to our Walk in Centres.

Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2018-2019

Data Security and protection (DSP) toolkit

The DSP has replaced the information governance toolkit. The Trust's auditors have confirmed that CLCH has met all standards required of the DSP toolkit.

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 2018-2019 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 six (100%) of the national clinical audits that the Trust was eligible to participate in. These audits, for which data collection was completed in 2018-2019, 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 six national clinical audits were reviewed by CLCH. The actions that CLCH intends taking in response to the audit are incorporated into the table below.

NATIONAL CLINICAL AUDITS

Please note that for all cases data collection and analysis is still in progress and won't be finalised until the final account is produced.

National Clinical Audits	Participation	Submitted Cases or Reasons for non-Participation	Outcomes and Actions
<p>Sentinel stroke national audit programme (SSNAP)</p> <p>(Previously known as the national stroke audit)</p>	<p>Yes</p>	<p>Xxx cases submitted which is yyy% of total required.</p> <p>This continuous audit aims to drive improvements in the quality of care and services provided for COPD patients. The period under review has been addressing service improvement</p> <p>The services/teams taking part were the Stroke ESD team, Merton ESD team, Merton community neuro rehab team.</p>	<p>Actions: TBC but will address service improvement.</p>
<p>National Audit of Intermediate Care (NAIC) 2018</p>	<p>Yes</p>	<p>Xxx cases submitted which is yyy% of total required.</p> <p>Please note that unlike in previous years this information can no longer be obtained NAIC. Therefore we are calculating the figures but the final information is not currently available</p> <p>Services that took part: Athlone Rehabilitation Unit, Alexander Rehabilitation Unit at Princess Louise Nursing Home, Harrow (Peer 1 & 2), Harrow (Locality 2 & Night Service), Barnet Intermediate Care Services, Harrow Rapid Response, Harrow (Peer 5 & 6), Intermediate Bedded Unit, Merton, MERIT-Home based Intermediate Care, Jade Ward, Edgware Community Hospital (Barnet CCG patients), Marjory Warren Ward, Finchley Memorial Hospital (Barnet CCG patients), Adams Ward, Finchley Memorial Hospital (Barnet CCG patients), Intermediate Care Services Wandsworth</p>	<p>Outcomes: Evidence indicated that intermediate care works with more than 93% of service users weather maintaining or improving their level of independence in undertaking activities or daily living during their episode of care (up from 91% in 2017).</p> <p>Action: The NAIC has been removed from the 2019/20 Quality Accounts List. The audit is not being funded by NHSE for 2019/20 and will therefore not be collecting data during this financial year.</p>

National audit of hip fracture services	Yes	<p>Xxx cases submitted which is yyy% of total required.</p> <p>(Due to a key member of staff leaving we are not currently able to finalise the number of cases submitted)</p> <p>Barnet intermediate Care Services</p>	<p>Outcomes: Evidence indicated there was variation in understanding how many patients were transferred from acute to rehabilitation units which resulted in some hip fracture teams not knowing whether rehabilitation was successful.</p> <p>Action: This audit has been redesigned so that in future it will transition from a 'snapshot' to the National Audit of Inpatient Falls (NAIF). This will provide continuous data collection.</p>
National diabetes foot care audit (NDFCA)	Yes	<p>Xxx cases submitted which is yyy% of total required.</p> <p>The NDFCA is continuous, and measures care structures, patient management and care outcomes for people with diabetic foot ulcers.</p> <p>Services participating: Community Diabetes Podiatry Service (Westminster), Community Diabetes Podiatry Service (Kensington & Chelsea).</p>	<p>Outcomes: The report indicated that services needed to establish local pathways that minimise the time taken to be seen by a specialist foot care service</p> <p>Action: TBC</p>
National Audit of Cardiac Rehabilitation (NACR)	Yes	<p>Xxx cases submitted which is yyy% of total required.</p> <p>The NACR aims to increase the availability & uptake of cardiovascular prevention and rehabilitation, promote best practice and improve service quality in cardiovascular prevention and rehabilitation service</p> <p>Harrow COPD Respiratory Service, West Herts Respiratory Service, Merton Cardio-Respiratory Service, and Barnet Community Respiratory COPD Service</p>	<p>Outcomes TBC.</p> <p>Action: TBC</p>

<p>National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit</p>	<p>Yes</p>	<p>Xxx cases submitted which is yyy% of total required.</p> <p>This audit aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult; children and young people) and chronic obstructive pulmonary disease (COPD).</p> <p>Data collection in progress because this was registered in December 2018. Therefore this will not be finalised until November 2019.</p>	<p>Outcomes: TBC</p> <p>Action: TBC</p>
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Local clinical audits

The reports of xxx local clinical audits were reviewed by CLCH in 2018-19. 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.

Information concerning local audits is currently being worked upon. We will be reporting on 40 local audits. This information will be included in the final quality account.

Acronyms and explanations of terms

AAC	Assistive Communication Service within the Children Health's Division
AAF	Amino Acid Formula (infant feeding formula)
AECOPD	Acute exacerbation of COPD
BERG Balance Score	The BERG Balance Scale is a clinical test of a person's static and dynamic balance abilities
BMI	Body Mass Index
Braden Scale	The Braden Scale uses a special scoring system to evaluate a patient's risk of developing a pressure ulcer
CAMHS	Child and Adolescent Mental Health Services
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)
ESP	Extended Scope Physiotherapist
EQ-5D-5L	A standardised measure of health status that provides measures of health for clinical and economic appraisal
FRHA	First Review Health Assessment
FOM	Faculty of Occupational Medicine
HARI	Holistic assessment and Rapid Intervention.
HETF	Home Enteral Tube Feed
ICS	Intermediate Care Service
IG	Information Governance
IHA	Initial Health Assessment
IP	Infection Prevention
IPN	Infection Prevention Nurse
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
PMLDTC	Profound and Multiple Learning Disability Therapies Clinic
PR	Pulmonary Rehabilitation
PRN	'pro re nata' - medicines that are taken "as needed"
RCW	Rehabilitation Care Worker
SMART	Specific, Measurable, Accurate, Realistic and Timely
SIFP	Specialist Infant Formulae Prescribing guidance
SRHA	Second Review Health Assessment
SOP	Standard Operating Procedure
TI	Technical Instructor
TOMs	Therapy Outcome Measures
WHO	World Health Organisation

PARTICIPATION IN RESEARCH

Research is essential to find out which treatments work better for patients; it also enables the development of new treatments. CLCH is committed to high quality research and to this end, the CLCH Research Strategy 2018-2021 identified the following aims:

- To allow all CLCH staff and service users the opportunity to participate in health care research.
- To expand research opportunities across services and geography tapping into all 4 divisions.
- To increase the research culture within CLCH.
- To become a leader for healthcare research in community settings.

During the last year CLCH demonstrated an increase in research activity. This related to both the recruitment of patients into studies and also the number of studies open. Additionally there were more staff trained in Good Clinical Practice training, which is a requirement for research. Examples of current studies that CLCH are involved in include:

Sexual health services:

- PreP Impact study: the study is the clinical trial of a drug, which 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. This study is continuing and has recruited well across all sites.

Children's services:

- Active Child study: CLCH is working with researchers at Newcastle University to invite parents with children where there are motor developmental delays to participate in this study.

Parkinson's service:

- Parkinson's Pain study: this study looks at the type and frequency of pain experienced by patients with Parkinson Disease.
- Parkinson's communication study: this is a randomised control trial, for patients requiring speech and language therapy.

During 2018-19, there were over 25 clinical staff participating in 14 clinical research studies in 5 specialities: respiratory; sexual health; Parkinson's; children's; and speech and language therapies that had been approved by a research ethics committee. CLCH is a host site for 11 studies, and CLCH acts as a participation identification site (PIC) for the remaining studies.

The number of patients receiving relevant health services provided or subcontracted by CLCH during 2018-19 that were recruited during that period to participate in research approved by a research ethics committee was 304.

FREEDOM TO SPEAK UP (FTSU)

Staffs are encouraged to raise concerns over the quality of care, patient safety or bullying and harassment within CLCH so that we have an opportunity to address them. Staff can raise concerns through their line manager or clinical lead, freedom to speak up (FTSU) guardians, the patient safety team, staff representatives, directors, nominated non-executive director, trust local counter fraud specialist. Staff are also provided with details as to how they can speak up to an outside body. Occasionally, concerns may come to light through, for example, an HR process.

Staff can raise concerns in person, by phone or in writing, including email. There are separate email addresses for FTSU (*accessed by FTSU Guardians*) and Whistleblowing (*accessed by the Nominated Non-Executive Director*).

Staff can choose to raise their concern by name, confidentially or anonymously. If confidential, we strive to maintain confidentiality unless we are required to disclose it by law, e.g. by the police. Staff are encouraged to provide their name to make it easier to investigate thoroughly and to provide feedback on the outcome.

Feedback will be given to staff who raise concerns through progress updates and, wherever possible, by sharing the full investigation report with them whilst respecting the confidentiality of others.

CLCH wants staff to feel safe to raise their concerns. Within the FTSU: Raising Concerns Policy, it makes clear that staff will not be at risk of losing their job or suffering any form of reprisal as a result. The policy also confirms that the Trust will not tolerate the harassment or victimisation of anyone raising a concern or any attempts to bully staff into not raising any such concern.

Furthermore the FTSU Guardian will escalate to the board any indications that staff are being subjected to detriment for raising their concern, regardless of whether it was before or after the staff member contacted a FTSU Guardian.

In addition to the FTSU policy, staff are made aware and reminded of other routes to raise concerns. This includes the 'How to Raise a Concern' handout; the CLCH Welcome Booklet for new starters; a handout given to new volunteers and bank workers; induction talks for new staff and those TUPEed into CLCH; the Statutory and Mandatory Handbook that requires completion by staff annually; ad hoc team talks and presentations; events such as the AGM; intranet page, posters and articles in CLCH communications.

Regular reports on FTSU are provided to the Trust Board; the workforce committee and the FTSU working group. Additionally data and themes are fed through the patient safety and risk group and to the quality committee.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) PAYMENT FRAMEWORK

A proportion of CLCH's income during 2018-19 was linked to achieving national CQUIN 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), and NHS Harrow.

Achieving the agreed CQUIN goals represents an additional 2.5% of the contract values of these contracts. For 2018/19, as with 2017/18, only 1.5% of the total CQUIN value was associated with actual CQUIN schemes. The remaining 1% was divided between STP engagement (0.5%) and a risk reserve relating to the control total (0.5%).

Please note that it was agreed within the STPs that full payment would be made regardless of achievement.

Some of the more recently commissioned services procured through contracts with NHS Merton CCG and the Battersea Community Healthcare Community Interest Company (for the Wandsworth Adult Community Health Services contract) are not driven by CQUIN schemes; they are delivered by local incentive schemes.

Our achievements against the CQUIN goals and incentive schemes for 2018-19 are detailed in the following tables.

CENTRAL LONDON, WEST LONDON, HAMMERSMITH AND FULHAM, HOUNSLOW AND EALING (CWHHE) CCGS

CQUIN Title	Goal	Plan for 18/19	Forecast Achievement for 18/19
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£261,975	£261,975
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£261,975	£261,975
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£157,185	£157,185
Health & Wellbeing	Improvement of staff health and wellbeing	£157,185	£157,185
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.	£157,185	£157,185
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£157,185	£157,185
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.	£157,184	£157,184
		£1,309,874	£1,309,874

BARNET CCG

CQUIN Title	Goal	Plan for 18/19	Forecast Achievement for 18/19
Supporting Local Areas	To achieve financial control targets set by the STP planning process	£184745.50	£184745.50
Supporting Local Areas	To demonstrate engagement with the STP process and engaging with locality and system wide pathway developments	£184745.50	£184745.50
Health & Wellbeing	Improving the uptake of flu vaccinations for frontline clinical staff	£110,847.24	£110,847.24
Health & Wellbeing	Improvement of staff health and wellbeing	£110,847.25	£110,847.25
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.	£110,847.25	£110,847.25
Improving Wound Care Assessments	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	£110,847.25	£110,847.25
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.	£110,847.24	£110,847.24
		£923,727.23	£923,727.23

HARROW CCG

CQUIN Title	Goal	Plan for 18/19	Forecast Achievement for 18/19
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	£24,281.88	£24,281.88
Health & Wellbeing	Improvement of staff health and wellbeing	£24,281.88	£24,281.88
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
		£202,349.05	£202,349.05

INCENTIVE SCHEMES

MERTON CCG

Merton CCG's incentive scheme relates to the reduction of emergency hospital admissions and the achievement of patient outcome measures:

This scheme is worth 10% of the contract value, which would represent **£698,669** over and above the contract value.

LIS Title	Goal	Scheme values £	Forecast Achievement for 18/19
Prevention of hospital admissions	To reduce and prevent hospital admissions that also reduces mortality rates.	£139,741	£39,302
Overall experience rating	Annual improvement in proportion of people who rate their overall experience as good or excellent.	£41,921	£41,921
Involvement in care and support	Annual improvement in proportion of people who said they were involved as much as they wanted to be in decisions about their care and support.	£41,921	£41,921
Before and after outcomes measures	1) Annual improvement of number of patients who have recorded before and after outcomes measures. 2) Annual improvement in proportion of patients who have recorded before and after outcome measure/ indicator reported in patient record and achieve improvement in PROMS.	£41,922	£41,922
Rate of non-elective admissions	Annual reduction of the rate of non-elective admissions for people know to community services.	£349,350	£122,273
Managing your own health	Annual improvement in proportion of people who answer positively to the question "How confident are you that you can manage your own health?"	£41,922	£0.00

People working well together	Annual reduction in proportion of people (patients and referrers) who respond “no, they do not work well together “ to the question: “do all the different people treating and caring for you work well together and give you the best case and support?”	£41,922	£41,922
		£698,699	£329,261

WANDSWORTH (Battersea Healthcare CIC)

The Wandsworth incentive scheme is worth 10% of the contract value, which would represent **£1,568,552.40** over and above the contract value.

LIS Title	Goal	Scheme values	Forecast Achievement for 18/19
LAS – Care Pathways	To set up referral pathways and processes to enable LAS to quickly and safely refer agreed patient cohorts to CAHS services (e.g. MI / QS / Care Home Support team and community nursing) and for relevant CAHS services to provide a rapid response.	£104,570.16	£104,570.16
SPA for Enablement	To provide a simple, single and safe referral route for St George’s Hospital (SGH) and other local trusts to send referrals for all Wandsworth patients requiring enablement services from health or social care into CLCH SPA.	£104,570.16	£104,570.16
Facilitated and Supportive Discharge	To improve seamless care for patients on ECP caseload and reduce the DTOCs relating to this group of patients.	£104,570.16	£104,570.16
GSF	To support MDT discussions at GSF meetings by increasing attendance by community nurses at these meetings	£104,570.16	£104,570.16
IV Pathway Implementation	To have a safe, sustainable and cost effective IV therapy provision provided by CLCH for health conditions listed under goals.	£104,570.16	£104,570.16
Caseload and Acuity Management	To continue to refine and develop outputs of LIS schemes 2a and 2b of 2017/18 to enable better understanding of demand and capacity across all functions of care.	£313,710.48	£313,710.48
Workforce – Staffing/ budgets	To establish the current staffing levels across functions of care. To agree the means to agree/sign off future changes.	£313,710.48	£313,710.48

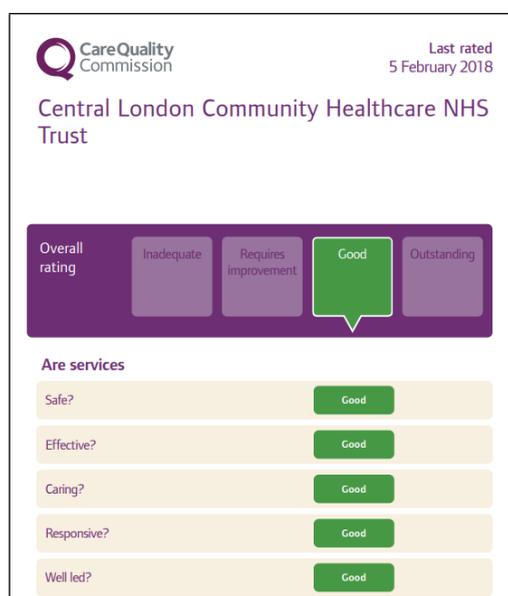
MDT developments	To implement the SOP (which will include access to information, expected attendees with reasons for exception, meeting structure, TOR) Audit compliance against the SOP and meeting structure to support the SOP.	£104,570.16	£104,570.16
SPA	To review referral pathways as specified under goals and document and implement any recommendations for change to the pathways.	£104,570.16	£104,570.16
Diabetes Pathway	To implement a new model of care for Diabetes Specialist Nurses across Wandsworth that is more efficient, ensures the DSNs review more appropriate patients while upskilling and supporting primary care.	£104,570.16	£104,570.16
Care Homes	To develop the model for, and recruit to a Care home in-reach team.	£104,570.16	£104,570.16
		£1,568,552.40	£1,568,552.40

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 2018-2019.

CLCH has not participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2019.

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 caseloads within the health visiting service, and using the Laming recommendations found that caseloads were higher those recommendations.

Whilst the CQC accepted that, a new clinical model had been introduced utilising the skills of nursery nurses, the assessors concluded that the model was not clearly understood by the staff in the service. In response this, the division created and have delivered an action plan to work with the health visiting teams to increase their understanding of the clinical model.

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.

DATA QUALITY

CLCH appreciates that high quality data is a key component of Information Governance. It also recognizes that it is essential for both the effective delivery of patient care and enabling continuous improvements in care provision. 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 Trust recognizes the importance of keeping personal data 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.

The following is a summary of the actions that CLCH has taken to improve its data quality during the 2018 - 2019 year:

- Completed a single version of the truth Trust Data Warehouse.
- Provided a data quality plan. The plan has been overseen by the Trust Data Forum that has both clinical and operational input.
- Delivered a data quality portal and assurance tool which is in use by relevant divisional staff.
- Appointed a Trust lead for data quality and an Assistant Director for Business Intelligence and Information Management.

The Data Forum (DF), led by the Chief Information Officer, has oversight of this area of work. It has a strong operational input from divisional Business Managers. In the context of data quality, this group has the following specific aims to improve data quality in 2019-20:

- 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 also be taking the following actions in 2019-20 to improve data quality.

- Working with teams to improve the quality of their data collection and reporting, utilising tools developed in the previous year.
- Working with the BI function to make data more accessible and visible, thereby increasing understanding of Trust activity and identifying data quality issues more quickly.

LEARNING FROM DEATHS: 2018 - 2019

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. This is the report linked to the Learning from Death Policy and case record reviews.

In October 2018 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 ongoing refinement but has now become embedded across the Divisional teams. All deaths within the Trust are reported via Datix. Named Team Leaders with each team triage each case to ascertain whether a case record review should be carried out using a modified PRISM 2 (Preventable Incidents, Survival and Mortality Study 2) form. The case record reviews are completed by the Divisional Directors of Quality or the Clinical Directors from the relevant divisions.

Improvement is required in documentation and collation of the reporting.

Table 1

	Prescribed information	Form of statement
1	The number of in- patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	<p>During 2018 - 2019, 1291 CLCH patients died as follows (Includes expected hospice deaths)</p> <p>292 in the first quarter 354 in the second quarter 325 in the third quarter 320 in the fourth quarter</p>
2	The number of deaths included in item 1 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.	<p>In 2018 - 2019, 11 case record reviews and 2 investigations were carried out in relation to the 1291 of the deaths included in item 1</p> <p>In 2 cases, a death was subjected to both a case record review and an investigation.</p> <p>The number of cases in each quarter for which a case record review or an investigation was carried out was:</p> <p>2 in the first quarter; 6 in the second quarter; 2 in the third quarter; 1 in the fourth quarter;</p>
3	An estimate of the number of deaths during the reporting period included in item 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.	<p>0 representing 0% 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.</p> <p>In relation to each quarter, this consisted of: 0%</p>

	Prescribed information	Form of statement
4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3.	<p>Case 1: No action points noted. The Coroner commended the unit on its record keeping around cognitive assessment and relevant documentation</p> <p>Case 2: No action points noted</p> <p>Case 3: No Next of Kin documented in medical records which caused a delay in the Next of Kin being contacted *</p> <p>Case 4: No action points noted</p> <p>Case 5: No action points noted *</p> <p>Case 6: No action points noted</p> <p>Case 7: No action points noted *</p> <p>Case 8: No action points noted</p> <p>Case 9: No action points noted</p> <p>Case 10: No action points noted</p> <p>Case 11: No action points noted</p>
<p>* Please note that in cases 5 and 7 we did not judge that there were any shortcomings in our practice as the care provider and there was no learning from these cases with regard to the provision of patient care. However in both these cases there was learning for the Trust and this is described in the paragraph below.</p>		

5	<p>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 4).</p>	<p>Case 3: NOK now audited quarterly as part of the service’s medical record audit. From 2020, NOK documentation to be audited as part of the Annual Trustwide Clinical Record Keeping audit.</p> <p>Case 5: This case record review was conducted as the communication between staff and family members had been poor during the patient’s admission. Staff in the unit reflected that in future, cases such as these will be investigated via the complaints process rather than by case record reviews.</p> <p>Case 7: Information was missing regarding a Mental Capacity Act assessment which had been conducted shortly prior to the patient’s death as the assessment was carried out by a third party and we did not have access to these records. The Trust’s Medical Director liaised with NHS England Deputy Medical Director to enquire whether there was any way that we could gain access to records held by third parties for the purposes of completing case record reviews and investigations following patients’ deaths but was informed that this was not possible due to data protection laws. The Medical Director is liaising with the Trust’s Clinical Chief Information Officer to see what process, if any, we can follow for obtaining relevant information when third party organisations are involved.</p>
6	<p>An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.</p>	<p>Case 3: No impact as yet</p> <p>Case 5: No impact as yet</p> <p>Case 7: No impact as yet</p>

	Prescribed information	Form of statement
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 2 in the relevant document for that previous reporting period.	0 case record reviews and 0 investigations completed after 2017 -2018 which related to deaths which took place before the start of the reporting period.
8	An estimate of the number of deaths included in item 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 representing 0% of patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the PRISM 2 (Preventable Incidents, Survival and Mortality Study 2) CLCH Review Form, which is a tool recognised by NHS Health Research Authority used for assessing case records, and which has been adapted for use by CLCH.
9	A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8.	0 representing 0% of the patient deaths during 2018 - 2019 are judged to be more likely than not to have been due to problems in the care provided to patients.

INCIDENT REPORTING

The following two questions have been 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 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.

For the period 2018-19 there were 8946 patient safety incidents reported within CLCH. Of these incidents 33 (or 0.368%) resulted in severe harm. There were no patient safety incidents that resulted in a death. (Community Trusts are no longer provided with information from the National Reporting and Learning System (NRLS) regarding the rate of patient safety incidents so this information is not available). The patient safety incidents reported that resulted in severe harm consisted of thirty pressure ulcers, one fall, one delay/failure to diagnose and one information breach.

Within the arena of patient safety it is considered that organisations that report incidents have a better and more effective safety culture. This is because to learn and improve you need to know what any problems and issues are.

CLCH considers that this data is as described for the following reasons:

- The Patient Safety Managers continue to work closely with clinical colleagues to raise awareness about the types of incidents that should be recorded on the incident reporting system
- The patient safety team actively promote the work of the team, providing presentations at induction and being part of the apprenticeship scheme for staff on development programmes.
- Regular feedback is provided through communication channels such as the Hub and Spotlight on Quality as well as direct feedback to incident reporters so that staff can see that we do respond to the incidents reported and action is taken as a result.
- The number of severe harm pressure ulcers has reduced and during the last year we have provided monthly and quarterly feedback on the lessons learnt from pressure ulcer investigations completed.
- Maintenance of a fair-blame culture so that staff feel confident in reporting incidents.

The Trust has taken the following actions to improve this and so the quality of its services, by:

- Sharing learning from incidents through the Trust's publication *Spotlight on Quality*.
- Including key themes and learning from the pressure ulcer incident investigations on the pressure ulcer pages on the Trust's intranet.
- Collating the themes into a quarterly report which is shared every month with each division for discussion and dissemination.
- Encouraging incident reporting at all available opportunities including presentations at the new face to face induction and delivering training to apprenticeship and other development programmes.
- Developing and sharing 'how to' guides so that staff are helped to report incidents.
- Sharing learning from incidents through a standing item on the patient safety and risk group.
- Developing a Trust wide action plan for pressure ulcers which is monitored and maintained by the pressure ulcer working group.
- Implementing action plans following the completion of investigations to prevent reoccurrence

PART 3: OTHER INFORMATION

QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2018-19

Trust wide quality scorecard: The following scorecard describes Trust performance against the quality campaign KPIs. Where performance targets were not achieved, further information is provided. Additionally performance against our quality strategy measures of success is incorporated into the relevant tables below.

Quality Campaign	Key Performance Indicator	Target 2018-19	Performance	
			Year end 2018-19	Previous year 2017-2018
A Positive Patient Experience	Proportion of patients who were treated with respect and dignity	95.0 %	98.3 %	97.4%
	Friends and family test (FFT)- percentage of people that would recommend the service	95.0 %	94.5 %	92.1%
	Proportion of patients whose care was explained in an understandable way	92.0 %	95.4 %	92.9%
	Proportion of patients who were involved in planning their care	90.0 %	92.6 %	84.5%
	Proportion of patients rating their overall experience as good or excellent	92.0 %	94.2 %	92.2%
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	99.8 %	99.3%
	Proportion of complaints responded to within 25 days	100.0 %	100.0 %	100.00%
	Proportion of complaints responded to within agreed deadline	100.0 %	100.0 %	100.00%
	Proportion of complaints acknowledged within 3 working days	100.0 %	100.0 %	100.00%
Preventing Harm	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	96.0 %	97.5 %	97.2%
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	8	NA – new measure
	5% reduction in pressure ulcers Category 3 / 4 (on 2017/18 baseline)	96	133	105
	Zero tolerance of new (CLCH acquired) category 3 & 4 pressure ulcers in bedded units	0	5	5
	Proportion of external SIs with reports completed within deadline	100.0 %	100.0 %	98.6%
Preventing Harm Prevalence (NHS Safety Thermometer)	Proportion of patients who did not have any NEW harms	98.5 %	98.4 %	98.3%
	Proportion of patients who did not have a NEW (CLCH acquired) pressure ulcer	98.5 %	99.0 %	99.00%
	Proportion of patients who did not have a fall	98.5 %	99.3 %	99.2%

Quality Campaign	Key Performance Indicator	Target 2018-19	Performance	
			Year end 2018-19	Previous year
Smart, Effective Care	Proportion of patients who did not have a catheter associated urinary tract infection	99.0 %	99.6 %	99.5%
	Proportion of patients who did not have a venous thromboembolism	100.0 %	99.8 %	99.8%
	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.0 %	0.3%
	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90.0 %	100.0 %	100%
	Percentage of hand hygiene episodes observed across CLCH services (excluding bedded areas) that are compliant with policy	97.0 %	98%	100%
	Percentage of local clinical audits, service evaluations and quality improvement projects undertaken by services.	40.0 %	65.9 %	71.7%
	Percentage of services completing NICE Baseline Assessment Form within agreed timeframe	80.0 %	99.3 %	65.00%
Modelling the Way	Statutory and mandatory training compliance	95.00 %	92.9 %	89.82%
Here, Happy, Healthy & Heard	Staff Vacancy rate (Clinical)	10.00 %	12.50 %	12.14%
	Staff Turnover rate (Clinical)	10.00 %	14.91 %	16.67%
	Staff engagement index score	7.6%	7.1%	3.89%
	Sickness absence rate - 12 month rolling (Clinical)	3.50 %	3.91 %	3.65%
	Percentage of staff who have an appraisal	90.00 %	87.80 %	86.48%
Value Added Care	Staff to have been trained to basic level in improvement skills including Lean	10.0 %	11.4 %	6.0%
	Services have used improvement tools	1.0 %	7.6 %	4.9%

PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

Key Outcomes	Measures of success 2018/19	Update
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	Achieved
	90% of proportion of patients who were involved in planning their care	Achieved:
	The use of co-design will be evaluated across the organisation	Partially achieved: A formal evaluation of the use of co-design has not yet been completed but will be completed in the first quarter of 2019-2020.
	Evaluation from patient feedback of their involvement in the Quality Councils	<p>Partially achieved: The Assistant Director of Patient Experience chairs the Shared Governance Council addressing the challenges with staff and patient representative’s recruitment and retention. The feedback from patients on their involvement in quality councils is being shared. This included the need for a role specification for patient representatives to ensure they are aware of what is involved and ensuring that chairmanship training is available for patients and staff alike.</p> <p>As a result of the feedback, two patient representatives have completed training and further sessions will be taking place. Members of the council will be the first to pilot patient focussed QI training.</p>
Patient stories and diaries used across pathways to identify touch points and ‘Always events’ Patient stories <i>contd.</i>	Evaluation of <i>Always Events</i> and their impact on patient experience	<p>Partially achieved: The evaluation of the first Always Event has been completed and its impact can be evidenced through the successful achievement of our PREMs indicators and the positive feedback that we get through patients stories and compliments.</p> <p>The Patient Experience Team have audited the use of the improvement tools implemented through the initial Always Event. This focused on staff awareness and use of the three initiatives rolled out as part of the Always Event.</p> <p>The training aspect of the Always Event has is now embedded in the Band 5 Core Competency training and therefore is no longer specific only to the District Nursing teams.</p>

	Quality Councils to start leading on the development of <i>Always Events</i> with local implementation	Not achieved: The patient and staff recruitment and retention council are currently looking at how <i>Always Events</i> can be supported through Quality Councils. Alongside this, the Patient Experience team continue to engage patients and staff in the <i>Always Events Journey</i> and involve established Quality Councils where possible.
	Thematic analysis of previous year's stories with shared learning	Achieved: The thematic analysis of patient stories was completed and used to help shape the 2018-2020 PPE strategy. The Patient Experience team have started collating the patient stories collected in 2018/19 and these will be shared across the Trust.
	Continued use of patient stories by all services and shared at Divisional and Trust forums	Achieved: The Patient Experience Team continue to deliver patient stories training across each of the divisions supporting staff to collect and learn from patient stories. The Patient Stories information pack has also been updated. There were a total of 227 patient stories submitted to the team in 2018/19 which were shared across the Trust at Divisional and Trust Forums
Patient feedback used to inform staff training	Patient feedback will be integral to the review and development of education and training	Partially achieved: To ensure that the patient voice is heard, any incidents or complaints where staff training needs have been identified are shared at the Modelling the Way forum. Incidents and patient feedback continue to be discussed at the Trust End of Life Care Operational Group and Learning Disability forum to identify any specific training requirements.
	Evaluate how patient feedback has influenced training and education	Achieved: Following the inception of the patient and staff representative recruitment and retention shared governance council; patient representatives have continued to reiterate the importance of training, education and accreditation to ensure that they feel confident to be an equal decision maker alongside NHS professionals.
	Evaluate the use of patient stories as part of learning from serious incident reviews	Achieved: A member of the Patient Experience team attends each of the serious incident panels and works closely with lead investigators to engage with the patients involved.

Amber quality KPI not described in table above - Family and friends test: In line with the national target for the number of patients who would recommend the service to their families and friends, the Trust has a target of 95%. We did not achieve overall year-end target of 95% falling just short with a score of 94.%%. significant improvements have been made and in the final quarter of the year (Q4) the Trust exceeded its target with a score of 95.2%.

PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN TWO PREVENTING HARM

Key Outcomes	Measures of success 2018-19	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 (Safety Thermometer)	Achieved
	Incidence of PU and falls will continue to fall	<p>Pressure ulcers: Not achieved as the final YTD figure for category 3 /4 pressure ulcers was 133. This exceeded the target of 96. As measured by the NHS Safety Thermometer 99% of our patients did not acquire a pressure ulcer whilst under CLCH care. Actions are being taken to address the issue. These include monthly feedback to divisions on the numbers of reported pressure ulcers and the sharing of the top learning points from completed investigations.</p> <p>Falls: The target was not achieved as the final YTD figure was 8 falls with moderate harm reported on the bedded units however the level of harm attributed to each fall has reduced this year.</p> <p>As measured by the NHS Safety Thermometer 99.3 % of patients did not fall. The Trust Falls Steering group continues to review actions that can be taken to support reduced falls and divisions are working with acute trust providers and commissioners to ensure that appropriate patients are transferred to our rehabilitation units.</p>
	Reporting of incidents increases whilst levels of harm reduce	Achieved: There was an overall increase in incident reporting (incidents affecting patients) in 2018/19.

Systems in place – <i>contd.</i>	Zero tolerance of category 3 and 4 PU acquired in bedded areas	Not achieved: The final year to date figure was 5 category 3 or 4 pressure ulcers reported as acquired in bedded areas. All the cases are investigated via a root cause analysis and we continue to look at improving the way we share specific learning from pressure ulcers occurring on our bedded units.
	100% RCA completed on time	Achieved; all external Serious Incident Root Cause Analysis reports were submitted on or ahead of schedule during the year.
	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	Achieved:
Safety culture and activities signed up to in ALL services	Safety culture and activities signed up to in all services	Achieved: During the year the quarterly reports on learning from pressure ulcer investigations were shared with the South, Inner and North Divisions. The North Division continues the Wound Wednesday initiative and other areas are now replicating this. The South Division has implemented a new Quality Forum and the Inner London division continues to discuss safety initiatives and activities in their quality forum. The Spotlight on Quality newsletter is used to share news and learning.
Variations in practice identified and acted upon	Quality Action Teams to develop areas to exemplars	Partially achieved: During 2018/19, six services were assessed and awarded Quality Development Unit status, although none were developed from QATs.
	Develop a learning repository to enable teams and services to share issues identified from incidents and evaluate the use of the repository	Achieved: the key learning from pressure ulcer investigations has been shared on a dedicated pressure ulcer learning page of the Hub during 2018/19, and a survey was developed to evaluate the use of it. The survey was targeted to those who may find the web page useful in their work.

PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Outcomes	Measures of success 2018/19	Update
Clinical staff use the most up to date clinical practices	CAS alerts (Inc. PSAs) –Monthly Board KPI target for timely alert closure ≥90%	Achieved
	NICE – 80% of services complete a Baseline Assessment Form for NICE Guidance within the agreed timeframe	Achieved
There will be a demonstrable culture of clinical enquiry and continuous improvement across the trust	78% staff able to contribute to improvements at work (staff survey)	Partially achieved: Results from the National Staff Survey 2018 indicated we had achieved 74.6% compared to 77.8% in 2017 on the question of whether staff can suggest improvements to their work.
	Central resource dedicated to improvement analytics	Achieved: Staff had access to the Continuous Improvement page on the Hub which contains analytical tools, support materials and training information. Support and training can also be accessed from peers or the Improvement Team via the analytics and improvement networks using a web-based forum on the Hub.
CLCH will be a leader in innovative community practice	Each Division to identify within business planning process an innovation for 2018/19	Partially achieved: The West Herts service continues working on setting up innovative work to improve patient care and outcomes. Work continues to work with divisions to ensure innovations are identified.
	Research activity increased by 5%	Achieved:

Amber quality KPI not described in table above - Proportion of patients who did not have a VTE: We count the number of patients on the day of the patient safety thermometer survey who have a VTE, such as a deep vein thrombosis (DVT). Throughout the course of the year 2 patients were identified with new VTEs in two of our rehabilitation units. Appropriate measures were taken by the relevant divisional directors of nursing to deal with these incidents.

PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN FOUR: MODELLING THE WAY

Key Outcomes	Measures of success 2018/19	Update
New roles and career pathways are in place which supports the needs of patients/service users.	Reduction of vacancy rates across the Trust (10%)	<p>Not achieved: In February 2019, the Trust vacancy rate was 12.48%.</p> <p>The Trust continues to engage with our partner HEIs attending job fairs and placement forums to actively promote the recruitment of newly qualified staff into band 5 posts. The 18 host students due to qualify September 2019 have all received offers of Band 5 community nursing posts.</p>
	Improved staff turnover across the Trust (10%)	<p>Not achieved: In February 2019, the Trust’s clinical turnover rate was 14.91%.</p> <p>The Trust continues to support and implement a number of training and development programmes to support staffs career development. The Trust will focus on the AHP development portfolios undertaking an initial review to identify gaps and develop a plan accordingly. A survey has been undertaken with AHP staff across the Trust to identify what is their experience about access to learning and development opportunities and a paper will be presented to modelling the way in April 2019 outlining the key themes.</p>
	The continued implementation of Apprenticeship roles	<p>Achieved: The Trust has seen the number of apprentices increase over 2018/19 with over 70 staff undertaking an apprenticeship across the Trust.</p> <p>58 Apprentice Nursing Associates (ANAs) commenced since November 2019, as noted in the campaign update, 4 ANAs are based within learning disability services across the Trust.</p>

New roles – <i>contd</i>	The evaluation of the Nurse Associate pilots in Adults and Children services	Achieved: The Trust remains involved in 4 pilot sites across London and are involved in the evaluation of these with Health Education England. 2 training nurse associates (TNAs) have successfully completed their programme and registered with the NMC moving into band 4 Nursing Associates positions within the Inner Division. The remaining 5 are due to qualify in April 2019
	The evaluation of the Capital Nurse Foundation rotation programme pilots	Achieved: The Trust continues to offer the Capital Nurse Foundation Programme with positive feedback from staff and the divisions. Currently 34 staff are on the programme and there has 100% retention on the programme. The Trust was also successful in obtaining the CapitalNurse Preceptorship Charter mark.
	The evaluation of the staffing models in all clinical services	Partially achieved: Work is taking place across all divisions to review staffing models to support new ways of integrated working. A new Clinical Staffing Establishment panel has been implemented chaired by the Director of Nursing and Therapies. The panel will review establishments with no change annually and where changes are being made, to ensure they are in line with national and trust safe staffing models.
	Staff survey results	<p>Not achieved: The 2018 staff survey results showed that we were below average in equality, diversion and inclusion. The Academy team continue to work across a range of groups inputting into the WRES action plan. The plan was published at the end of September 2018 before the survey was run and it was too early for the impact of the WRES action plan to be reflected in the 2018 survey results.</p> <p>The results identified 'leaving for education and training' as one of the top 5 reasons for leaving the Trust. To ensure staff have a positive experience of education and training, we have been implementing initiatives such as the Academy, apprenticeships for both clinical and non-clinical staff and the launch of the new Clinical Workforce strategy.</p>

New roles – <i>contd.</i>	Evaluation of fast track programmes	Achieved: An evaluation of the fast track programme was undertaken and the recommendations implemented.
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	Partially achieved: Following workforce events, staff have proposed a number of models of professional practice. These will be shared Trustwide. The feedback from this will be collated and developed in to a draft model of professional practice by May 2019.
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	Partially achieved: The Trust has attended an initial meeting hosted by HEE to look at how across NW London we support clinical academic careers.

Amber quality KPI not described in table above –statutory and mandatory training compliance: The Trust has not yet reached its target of 95% compliance. However improvements have been made and a number of actions have been taken to achieve the target. These include additional training sessions being implemented in local areas and staff being written to when they are not compliant and if necessary, invited to attend meetings with the divisional management team. Divisions have also been asked to support staff with protected time in order to complete their training.

PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN FIVE: HERE, HAPPY, HEARD AND HEALTHY

Key Outcomes	Measures of success 2018/19	Update
Staff are fully engaged and involved in the model of shared governance	Four to five Quality Councils are established per division and well attended.	Partially achieved: There are currently 18 Quality Councils across CLCH. The recruitment drive continues with an emphasis on recruiting and retaining patient representatives and increasing the number of frontline staff. The Quality Councils
	Shared governance forums are effective at resolving issues and concerns	Partially achieved: The profile of using shared governance to make quality improvements has been raised and there has been an increase in staff completing the Quality Improvement training and using quality improvement methodology. The information gained through shared governance has started to be shared across all divisions and we anticipate that this will increase in the future.
Voluntary staff turnover below 8% by 2020	Voluntary staff turnover at 10%	Not achieved: The year-end position was 14.91%. To address this a new working group has been formed and is focused on delivering elements of the NHSI retention agenda including looking at: retire and return; an internal transfer scheme and “itchy feet” conversations and focussing on clinical staff who leave within 12 months of joining
Staff vacancies to 10% by 2020	Staff vacancy rate to 10% by March 2018	Not achieved: The clinical vacancy was 12.50 Each Division has its own plan to reduce their vacancy rates
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	Partially achieved: The national metric has been re-indexed from a 0.01-5.00 scale to a 0.1-10.0 point scale. The Trust score is now 7.1.

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	Not achieved: The 2018 survey published position on stress worsened with an increase to 41.3%. The Trust has a Mental Health nurse and counselling facilities available via Employee Health which are being advertised widely to ensure staff are aware of them.
	Sickness absence remains below target of 3.5%	Not achieved: (As of February) the absence was 3.87%. The overall picture is of an increasing issue that the HR team are seeking to address with operational managers.
The Trust is committed to and makes demonstrable reductions to agency spend	Agency spend is proportionally reduced as sickness, turnover and vacancy rates reduce	Achieved: At the close of Month 11 (February 2019), the Trust posted a year to date agency spend of £3,865,664.93 against the stretch target of £4,818,043.23
	The number of staff recruited to staff bank increases by 15%	Achieved: At the end of 2016/17, CLCH had 942 pure bank staff; at the end of 2017/18 it was 1261 and at the close of February 2019 CLCH have 1391 on the system.

Amber quality KPI not described in table above – Staff appraisals: Significant work has been undertaken to improve the appraisal rate. Details of staff who have not been appraised and those due to be appraised are shared with managers to ensure that the appraisals can be planned and undertaken in a timely manner. This is being monitored within divisions and reported monthly at the Trust Performance meetings.

PROGRESS AGAINST OUR QUALITY PRIORITIES – CAMPAIGN SIX: VALUE ADDED CARE

Key Outcomes	Measures of success 2018 -19	Update
The user experience across CLCH, primary care, specialist services and social care is as seamless as possible	Implement actions from assessments undertaken in 2017/18	<p>Partially achieved: A Shared Governance Council is now in place for staff and patient representatives are involved in recruitment and retention. Issues being addressed by the group include</p> <p>Members of the council will be the first to pilot patient focussed quality improvement training – this is being developed with the Continuous Improvement team.</p>
Clinical staff use the latest technology to improve care delivery	Each Division to identify within business planning process an innovation for 2018/19	<p>Partially achieved: The CLCH Way programme work streams ‘Improving our digital competence’ and ‘Telemedicine’ are supporting divisions to explore and implement the opportunity for technology enabled innovation.</p> <p>The Innovation Portal has now been launched online on the CLCH hub and new technology applications for funding have commenced. Community nurses and Health Visitors are being supported to use laptops when visiting their patients and families and scheduling technology is being procured to help with route planning and visit allocation</p>
	Each division has used improvement tools to improve 1% of services.*	Achieved: Eight services and four quality councils have demonstrated all the requirements for this KPI. This represents a Trust position of 7.6% which is ahead of trajectory (1%). All divisions have met this requirement.
Front line staff lead new lean ways of working	10% staff to have been trained to basic level in improvement skills, including lean	Achieved: 377 staff have achieved basic level improvement knowledge. This represents 11.4% of staff in post

DIVISIONAL QUALITY COUNCIL OBJECTIVES

There are currently a total of 18 Quality Councils as follows:

North: 5 quality councils

Inner: 3 quality councils

South: 2 quality councils

Children's: 4 quality councils

Trustwide: 4 quality councils

The following is a summary of their work.

Division	Quality Campaign	Project
North	Modelling the Way	Increasing compliance against mandatory training: This council is focussed on improving statutory and mandatory training across the North Division. They have recently started a pilot study concentrating on Infection Control compliance Level 2 in District Nursing. Questionnaires have been completed and distributed to staff to obtain data on the ease of booking, management support, and suitable reminders. The results will be analysed and shared with the Modelling the Way forum.
	Here, happy, heard and healthy	Local induction for new starters: This project commenced in February 2019 and its objective is to create a standardised local induction pack to make the workplace for new starters more welcoming and supportive. It will be piloted in the North Division with the aim to be shared across all divisions. The council have started to collect data specifically looking at different types of induction packs already being used across clinical and non-clinical teams.
	Preventing Harm	Monitoring and maintaining healthy pressure areas in care homes: This council has focussed on supporting residential home staff in maintaining healthy pressure areas for residents to prevent pressure damage. A Pressure Ulcer Core Care Resource Pack is now completed, and has been disseminated out to care homes in the North Division. This will be used as a resource to the care home staff and has also been shared across CLCH to be used as a resource for all staff. Impact and outcome of these resources to be reviewed in 3 months.

	Value added Care	Improve the quality of referrals in Barnet received in planned care in order to improve patient care within the next 6 – 12 months. The council started in March 2019. At present, the team is on a fact finding mission to collect relevant data.
	Smart, effective care	Identify the causes of breaching the length of stay in Adams Ward and to reduce the length of stay to 21 days. The council commenced in January 2019 to review the journey of 11 patients on admission through to discharge. Social Services have been included and initial recommendations have been discussed.
Inner	Modelling the Way	Adherence with the Accessible Information Standards Policy across the Trust. The project has conducted an initial baseline survey and an audit of SystmOne template completion in patient records across 3 DN teams in Westminster. This will enable the council to understand if there are any gaps and understand what actions need to be taken to improve adherence with the Accessible Information Standard.
	Here, Happy Heard and Healthy	To address staff happiness and increase staff morale. The project aim is to gain a better understanding of what effects staff morale in the workplace and to make recommendations to the trust on potential areas for improvement. An initial survey demonstrated that some staff do not feel valued and listened too. "Talking Mondays" was piloted across 4 teams where staff could discuss any chosen topics work or non-work related. Outcomes of this project will be reviewed through a further survey and feedback from staff.
	Here, Happy, Heard and Healthy	Improving staff morale across Harrow Community Services: The project aims to reduce the proportion of staff feeling that they are wasting time due to a lack of awareness of other services. A list of services and access detail lists are being compiled. They will be reviewed to ensure they are accurate, then disseminated in both hard and soft copies. The council will then gather reviewing data to analyse if the information has reduced wasted time from 54.6% to 30% by December 2019.
South	Positive Patient Experience	Reduction in numbers of patients on podiatry waiting lists: The project aim was to agree a systematic approach to reducing the numbers of new and follow up patients waiting on the podiatry waiting lists to improve patient experience. The project has made improvements to patient experience by reducing the waiting lists. The Council Chair is working with the Continuous Improvement Team to present the outcomes in data form which can be used across the Trust.

	Smart Effective Care	Communication information folder for patients in the Community in Merton: The aim of the project is to improve communication and share information through the introduction of a patient information folder into the home. The folder contains contact numbers and names of therapists that the patient is seeing and will contain non-confidential information.
Children's	Smart Effective Care	To reduce DNA rates for Health Reviews (HR) 1 and 2 in Barnet and Brent: This is a new project for the council There is a high rate of DNAs of HR1s and HR2s across Barnet and Brent. Data on DNAs of HR1 and HR2 is being collected . The process of the Health Review from booking to appointment date with the health professional is being mapped.
	Positive Patient Experience	Development of bespoke PREMS for children/families: The objective of this project is to make PREMs more relevant and user friendly to school age children, encouraging an increased return and to utilise the feedback to maintain the quality of the service. Richmond School Nursing team have piloted PREMs with changes and following the feedback from the pilot they have involved a focus group of students to make further changes which they will review.
	Here, Happy, Heard and Healthy	Improving Communication within Merton's Children's Service. The aim is to improve communication between staff and senior management in Merton's Children's Services and to increase from baseline % by 20% by September 2019. Feedback from ICN and 0-19 Forums have been collected, data analysed and issues such as the timing of information and not being involved in change has been highlighted. The results have been represented in a Bar Chart and comments listed into positive and negative sent to Line managers to do "you said" "we Did".

	Preventing Harm	Improving the communication of safeguarding information between Social Care services, Health Visitors and School Nurses: The project aim is to improve the flow of communication and increase the knowledge and education of roles. Questionnaires for both 0 to 19 and Social Care have been disseminated. Presentations at relevant forums have been carried out by the council. Data will be analysed to take feedback to senior management and move forward improvements.
Trust wide Quality Council	Preventing Harm	Safe implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI): The objective of the Council was to ensure communication of the changes and education of relevant staff was carried out safely to describe the thickness of modified foods and fluids and to prevent harm to patients due to choking. Outcomes of knowledge and safety of the IDDSI will be collected in June 2019.
	Here, Happy, Heard and Healthy	Reduce the staff turnover rate from 14.7% to 8% by March 2020: the Council is gathering data about staff retention and recruitment. Each division has started collecting information from staff who are thinking of leaving. This information will be analysed for themes and issues and this will be forwarded to the relevant management and HR team.
	Positive Patient Experience	Recruitment and retention of Patient Representatives and Staff in Quality Councils: This council's objective is to improve the recruitment and retention of Quality Council Members through updated marketing resources such as posters and ensuring there is a clear role specification for patient representatives and staff to ensure they are fully aware of the role and the commitment involved. Training for Chairs and Quality Improvement training is now being taken forward for patient representatives.
	Here, Happy, Heard and Healthy	Recommending the Trust as a place to work to Friends and Family: The council's objective is to collect data across CLCH regarding the reasons for and against recommending the Trust as a place to work and to confirm the understanding of the question.

TRUST QUALITY PROJECTS AND INITIATIVES

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

CLCH Academy: This is an exciting new initiative which supports a hub of learning and development for both trust and primary care nursing staff (both registered and unregistered). The Academy will provide an excellent opportunity to support the development of a workforce that is both fit for the future and that is competent and capable to provide care within new models of working.

As part of the Academy, the Trust awarded London Southbank University as its University partner. Working with them we are establishing a hub of learning and development activities. We will also be exploring the use of innovative approaches to review the way in which training and education is delivered. With the move towards new ways of working and a more integrated approach to borough based care around the patient, the Academy will provide an opportunity to support primary care nurses with their career development. It will also enable community and primary care nurses to train and learn together; looking at how care models can be adapted. The Academy will provide the opportunity to standardise learning across boundaries and to support the workforce with roles, such as the apprenticeship nursing associate, apprenticeships and potentially integrated roles, or a pool of suitable and appropriately skilled staff who can work in a number of environments.

Quality Development Units (QDU): QDUs were introduced as a way of recognising those teams or services which have shown excellence in quality through the assessments process. As described in our Quality Strategy, to achieve QDU status teams/services must have both completed a CQC self-assessment and must not have triggered any red flags. (A red flag is triggered if there has been no team leader for 2 months; vacancies over 10%; high levels of sickness; a reported serious incident or an increase in incidents causing harm and increase in complaints). The team or service must also have evidence that it has implemented quality improvements. Following this, a panel, chaired by the Chief Nurse, will review the evidence and consider a presentation made by the team demonstrating why they should be awarded QDU status. The panel will assess the team within their working environment; this allows all members to take part in the assessment and enables the team to showcase their working environment. It also gives the panel an opportunity to speak to service users.

Teams and services that have been awarded QDU status will be held up as centres of excellence. They will receive a team award of a £1000 and team members will be given lapel badges. Additionally QDUs will be expected to: trial new ways of working; to offer advice to other teams who are struggling and to play a prominent role in our quality councils. Since the introduction of QDU status two years ago, 7 services/teams have been awarded this status. These are Barnet muscular skeletal (MSK) team; Inner London paediatric dietetics; Merton holistic and rapid investigation services (HARI); Hertfordshire respiratory service; Harrow podiatry service; Colville health visiting team and Hammersmith & Fulham speech and language therapy education team

Shared governance: This is a dynamic staff-leader partnership that promotes collaboration, shared decision making and accountability for improving quality of care, safety and enhancing work life. We are using a model of shared governance to support the delivery of our Quality Strategy. Following the introduction of shared governance two years ago, each of our operational divisions now has Quality Councils

in place. The councils are chaired by a member of staff more junior than a Band 6 with membership consisting of varying numbers of staff from across professions and grades.

Uniquely at CLCH we have decided to include patients and members of the public in our shared governance model and to this end, there are two patients or members of the public on the councils.

Quality Councils have two key functions. Firstly, working within clear guidance, each council has one objective for their division. They will work on that objective throughout the year, pulling in support as required from both their division and across the Trust. Secondly, they act as a resource for other front line staff and managers and will give informed advice on issues. For example if the Chief Nurse was not sure how to take a particular problem or issue forward he might request the advice of one of the quality councils. Alternatively front line staff may want to ask the opinion of a quality council.

We currently have 18 quality councils looking at shared governance projects that include; increasing compliance with mandatory training; creation of a standardized induction pack; supporting residential care home staff in maintaining healthy pressure areas for residents to prevent pressure damage; reviewing the length of stay in Adams Ward with the aim of reducing this; increasing staff happiness and morale, reducing numbers of patients on podiatry waiting lists; and improving the communication of safeguarding information between social care services, health visitors and school nurse and reducing staff turnover rate from 14.7% to 8% by March 2020. We welcome the fact that patients are engaged with our forward facing quality councils.

Other quality initiatives included:

15 Steps Challenge: this continued to be delivered with great success throughout the year. The 15 Steps Challenge team consists of a patient/carer, a staff member and a board member, including non-executive directors who visit services and speak to patients and staff to discuss the impressions of care they have received. The conversation is structured around a specific set of questions and explores what is working well and where there is room for improvement. After these discussions, the 15 Steps Challenge teams feedback to services focusing on building continuous improvement with the patient's voice at the heart of the process. We are pleased that 15 steps challenges are being made to our hard to reach cohort of patients. This initiative helps staff, patients and the public to work together to help identify improvements that can be made to enhance the overall patient experience

Allied Health Professional's (AHP) Day: On the 15th October 2018 we held an AHP's day where we took the opportunity to celebrate our AHPs.

Capital Nurse Preceptorship: CLCH was successful in its application for the Health Education England Capital Nurse Preceptorship Quality Mark. Preceptorship workshop and study days are being planned for all professional disciplines; preceptors will be trained to support newly qualified registrants through the preceptorship programme.

Complaints and PALS surgeries: these were launched to raise awareness of how to raise a concern; make a formal complaint and provide positive feedback. These were positively received in North Divisional services with some positive feedback at the Edgware Walk in Centre.

CLCH Dental Service for Homeless People: is supporting research about the appropriateness of offering HIV testing to clients of our Great Chapel St Dental Clinic. The research is part of a wider study to assess the feasibility of dentists offering HIV tests to their clients. If the uptake is good it will save lives by facilitating early diagnosis of HIV positivity, especially in hard to reach groups such as homeless people.

End of life/ bereavement: This was the subject of an *Always Event* that looked at the end of life care provided by our district/ end of life care nurses. Surveys were sent out to relatives following the death of a loved one (who had died in the last 3-6 months) and some relatives were invited to a video interview about the care that was provided to them.

Infant feeding: the health visiting teams from Hammersmith and Fulham, Westminster and Kensington and Chelsea achieved re-accreditation of their Level 3 Baby Friendly Initiative (BFI) status with exceptional results. This recognised the high level of support they provide families around infant feeding. The Infant Feeding Leads will be working together with the health visiting teams through 2018 /19 to implement the standards for sustainability in order to achieve the gold award

Patient stories: These are an individual's personal account of their healthcare experience described in their own words. Through listening to the patients' voice we capture evidence about the quality of our services and use this to improve our services. CLCH now has a dedicated patient story web page which can be found here: <https://www.clch.nhs.uk/get-involved/help-improve-services/patient-stories>

Volunteers: We have been working to increase the number of volunteers. To this end, we undertook engagement work with patients to find out whether they would benefit from interactions with volunteers and we also consulted with them as to the kind of activities they would like to see volunteers undertake. In response, our patients advised us that they had gaps in their day and suggested that volunteers might be able to address this with various activities. For example patients suggested that volunteers help with talking, poetry reading, gentle exercise encouragement and music.

Awards:

We are proud of the work our staff do and we were delighted that this work was twice acknowledged through national award schemes. As well as being awarded the HSJ patient safety award for the organization of the year, our West Herts respiratory team, in collaboration with Herts Valley CCG, was shortlisted in the optimisation of medicines management category at the 2018 HSJ awards. The award was for optimising the use of oxygen for patients with respiratory illnesses in the home.

As well as external validation, CLCH also recognizes outstanding individuals at its own staff awards ceremony. This year 17 different awards, from over 500 nominations, were presented to a range of outstanding teams and individuals.

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

The quality account will be sent out for consultation on or before the 30th April 2019. The response from our commissioners etc. is unlikely to be received until June.

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 2018-2019 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 2018 to *date of statement*
 - papers relating to quality reported to the board over the period April 2018 to *date of statement*
 - feedback from commissioners dated xxxx
 - feedback from local Healthwatch organisations received in xxxx
 - feedback from overview and scrutiny committees received in xxxx
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.
(NB: The complaints report will be attached as an appendix the Quality Account)
 - the latest national patient survey dated xxx
 - the latest national staff survey dated March 2019
 - 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

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:

Angela Greatley OBE



Chair

Andrew Ridley



Chief Executive

dd/mm/2019

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

C/o Community Barnet

Barnet House, 1255 High Road

London, N20 0EJ

Tel 020 8364 8400 x218 or 219

www.healthwatchbarnet.co.uk

Central West London Healthwatch

For Hammersmith and Fulham, Kensington and Chelsea and Westminster

5.22 Grand Union Studios, 332 Ladbroke Grove,

London, W10 5AD

Tel: 020 8968 7049

info@healthwatchcentralwestlondon.org

www.healthwatchcwl.co.uk

Hertfordshire Healthwatch

1 Silver Court

Watchmead

Welwyn Garden City

Hertfordshire

AL7 1LT

Merton Healthwatch

Vestry Hall, London Road

Mitcham

CR4 3UD

Tel: 0208 685 2282

<https://www.healthwatchmerton.co.uk>

Wandsworth Healthwatch

3rd Floor Trident Business Centre

89 Bickersteth Road

Tooting

SW17 9SH

Tel: 0208 8516 7767

<https://www.healthwatchwandsworth.co.uk>

LOCAL CLINICAL COMMISSIONING GROUPS

Barnet CCG

Tel 020 8952 2381 www.barnetccg.nhs.uk

Central London CCG

Tel 020 3350 4321 www.centrallondonccg.nhs.uk

Hammersmith and Fulham CCG

Tel 020 7150 8000

www.hammersmithfulhamccg.nhs.uk

East and North Hertfordshire CCG

Tel 01707 685 000

www.enhertscg.nhs.uk/contact-us

Harrow CCG

Tel 020 8422 6644

www.harrowccg.nhs.uk

Hertfordshire Valleys CCG

Tel 01442 898 888

www.hertsvalleysccg.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

Hertfordshire County Council

Tel 0300 123 4040
www.hertfordshire.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 (CQUIN): The CQUIN payment framework enables commissioners to reward excellence. It links a proportion of a healthcare provider's income to the achievement of local quality improvement goals.

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

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

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

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 is 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.

PSAs: These alerts rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death

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

Repository: the lessons identified from pressure ulcer learning are placed in a 'repository'. This allows staff to reflect on their practice and modify future actions as appropriate.

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.

Quality report 2018/19

Our journey of improvement

Where relevant, data will be updated with the most recent figures. Spelling and grammatical errors will also be corrected prior to final publication

Quality report 2018/19

Part one: Achievements in quality

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Part one: Embedding quality

1.1 Statement on quality from the chief executive

This will be included in the final report

DRAFT

1.2 Our trust: our journey of improvement

The Royal Free London NHS Foundation Trust is one of the largest hospital trust in the country, employing more than 10,000 staff and serving almost 2 million patients across our three main hospitals and other sites in north London and Hertfordshire.

Our trust attract patients from across the country and beyond to our specialist services in liver and kidney transplantation, haemophilia, HIV, plastic surgery, immunology, neurology, Parkinson's disease, vascular surgery, cardiology, amyloidosis, scleroderma and infectious disease (which can be treated in our high-level isolation unit)

We are also a member of the academic health science partnership UCL Partners, which brings people and organisations together to transform the health and wellbeing of the population.

At the Royal Free London our **vision** is clear: to deliver world class expertise and local care. We combine globally recognised clinical expertise with local and friendly hospital care to represent the NHS at its best.

Our **mission** is to be world class in terms of healthcare treatment, clinical research and teaching excellence. We aim to deliver and develop leading local healthcare in all three of our hospitals, to improve lives and help people to thrive

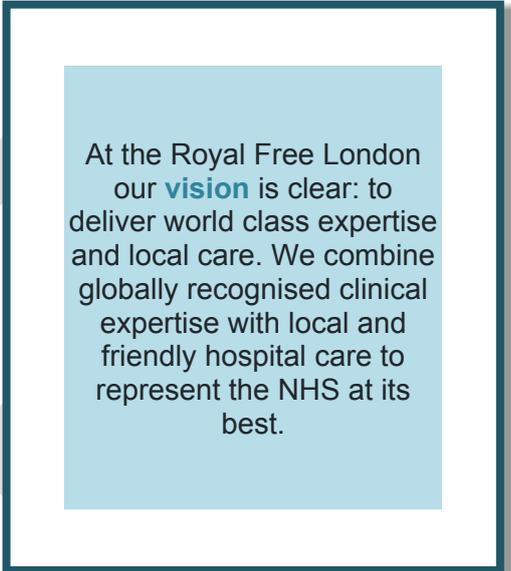
Our **governing objectives** set out how we will achieve our mission:

- Excellent outcomes in our clinical services, research and teaching
- Excellent experience for our patients and staff
- Excellent financial performance
- Safe and compliant with our external duties
- Continual development of a strong and highly capable organisation

In 2017, we became a **group**, working alongside other healthcare experts to share ways of working which know deliver the best outcomes.

- By working collectively we can reduce variations in patient care and the cost of treatment across the group.
- 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 the **clinical practice groups** where we can introduce innovation and continuous improvement for the benefit of patients who come into any of the hospitals within our group.



At the Royal Free London our **vision** is clear: to deliver world class expertise and local care. We combine globally recognised clinical expertise with local and friendly hospital care to represent the NHS at its best.

Clinical practice groups

Patients are at the heart of our clinical practice groups and the overall aim is to work in partnership to co-design new pathways of care and define the outcome measures that matter. The central focus of our CPGs is the reduction in unwarranted variation in clinical practice and processes as the variation in care adds no value for our patients and is inefficient use of health care resources.

Our current CPG pathways
1. Preoperative assessment
2. Elective hip
3. Elective Knee
4. Right Upper Quadrant Pain (RUQP)
5. Induction of Labour
6. Admissions to Neonatal Unit ('Keeping Mothers and Babies together')
7. Dermatology
8. Prostate pathway
9. Lung Cancer pathway
10. Lower GI cancer pathway
11. Haematuria pathway
12. Wheeze Child pathway
13. HPB Cancer
14. Early Pregnancy pathway
15. Anaemia
16. Pneumonia
17. Frailty
18. COPD
19. Heart failure
20. Chest pain/Pulmonary embolism
21. Cataract - Med iSOFT

An example of one of our CPGs where we have worked with our patients is within our paediatrics clinical teams to support the wheezy child.

The CPG was set up to the aim to ensure that 100% of children presenting with wheeze will receive a standardised severity score and follow a clinical algorithm that will achieve the highest standard of clinical outcomes by July 2019.

The team are seeing early signs of improvement with an overall reduction in admissions and re-attendances at 7 and 30 days and are looking forward to go live of the digitised pathway July 2019.



Members of our 'wheezy child' CPG with Dr Chris Streather, chief medical officer and Caroline Clarke, group chief executive

During 2018/19 we have made several key achievements that we are proud of. The following information is a snapshot of some of our key achievements in support of improving patient care and outcomes.

Key achievements

Team celebrates 2,000 liver transplants

Congratulations to our liver transplant team on reaching its landmark 2,000th transplant.



A second chance for 2,000th liver transplant patient



A patient who has become our 2,000th liver recipient since transplantation began at the Royal Free Hospital more than 30 years ago.

David Edgell, from Canning Town, east London, says he is incredibly grateful to the family who granted permission for their loved one's liver to be transplanted, granting him a second chance at life.

"It's a real landmark that we have reached our 2,000th transplant and I wish David well. I'd also like to pay tribute to our incredible multi-disciplinary team that collaborates to enable this life-saving work to take place."

Silence is golden: Using a 'silent' saw at Barnet Hospital to help children and older people to feel less anxious when having their plaster removed.

Our BH orthopaedic practitioners, or 'plaster techs', are celebrating the sound of silence after the recent delivery of a special saw.

The 'silent' saw helps young children, older people with dementia, as well as people with learning disabilities to feel less anxious when they are having their plaster cast removed. Marlon Ferro, an orthopaedic practitioner at Barnet Hospital, said: "Sometimes when children are having a cast removed they can become quite distressed by the sound of the saw which is very loud.

"This is quieter, and also much lighter and more mobile so we can also use it on the wards."

Thanks to a donation from Barnet Hospital Charity, patients are able to benefit from the quiet saw as well as an iPad and headphones which help to distract them while their casts are removed.

Steve Shaw, BH chief executive said: "It's often the small, simple things that make a huge difference to children and other patients.

"This will undoubtedly make it a more pleasant and less frightening experience for them."

"This new saw is really great. It can be a very frightening experience for young children having a plaster cast removed; even though it doesn't hurt, it's the noise that can scare them,"

Jane Markus, senior orthopaedic practitioner,



Left to right top row: Mark Baker, orthopaedic practitioner, Jody Graber clinical pathway manager orthopaedics, Steve Shaw, BH chief executive

Left to right bottom row: Jenny Randall, senior sister, outpatients, Jane Markus, senior orthopaedic practitioner, Marlon Ferro and Rita Sandhu orthopaedic practitioners, Carla Bispham, community fundraiser, Barnet Hospital Charity

Pathway to better care for haemophilia patients

The RFL is home to the UK's biggest treatment centre for haemophilia and other inherited blood disorders.



Using the pathway helps many people to avoid hospital attendances and admission, have better control over their condition and reduces unnecessary doses of costly medication.

People with haemophilia have little or no factor 8 or 9 in their blood – proteins that make the blood clot.

It is an inherited disorder that affects men, which means the centre looks after many generations of family members. In its most severe form haemophilia can cause extremely painful muscle and joint bleeding – usually at the hinge joints of the elbows, knees or ankles.

After many bleeds such as this, patients can develop haemophilic arthritis. Paul McLaughlin, a haemophilia physiotherapy specialist, has pioneered the establishment of a proactive pathway to support patients in managing the musculoskeletal (MSK) issues associated with haemophilia

Paul explains: “Many people think haemophiliacs bleed uncontrollably when they get cuts or wounds, but it is rare to see blood – most bleeding takes place internally.”

Paul describes his role as a bridge between haemophilia, orthopaedics and MSK physiotherapy. He says: “We have an exceptional multidisciplinary team providing a comprehensive service for people with haemophilia to manage their condition day-to-day, stay well and live as full a life as possible.”

Historically haemophiliacs were advised against doing exercise or sport, due to risk of bleeding. But with the excellent medical treatment now available the advice has changed, because strong joints and flexible muscles can reduce the risk of bleeds.

“We often see our haemophilic patients with pain after an activity like football, but it is not necessarily caused by a bleed, it may be an injury that could happen to anyone.” says Paul.

“Patients can come directly to our clinic and we will assess the possible reasons for their pain. We might arrange imaging, instigate a rehabilitation plan or see them in our combined orthopaedic clinic – whatever is clinically appropriate.”

New-look breast unit

A new-look specialist breast unit at Royal Free Hospital is helping staff to deliver better care and support to patients.

The unit has expanded, allowing the breast service to provide a much improved and more private environment for patients.

There are two new high-tech mammogram machines, offering 3D imagery and the ability to take biopsies. By doubling capacity and upgrading equipment, more patients are able to receive same day images, speeding up both diagnosis and referral to a consultant.

The space has also been improved with the introduction of additional consulting rooms and toilet facilities.

Tina Kelleher, lead nurse for breast services, has worked for the service for more than 40 years and is delighted to see the improvements. She said: “We knew that a better space was something that patients desperately wanted and we did too.

“We even have a dedicated nurses office now so that oncology and surgery cancer nurses can communicate more effectively. It will improve the patient experience, so much and we are already receiving lots of positive feedback.”

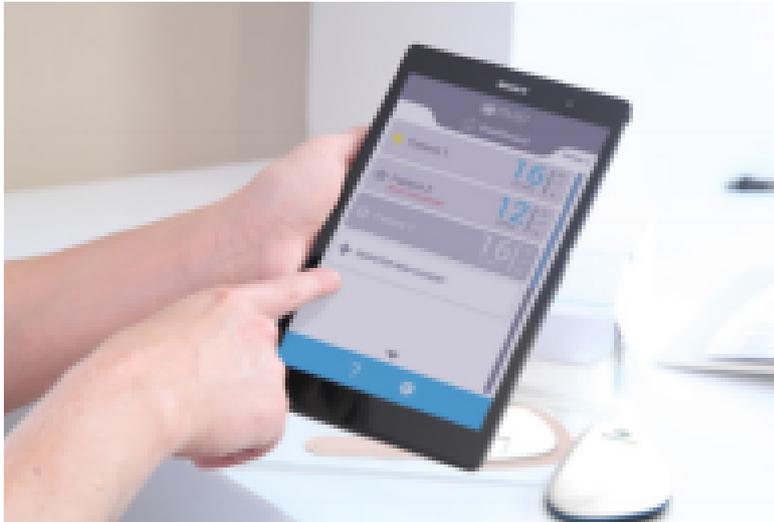


Left to right: Azita Moman, senior radiographer and mammographer and Gemma Fenlon, senior radiographer and trainee mammographer

Trial for new smart device

Chase Farm Hospital is trialling an innovative respiratory monitoring device to speed up the identification of patients whose condition is deteriorating.

Respiratory rate is the earliest and most sensitive indicator of a worsening condition, and is a key component of the new National Early Warning Score (NEWS2) which is set to become the standard for identifying patient deterioration in England by April 2019. However, it is not always easy to monitor.



We are one of four trusts selected from a number of applicants to work with UCL Partners on piloting the device.

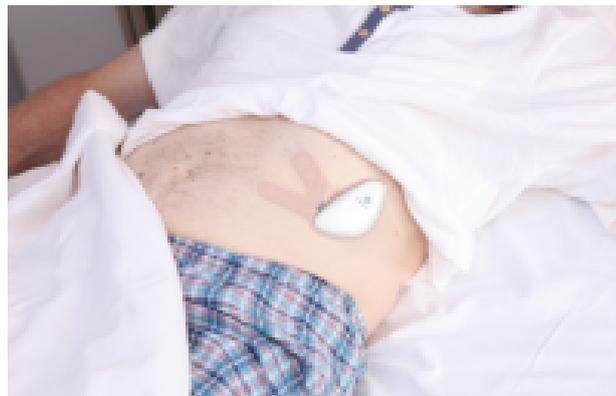
A set-up phase has begun in CFH's surgical ward. If this is successful, the ward will carry out a full pilot, receiving a free six-month supply of the monitors.

RespiraSense has been selected for the trial by NHS England's Innovations Accelerator, which supports the uptake and spread of proven, impactful innovations.

Fiona Morcom, clinical implementation lead, said: "Early identification of deterioration is a challenge for hospitals worldwide. It's vital to improve outcomes, reduce length of stay and avoid transfers to a high dependency unit.

It provides clinical teams with highly accurate readings enabling them to spot if a patient's condition is deteriorating up to 12 hours earlier than usual.

"Our task in the trial is to explore how it can be embedded in our work flows and how best to use the information it provides. We're delighted that we were chosen for the trial as this kind of innovation fits perfectly with our aspiration to be one of the leading digital hospitals in Europe."



Our IBD (Inflammatory Bowel Disease) patient panel

IBD is a long term, chronic condition that causes inflammation in the gastrointestinal tract. It can be divided into two illnesses; Crohn's Disease and Ulcerative Colitis. Often diagnosed at a young age, patients experience periods of relapse and remission. Most are managed with medical treatments but surgery is sometimes required. The Royal Free has a large IBD service and a significant proportion of its patients require care and support over many years

The IBD Patient Panel was set up in February 2018 and consists of a group of enthusiastic volunteers identified through a patient experience questionnaire.

Panel Aims:

- To provide feedback on patient service development.
- To advocate for IBD services in the Trust
- To provide a sounding board for the healthcare team
- To bring a patient's perspective to service development and improvement

IBD Journeys and Panel Values

The panel identified common journeys through the service encountered by patients at different stages of their IBD. These journeys ranged from diagnosis, initial treatment and on-going care, through to management of patients during periods when their symptoms flare.

They also identified underpinning values felt to be fundamental to the delivery of high quality care. These included confidence, efficiency, personalisation, effective communication, access to medicines and services, management of test results, support for patients and clear sign-posting to information and support for carers.

Pathway Review

The Patient Panel worked alongside the clinical team to coproduce a series of pathways that they felt represented excellent care. As a result of the development of these pathways, a number of recommendations were made and these have now been implemented by the IBD team.

Recommendations implemented by the IBD team:

- An improved cancellation management system that avoids recurrent and inappropriate clinic cancellations.
- A review of clinic letters, particularly the timescale for production and the use of attachments, e.g. for flow chart of blood results.
- A review of service information publications for patients and carers.
- The introduction of information for patients and carers about what to do when experiencing a flare of symptoms.
- A review and update of the service's website.
- A review of communication options for the clinical team and patients, including the introduction of video technology.
- A joint venture between NHS England and Crohn's and Colitis UK to produce a video about the role of the Patient Panel.
- Designing an individual patient care plan.
- Designing a patient questionnaire to gather regular feedback about the service.

Panel Objective:

To improve quality of care, efficiency and patient satisfaction by working with the IBD team in the Clinical Pathway Programme to coproduce care pathways for use across all sites.

The panel has proved to be a great success, providing a strong patient voice in service reviews and in bringing patients and clinicians together to really understand each other's priorities and demands.

Members of the panel have expressed their clear commitment to continuing with this work and to striving towards further service improvements and innovations in the future.



Stuart Berliner,
Member of the IBD
patients panel.

Dawn Atkinson,
Deputy director of
clinical governance and
performance

Kidney Peer Support Work



Over the last year a team of kidney nurses and doctors have worked together with the support of the hospital volunteer team and the kidney patient's association to re-launch the kidney peer support service.

Peer support involves putting a kidney patient in touch with another person with first hand experience of kidney disease for an informal one to one chat. Being a kidney patient can be challenging, having to make difficult decisions about treatments such as kidney transplant or dialysis, together with having to restrict what you eat and drink whilst remembering to take multiple medications.

Whilst kidney patients are offered education and support by nurses, doctors and other health professionals, many people find it helpful to talk to someone who is in a similar position or who has been through the same treatment. Indeed, what has struck me during our peer support training sessions is that all of our volunteers wished that they had had the opportunity to talk to another patient at some stage during their journey through the kidney service.

Since the relaunch of the peer supporter service in September 2017, 21 volunteers have attended one of our kidney peer support training sessions. The training session lasts 2-3 hours and is run by the peer support team; a group of nurses and one of our psychologists who are passionate about providing a peer support service for our patients. During the sessions I have been struck by the motivation and commitment of our volunteers who speak so passionately about their desire to help other patients through difficult times.

We have slowly been receiving referrals for peer support, mostly these come from the nursing and medical team but we are hoping that patients will also contact us directly for support. This is what led us to create posters featuring some of our active supporters and their journeys. We are hoping the posters will be ready in the next month and will be displayed in all of our kidney care centres.

Meet two of our Peer supporters:



Gillian

'I have been a kidney patient at the Royal Free Hospital for over ten years. My son, who is now 25, was also born there, so it feels like home and the staff feel like family. The medical care for Kidney patients is excellent, but kidney disease can be a huge challenge and just like any other challenge, the journey is made easier if the people who help through it, understand what you are going through, because they've been that way before. That's why I became a peer supporter, to help kidney patients have an easier time through Kidney disease, by sharing my experience and helping patients understand that there is life after Chronic Kidney disease.



Helene

"It all came as a rather nasty shock. I'm sure I did not take in much of what the doctors said at the time.

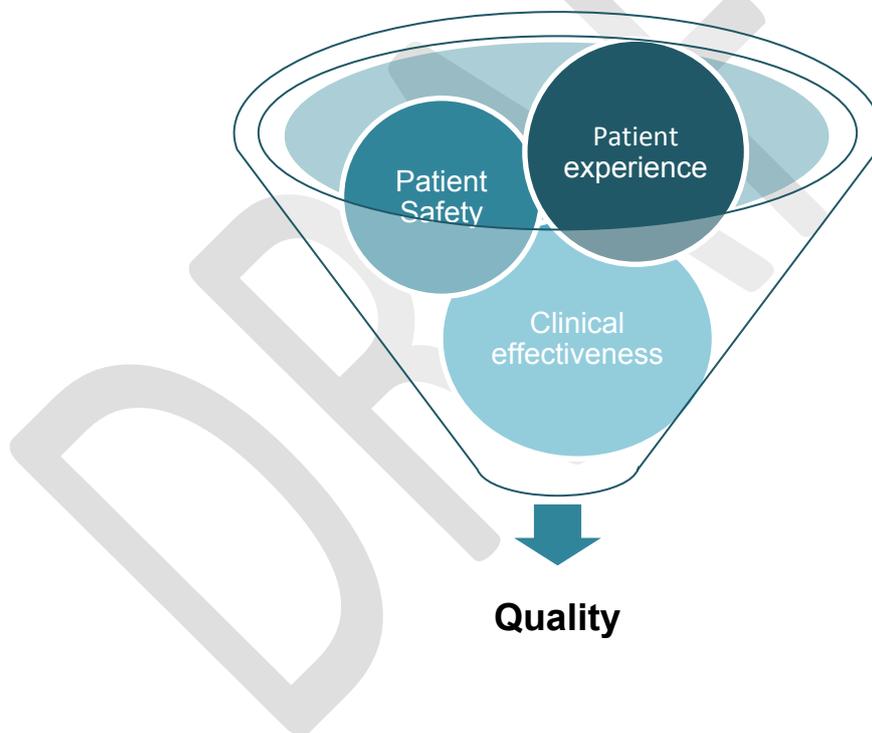
If only I could have spoken to someone who had been through a similar set of medical events I could have asked more pertinent questions and would have had a greater understanding of what lay ahead instead of muddling through".

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

Every year all NHS hospitals are required to write a quality report for our stakeholders about the quality of their services. The quality report allows us to be more accountable and helps us to drive improvement in the quality of our services.

Within the quality report we review our performance over the previous year, identify areas for improvement and publish that information. Areas include: patient experience, patient safety and clinical effectiveness

- **Patient safety** – how have we been keeping our patients safe from harm?
- **Clinical effectiveness** – what were the outcomes? how successful is the care provided?
- **Patient experience** - how was the experience for our patients using our services?



This section describes the following:

- Priorities for improvement: progress made against our priorities during 2018/19
- Outline on our quality priorities for improvement chosen for 2019/20
- Feedback on key quality measures as identified within the mandatory statements of assurance from the board.

2.1 Priorities for improvement

A look back at the progress made during 2018/19 to achieve our priorities for improvement.

Following consultation with our key stakeholders, the trust agreed that during 2018/19 we would focus on eight priorities. Five out of the eight priorities were carried forward from 2017/18 and the remaining three priorities were new areas that were identified for improvement as outlined in table 1

The eight priorities remain within the three domains of quality (patient experience, clinical effectiveness and patient safety) and continue to have an executive sponsor, a designated lead and an associated committee where progress was monitored and assurance provided.

Table 1: Overview of priorities for 2018/19 and associated committees.

Quality domain	Priorities for 2018/19	Carried forward from 2017/18	Associated committees
Patient experience	1 To achieve certification for <i>The Information Standard</i> .	✓	People and Population Health Committee (PPHC)
	2 To further enhance and support dementia care.	✓	
	3 To improve our involvement with our patients and carers.	✗	
Clinical effectiveness/ quality improvement	4 To build capability in the workforce and have an online project tracker tool.	✓	Clinical Standards and Innovation Committee (CSIC)
	5 To develop a superior change-management capability putting clinicians in charge of their clinical pathway.	✓	
Patient safety	6 To improve safer surgery and invasive procedures	✓	Clinical Standards and Innovation Committee (CSIC)
	7 To improve our learning from deaths	✗	
	8 To improve infection prevention and control	✗	

Priority one: Improving patient experience: delivering excellent experiences

The trust is committed to working in partnership with our patients to ensure that its services are both relevant and responsive to local needs.

Providing an excellent experience for our patients, staff and service users is central to the trust's governing objectives. Therefore, listening to the views of our patients helps us to better understand what we are doing right and what we need to improve.

Our patient experience team are involved in various works across the trust with the aim of improving practice and changing our patients' experiences for the better. For 2018/19 we chose the following priorities as they were linked to specific strands of work within the trust, in support of our vision to have strong positive patient experience.

Our quality priorities for 2018/19 were:

1. To achieve trust certification for 'The Information Standard'
2. To further enhance and support dementia care.
3. To improve our involvement with our patients and carers.

1

Improving the information for our patients.

A key objective for the trust has been to improve the consistency of the information available to patients and carers, as the provision of high-quality accessible information is crucial to embed our world class care values.

This priority was carried forward from 2016/17 as the trust identified that there was more to be done to improve the information for our patients.

The appointment of our Patient Information Manager in 2015 supported the trust's aim to improve the information for our patients and carers. Since the introduction of the trust wide patient information policy in 2016 and framework for producing information, the trust has approved over 200 information resources. All resources are available on our website, and teams and departments print their resources locally.

Progress to achieve the priority has been monitored at our People and Population Health Committee (PPHC) as part of our patient experience reporting.

What did we aim to do in 2018/19?

To achieve trust certification for 'The Information Standard'.

What were the key measures for success?

- To work with Clinical Practice Groups (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 The Information Standard for information produced by the radiotherapy department - the department will act as our exemplar for further rolling out the standard.

What did we achieve?

The trust's patient resources approval process has been integrated into clinical pathway group (CPG) work. Information for patients produced as a result of CPG work are reviewed via the trust process, and following approval, published onto the trust website.

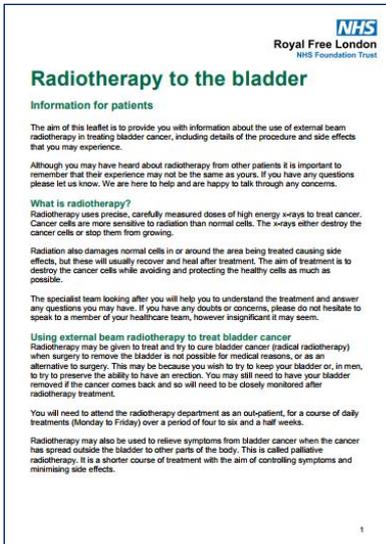
We are piloting the use of QR codes on resources produced via the women's and children's CPG to increase accessibility. We will be monitoring downloads to see if this is an effective method to reach our audience.

Following the closure of The Information Standard certification scheme in 2018, this priority has been closed. The trust will continue to follow the principles underpinning the Information Standard, which have been embedded into our framework for producing information and patient information policy.

We have also improved the transparency of approval and review dates of our information both in print and online, and have a stringent review process in place to keep resources up to date.

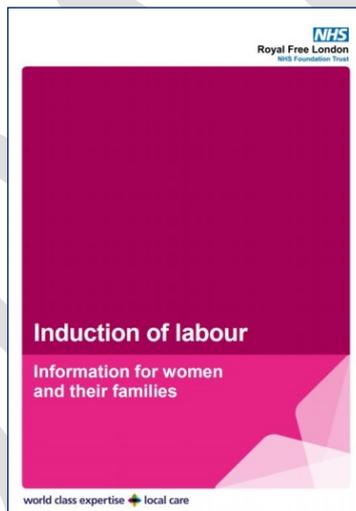
We will continue to strive to produce easy to understand, evidence-based, high quality information for our patients, carers and family members.

Examples of materials produces for our patients.



A

	About epidermal harvesting	Approved: 01/09/2018
	Service: Plastic surgery	
	.pdf (280 KB)	
	About lidocaine/prilocaine cream for micro-pigmentation	Approved: 08/02/2019
	Service: Plastic surgery	
	.pdf (258 KB)	
	Acute oncology service at Barnet Hospital	Approved: 20/03/2019
	Service: Cancer services	
	.pdf (278 KB)	
	Acute oncology service at the Royal Free Hospital	Approved: 20/03/2019
	Service: Cancer services	
	.pdf (303 KB)	
	Advice for kidney patients: Eating with a small appetite	Approved: 07/11/2017
	Service: Kidney services	
	.pdf (449 KB)	
	All about intermittent claudication	Approved: 09/08/2017
	Service: Vascular surgery	
	.pdf (394 KB)	



Anaemia clinic: A patient journey

If you have an anaemia clinic appointment, please watch the information video below before you visit to help you understand more about your condition and what will happen on the day of your appointment.



If you would like further information or to get in touch with us please contact the haematology department on: 020 7830 2301.

Useful downloads

[Information about anaemia](#)

[Information about intravenous iron therapy treatment](#)

Improving dementia care

People with dementia do not do well in hospital – they have longer lengths of stay, they have higher mortality rates and are less likely to go home after admission. This is thought to be related to the way we care for them in hospital – not because of the dementia itself.

Since 2015/16, the trust has prioritised to improve dementia care and has reported progress in previous quality accounts/reports.

Previous achievements have included:

- the production of a film for staff highlighting the carers perspective
- an increase in the number of dementia awareness trainers
- implementation of the 'John's campaign' (improving visiting rights for carers)
- Development of a 'passport' which entitles the holder to reduction in the staff restaurant, reduced parking costs, free massages
- Implementation of the 'forget-me-not' scheme, which alerts staff to the specific needs of the patient

In 2016/17 we developed a framework called CAPER which was designed to support and upskill staff working with patients experiencing dementia and/ or enhanced care needs.

CAPER stands for:

C	Collateral and Communication	getting the right information from the right people and using specialist communication techniques
A	Assessment	understanding behaviour as a form of communication and understanding reversible causes of distressed behaviour; pain and delirium
P	Partnership	working alongside patients, families and carers
E	Enablement	helping patients maintain the skills and function they came in with
R	Role-modelling	using your own skilled practice to inspire cultural change

Progress to achieve the priority has been monitored at our People and Population Health Committee (PPHC) as part of our patient experience reporting. Specific metrics which includes monitoring the length of stay, place admitted from, discharge destination and readmission within 30 days are also reviewed by the Dementia Implementation Group (DIG).

What did we aim to do in 2018/19?

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

What were the key measures for success?

- Improve dementia services for patients admitted to RFL and their carers
- Improve staff experience in caring for people with dementia
- To design new dementia strategy for 2019 – 21

What did we achieve?

During 2018/19, the trust has continued to prioritise the improvement of dementia care for our patients, carers and staff.

Highlights include the following:

- Action plan for the national audit of dementia has been completed. Audit currently in progress on the 3 reporting sites (8 West, 10 North and 6 South) results will be available in July 2019.
- Dementia key worker scheme implemented on 4 wards, providing specialist input and support for patients and families.
- Publication of RFL Guide to Dementia now available on all wards across the trust. Regular carer support sessions held on Hampstead and Barnet sites and 5 new “Sundown Sessions” currently in production.
- 8 important things about me document updated and new process implemented.
- “High Bay” project to launch in 2019 with an emphasis on resourcing and training NAs to facilitate group activities sessions for patients who are being cared for in an enhanced bay.
- Innovative Chicken Shed theatre training took place in January 2018 and CAPER Anchors are looking to further their training in communication and care for patients living with dementia.
- Music therapy training planned for interested staff complemented by an improved roster of musicians visiting the organisation under the RF Charity.
- Delirium pathway documentation continues to be piloted across the trust and the Dementia Implementation Group (DIG) will now be reviewing all PALS / incidents reported that relate to dementia or delirium which will help us to identify hotspots.
- Strategic event planned inviting the public, carers, patients and interested staff to feed into our new strategy.

Raise the curtain

Patients at the RFH will have the best beds in the house thanks to a refurbishment designed to improve the care of dementia patients.

8 West ward has been decorated to transport patients and visitors to the seaside, and now includes a theatre space for live performances by actors, musicians and poets.

The seaside theme was inspired by feedback from patients and relatives on the ward, and co-designed by Danielle Wilde, RFL dementia lead, Chito Gabutin, 8 West ward manager and the 8 West multi-disciplinary team.

Following months of hard work to bring the idea to life, the new look was met with a tremendous reception from all at its grand unveiling.

The event was held in 'The Royal Free Theatre' – a new day room on the ward.

Previously a patient bay, the area has been converted into theatre space, complete with a red-curtain backdrop.

The theatre will be used to provide patients with a weekly programme of activities while they are in hospital – it will also set the stage for the future of dementia care at the RFL, where art and engagement will be a key focus.

Showcasing how the space will be used, patients and staff were treated to a live musical performance during the opening by 40's swing trio, The Polka Dots.

"It was fantastic to see all the patients singing along with the music and enjoying themselves. This will be a great place we can bring our patients to."

"The opening ceremony was a great opportunity to showcase the day room, and everything that we will be doing in this space."

Michelle Cody and Allison Kelleher, therapists on 8 West ward

The refurbishment, which was funded by the Royal Free Charity, extends into the corridor areas.

Images of iconic British seaside towns line one side of the ward; beach huts signpost patient rooms and bays; and along another corridor, a reminiscent boardwalk mural has been created complete with an ice-cream van and gift shop.

The imagery on the walls will be used to stimulate conversations and help patients, particularly those with dementia, to feel more relaxed during their stay on a busy acute hospital ward.

The work on 8 West ward builds on the trust's commitment to deliver world-class dementia care and follows the refurbishment of 10 North ward at the RFH, Larch ward at BH and the dementia-therapy gardens at CFH.

3

What did we aim to do?

To improve our involvement with our patients and carers

What were the key measures for success?

- Following feedback from staff and patients a broader approach is being taken to ensure that we improve our involvement with our patients and carers.
- Building on previous involvement with our patient partners in CPGs, QI projects, hospital based committees/ groups and with task and finish groups

What did we achieve?

- The trust continues its approach to embedding experience and involvement in its services and development and has adopted the patient experience framework published by NHS England. The framework brings together the characteristics of organisations that consistently improve patient experience and enables boards to carry out an organisational diagnostic against a set of indicators.
- The patient experience has a role to play in a number of questions and the collation as a whole, and the document has been reviewed by the patient experience team. However, information will be required from quality improvement, HR, organisational development, Group, boards, medical directors and directors of nursing. Therefore the suggestion is that the document be taken to each Local Executive Committee (LEC) who can delegate across the hospital site ownership of parts of the assessment and from there we could collate to a group level score.
- In addition the patient experience team have strengthened their relationship with CPG team so that they can become more involved with the CPG work streams.
- Patient representatives have been appointed to the patient experience committees at both Barnet and Royal Free sites and the Mortality Surveillance Group. Work has begun on updating and improving the information on the patient experience section of the website for both patients and staff.

Priority two: improving clinical effectiveness: delivering excellent outcomes

The over-arching plan for 2018/19 was 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.

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. Driving quality improvement.
2. Clinical Pathway Groups (CPGs)

Quality Improvement (QI) priority:

4

What did we aim to do?

To build capability in the workforce and have an online project tracker tool

What were the key measures for success?

- Ability to prioritise QI projects based on local/Group need.
- Local ownership, at service, divisional and hospital unit level.
- To provide access to site-based QI help and support, site-based learning and access to expert QI knowledge.
- To create opportunities to share learning across the site and Group

What did we achieve?

- A key element of developing our infrastructure is creating an integrated quality improvement management system by which we can register, track and report on QI activity.
- A working group has been set up and a service specification has been developed to reflect the organisations and progress has been made with the introduction of *Leading for Improvement* with our senior leaders being trained as QI sponsors.
- In order to support local ownership we need to provide transparency of Quality Improvement projects through having an online system to register, track and report on QI progress. Life QI has been chosen as the system to do this and we aim to launch this in Q4 2018-19.
- Together with the leadership team we continue to look for effective ways to share learning across each site and the group.
- In November we hosted a QI showcasing event where 34 posters were displayed and presented, over 100 staff attended this event. Additionally, on Royal Free Hospital site we are including a QI presentation at the chief executives briefing. Next steps are to introduce similar events and learning opportunities at each site.

Clinical Practice Groups (CPGs)

Patients are at the heart of the CPG process and in partnership with clinical teams co-design new pathways of care and define the outcome measures that matter.

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 roll out of Millennium Model Content and opening of the new Chase Farm Hospital.

5

What did we aim to do?

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.

What were the key measures for success?

- Our measure for success for 2018/19 is to have seven digitised clinical pathways.

What did we do?

Work has remained in support of the digital transformation at the RFL. The trust has embarked on a journey which to become one of the most digitally advanced trust in the UK by 2020.

Multidisciplinary teams are working together to design the clinical pathways; ensuring that the diagnostic and treatment decisions are consistent and based on the latest evidence to deliver the best possible outcome. All the pathways are being co-designed with patients; their experiences are being taken into account, which will in turn improve outcomes.

The new Chase Farm Hospital opened and seven pathways have been fully digitised. These include:

1. Preoperative Assessment
2. Elective Hip
3. Elective Knee
4. Right Upper Quadrant Pain (RUQP)
5. Induction of Labour
6. Admissions to Neonatal Unit (Keeping mothers and babies together)
7. Dermatology

The following information highlights some of the work specifically undertaken within our CPG program.

Pathways to better health: Our patients are having a direct impact on the way their healthcare is delivered, resulting in better care



Our surveys and focus groups told us that women didn't want to see lots of different staff, what they wanted was continuity and a relationship with a named midwife."

Katerina Christodoulou with her son, Jason

Katerina Christodoulou with her son, Jason who had given birth at Edgware Birth Centre,.

She told the audience that being able to have continuous care with a designated midwife had enabled her to have an incredibly positive experience.

She said: "I actually suffer from paranoia about hospitals and was almost convinced I would go private. But being able to have a named midwife with me from the start to the finish means I plan to have all my babies with the NHS! It's restored my trust. I think this new approach will also have other benefits like reducing incidents of post-natal depression."

Cathy Rogers, the BH consultant midwife who is leading on the 'Better birth pathway' explained that listening to their patients was at the core of the new pathway, which included introducing named midwives.

She said: "As midwives we do the job because we care but we also made assumptions about what women wanted. When we talked to mums-to-be and to midwives we actually found out there was a lot of common ground.

Dr Chris Streather, group chief medical officer, told members that the work on new patient pathways – the way a patient is treated for a particular health issue – was based on best practice and the latest clinical evidence.

He said: "We will be looking at 44 pathways in the first three years and we think that we will deliver savings of approximately half a million pounds on each through actually improving the patient experience and removing waste. That's £20 million that we can spend on our patients."

Priority three: Patient safety priorities

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. Actions such as debriefs and safety huddles help our staff to provide quality care to our patients.

For 2018/19, focus was made on safer surgery, learning from deaths and infection prevention and control.

Safer surgery



What did we aim to do?

To improve safer surgery and invasive procedures

What were the key measures for success?

- 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

What did we achieve?

Unfortunately, we reported nine never events during 2018/19. The majority of these incidents have resulted in no or low harm to our patients.

We have continued to work closely with our commissioners, NHSI and NHSE to learn from these never events and put in place robust actions to prevent reoccurrence. This has included undertaking additional risk assessments relating to high risk areas for never events and developing a trust wide action plan to bring together learning from across all the previous never events.

	Site	Date	Type	Harm
1	CFH	18/04/2018	Wrong side hernia	Low
2	CFH	19/04/2018	Wrong side ureteroscopy	None
3	RFH	14/06/2018	Retained swab after a laparoscopic cholecystectomy	Moderate
4	BH	19/06/2018	Air/oxygen mis-connection	None
5	RFH	20/06/2018	Air/oxygen mis-connection	None
6	RFH	27/06/2018	Wrong eye injection	None
7	RFH	04/07/2018	Wrong knee prosthesis	Moderate
8	BH	30/08/2018	Retained needle post episiotomy	None
9	Other	02/10/2018	Wrong side epidural injection	None

The Patient Safety CPG has focussed on developing Local Safety Standards for Invasive Procedures (LocSSIPs) for three pathways identified as those where never events had occurred previously and where the most procedures were undertaken: cardiology, radiology and endoscopy.

- The design and testing of the data collection tool is complete. The tested data collection tool is being incorporated into the 'Perfect Ward' App, with initial testing at RFH in the Cath Lab and Endoscopy unit.
- Clinical areas are collecting compliance data (most areas weekly), in line with their implementation phase audit plan.
- The Statistical Process Charts (SPC) on the quality improvement platform (Life QI) are used to analyse and share the LocSSIPs compliance data dynamically among the clinical, quality governance and senior leadership staff.

All incidents resulting in moderate or severe harm or death are reviewed at our weekly review panels where serious incidents, reports and actions are discussed with all Divisions, so that the information can be shared at divisional quality meetings.

We publish a weekly précis of serious incidents as they are reported and share further general and speciality specific newsletters online and by email.

We also hold learning events, seminars and workshops in order to disseminate lessons learnt.

All serious incidents are reviewed at our board level clinical innovations and standards committee (CSIC), chaired by one of our Non-executive directors where we triangulate serious incidents with incidents, complaints, PALS and litigation to identify themes which might require system-wide work.

learning from deaths



What did we aim to do?

To improve our Learning from deaths (Lfd)

What were the key measures for success?

- 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

What did we achieve?

- 11% patient deaths were recorded centrally for review in 2017/18. Therefore, the aim is to increase this to 21%. .

- The 2017 NHS staff Survey showed that 68% of RFL staff agreed/strongly agreed that “When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.”
- We are working to use more dynamic survey data to show how we improve this metric.
- We have increased the numbers of deaths reviewed in 2018/19 Q1 to 15%.
- We are now communicating more via: Safety needs and incident learning (SNAIL), a weekly blog on key areas of learning from incidents and near misses using SBAR. Plus, we are distributing: Free Way to Safety (FWTS) our monthly newsletter (with key safety learning from serious incidents, emailed to incident managers); and Health and safety monthly newsletter (with key Health and safety information, emailed to Health and safety champions).
- The quarterly in-house staff survey has now been amended to include the question: “When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.”
- The patient safety culture survey, based on a survey tool derived from the Texas Safety Attitudes Questionnaire (Sexton et al 2006), elicits a snapshot of the safety culture from 17 questions. We have been using this since early 2016 to survey over 500 staff during training and development interactions. We will be using the following two questions to generate metrics demonstrate improvement relating to the sharing of the learning across the trust:
 - As a team, we discuss learning from errors/incidents
 - The culture in my area makes it easy to learn from the mistakes of others.

Infection prevention and control

8

What did we aim to do?

To improve infection prevention and control

What were the key measures for success?

- To achieve 10% reduction by year of meticillin-resistant *Staphylococcus aureus* (MRSA).
- To achieve Trust-attributed zero *Clostridium difficile* (C.diff) infections due to lapses in care by end of March 2019

What did we achieve?

MRSA

- MRSA bacteraemias – currently two attributed cases to Barnet and one attributed to RFH.

- Learning from the cases and measures for reduction are driven through the monthly IPC Divisional Leads group.

C.diff

- Currently three lapses in care for C.diff cases. Two at BH related to apparent transmission and one at RFH related to delays in identification, testing and incomplete documentation.
- Total cases for 2018/19 expected to be below threshold. Revised threshold for 2019/20 is 100 cases relating to more detailed definitions of attribution of cases.
- All cases have an Root Cause Analysis, with learning fed back through the monthly IPC Divisional Leads group

Through the Clinical Standards and Innovation Committee we have monitored, measured and reported progress made during 2018/19 to achieve the set priorities. The committee reports to the trust board.

Our Priorities for improvement (2019/20)

Looking forward to what our quality account priorities will be for the year ahead.

The 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 reported to the trust board as illustrated in figure 1.

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.

Progress reports will be sent to the Dementia Implementation Group, Population xxxxx and updates to our commissioners via Clinical Quality Review Group

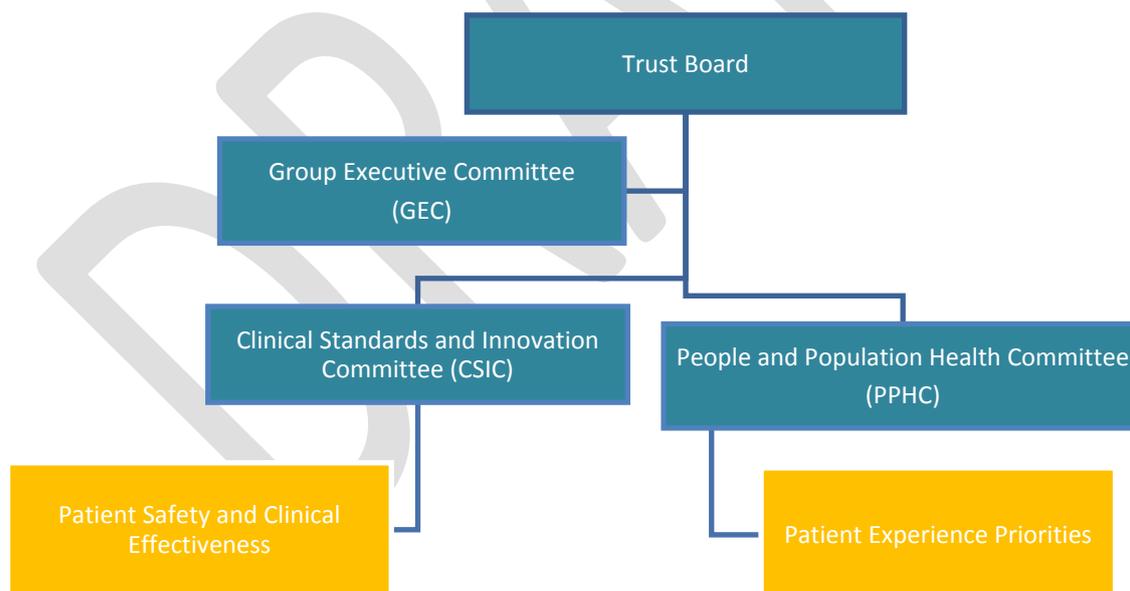


Figure 1: Strategic committees reporting to the trust board

Our consultation process

Our stakeholder's engagement event **Showcasing Clinical Excellence** was held in February 2019. Over seventy people attended which included, commissioners, governors and members from Healthwatch and staff.



Judy Dewinter, Lead Governor and Afsaneh Motabar, National Clinical Audit lead.

To include brief statement



James Mountford, Director of quality



Caroline Clarke, Group chief executive



Priority one: Improving patient experience: Delivering world class experience

We aim to put the patient, carers and our staff at the heart of all we do to deliver excellent experiences.

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>1</p> <p>To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • To improve the quality of care being undertaken in high need bays • To develop and build the dementia pathway via Clinical Practice Group work (CPG) • To further develop and roll out innovative communication workshops for staff working with dementia patients • To recruit and train volunteer led activity coordinators to increase use of activity groups in day rooms

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>2</p> <p>To improve our involvement with our patients and carers</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • To organise a suite of tools, strategies, and cultural elements into an easy-to-follow framework

Priority two: Improving clinical effectiveness: reducing variation and improving outcomes

The over-arching plan for 2019/20 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.

Quality Improvement (QI) priority:

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>3</p> <p>To build capability in the workforce</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • Increase Joy in Work for teams participating in the collaborative by 50% above baseline measures by 31 May 2020 • Be sustainable in delivering core QI training programmes toward our goal that 20% of staff (2,000 staff) have received formal training in QI by end of 2020 • Further incorporate QI into routine operations/processes across RFL, and further establish opportunities to share learning within and across our sites • QI embedded into Divisional Board meetings • QI integral to CEO briefings • QI learning events on major sites and annual RFL-wide event

Clinical Pathway Group (CPG) priority:

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>4</p> <p>To develop a superior change-management capability this puts clinicians in charge of their clinical pathway to deliver high quality care to their patients.</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • To have 20 clinical pathways digitised across our CPGs

Priority three: Patient safety priorities: Improving safety- improving care

Each year as we set the overarching quality priorities we recognise that delivery against the most important quality objectives often requires a focus lasting several years. The RFL group safety priorities are: zero Never Events, reducing avoidable deaths and zero avoidable hospital-acquired infections. Therefore for 2018/19 we will focus on:

- Safer surgery
- Learning from deaths
- Infection prevention and control.

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>5</p> <p>To improve safer surgery in line with trust aims/goals</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • To achieve zero never events by the end of March 2020 • To increase by 75% the number of LocSIPs in place by the end of March 2020

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>6</p> <p>Learning from deaths (LfD)</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • To increase by 10% the percentage of reviews of patient deaths recorded centrally • 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

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
<p>7</p> <p>To improve infection prevention and control</p>	<p>✓</p> <p>(previous performance shown in section 1.1)</p>	<ul style="list-style-type: none"> • To achieve zero trust attributed meticillin-resistant <i>Staphylococcus aureus</i> bacteraemias. (MRSA). • To reduce Gram negative bacteraemias in line with mandated threshold (- 25% reduction by 2021-2022 with the full 50% by 2023-2024) • To remain below mandated threshold for trust-attributed zero <i>Clostridium difficile</i> (C.diff) (100 cases 2019/20) To have zero infections due to lapses in care

2.2 Statements of assurance from the board

Review of services

During 2018/19 the Royal Free London NHS Foundation Trust (RFL) provided and/or sub-contracted 40 relevant health services.

The Royal Free London NHS Foundation Trust 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 2018 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2018/19.

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 2018/19 xx national clinical audits and xx national confidential enquires covered relevant health services that Royal Free London NHS Foundation Trust provides.

During that period Royal Free London NHS Foundation Trust participated in xxx% national clinical audits and xx% national confidential enquires of the national clinical audits and national confidential enquires 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 2018/19 are as follows: (Insert list)

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in during 2017/18 are as follows: (insert list)

The national clinical audits and national confidential enquiries that Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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. (inset list and percentages)

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 sources, usually hospital episode statistics (HES) data.

HES is a data warehouse containing details of all admissions, out-patient 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
- RFH = Royal Free Hospital
- BH = Barnet Hospital
- CFH = Chase Farm Hospital

Name of Audit	Data collection complete d in 2017/18	Trust Eligibility to participate	Participation 2018/19	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	N =167 total. [RFH-95, BH-72]
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) audit	Yes	Yes	RFH and BH CFH service not available	BH = 46 RF = 16
Diabetes: National diabetes audit (NDA)	Yes	Yes	RFH BH and CFH	Type 1 = 1205, Type 2 = 1675
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: 2017 National comparative audit of transfusion associated circulatory overload (TACO)	Yes	Yes	RFH BH and CFH	BH = 40 CFH = 26 RFH = 40
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)

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 2018/19, 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 2018/19:

During 2018/19, the trust participated in several other national audits which were not in the HQIP 'Quality accounts' list, published in December 2018. 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 2018/19 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:

The reports of 23 local clinical audits* were reviewed by the provider in 2018/19 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:

- 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

* the local audits undertaken relate to the quality improvement projects previously described which demonstrated modest to significant improvement through successful plan, do, study, act cycles

Participating in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 10,098

The above figure includes 4522 patients recruited into studies on the NIHR portfolio and 5576 patients recruited into studies that are not on the NIHR portfolio. This figure is lower than that reported last year.

The Trust is supporting a large research portfolio of over 800 studies, including both commercial and academic research. 168 new studies were approved in 2018 - 2019. 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.

Patients first to help new eye disease research at Barnet Hospital



Left to right: Dr Dinushni Muthucumarana and Dr Haseena Sadhwani, research doctors; Mr Martin Harris, ophthalmology consultant; Susan Freedman, patient; Dr Sarah Ah-Moye, junior clinical research fellow in ophthalmology; Adaora Udenze, clinic nurse; **Mr Hemal Mehta, ophthalmology consultant**; Gloria Ferenando, research nurse; Steve Paratian, research medical photographer

Barnet Hospital has recruited the first European patient to take part in an international study exploring a potential new treatment for wet age-related macular degeneration (AMD).

Mr Hemal Mehta, consultant ophthalmic surgeon, leads ophthalmology clinical trials at BH. The latest research project aims to establish the effectiveness and safety of a new eye drop to treat the condition. Wet AMD occurs when abnormal blood vessels grow underneath the retina. These unhealthy vessels leak blood and fluid, which can prevent the retina from working properly and lead to permanent loss of central vision. It does not usually cause total blindness but it can make every day activities difficult, such as reading or recognising faces.

We currently use injections to stabilise wet AMD and patients often need to have these every month or two.

“The potential benefits of using eye drops would be that fewer or possibly no injections would be needed, so it would be safer and less unpleasant for the patient.

It is also more convenient for them and their relatives as they would not need to attend hospital so often. We need clinical trials to establish how well these new drops work.”

Mr Hemal Mehta, consultant ophthalmic surgeon

The injections contain medicines called anti-vascular endothelial growth factor agents that reduce the growth of new blood vessels.

The molecules in the eye drops are a thousand times smaller than those in the injections, which mean they can enter and penetrate the eye more effectively.

CQUIN Payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2018/19 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 2018/19 and for the following 12-month period are available electronically at: (provide a weblink)

Table 6: CQUIN scheme priorities 2018/2019

CQUIN scheme priorities 2018/2019	Objective rationale
Staff health & well being	This national initiative made up of three areas of improvement: <ol style="list-style-type: none"> 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.
Preventing ill health by risky behaviours – alcohol & tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco
CQUIN scheme priorities	Objective rationale

2018/2019	
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 requirements 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).

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first CQUIN framework in 2009/10, many CQUIN schemes have been developed and agreed.

In **2018/19** a total of **xxxxxxx** of the trust's income was conditional upon achieving quality improvement and innovation goals. Our CQUIN payment framework was agreed with NHS North East London Commissioning Support Unit and NHS England. **The monetary total for 2018/19 was xxxxxxx**

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 the following conditions on registration none.

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 not participated in any special reviews or investigations by the CQC during 2018/19.

The trust was subject to an announced core service inspection across our three hospital sites Barnet Hospital, Chase Farm and the Royal Free Hospital during 11 to 13 December 2018 the inspection focussed on the following core services:

Chase Farm :

Urgent and Emergency Care; our Urgent care Unit

Surgery; Our surgical ward and day surgery services

Medical; Our medical ward and outpatient clinics

Barnet Hospital:

Surgery; Our surgical wards, theatres and day surgery services

Urgent and Emergency care; our Urgent and emergency care Unit

Medical; Our medical wards

Critical Care; Our critical care and high dependency Unit.

Royal Free Hospital

Surgery; Our surgical wards, theatres and day surgery services

Urgent and Emergency care

Medical; Our medical wards

Critical Care; Our critical care unit

Maternity; Our maternity wards and midwifery service.

In addition to the December 2018 core services inspection the CQC undertook the Well Led and use of Resources inspection between 8 to 10 January 2019. The trust is awaiting the final report from these inspections. See 'Section 3.4 our plans' for further information.

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 which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS numbers was:

% of records	2015/16	2016/17	2017/18	2018/19
For admitted patient care	98.6%	98.15%	98.8%	99.1%
For out-patient care	98.6%	98.65%	99.2%	99.5%
For accident & emergency care	94.4%	94.89%	95.7%	96.8%

General Medical Practice Code

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

% of records	2015/16	2016/17	2017/18	2018/19
For admitted patient care	99.95%	99.92%	99.8%	99.8%
For outpatient care	99.96%	100%	99.9%	99.9%
For accident & emergency care	99.94%	100%	100%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was **xxxxx** and was graded **xxxx**

	2016/17	2017/18	2018/19
Information governance assessment score	66%	68%	
Overall grading	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:

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 (approximately 1.02% of all admissions).

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.

During 2018/19, 2048 of the Royal Free London NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

In 506 cases a death was subjected to both a case record review and an investigation.

506 in the first quarter; 472 in the second quarter; ### in the third quarter; ### in the fourth quarter.

Due to differences in the reporting periods for Learning from deaths (LfD) reviews and the Quality Accounts, for completeness data are included here for 2017/18 quarters 3 and 4, as these were not included in last year's Quality Accounts. Likewise review data for 2018/19 quarters 3 and 4 are not available for inclusion in this year's Quality Accounts.

Table

Reporting period		Number of deaths	Number of reviews	Number of serious incident investigations	Number of the patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Third quarter	October 2017 to December 2017	549	52	5	4	0.72%
Fourth quarter	January 2018 to March 2018	563	40	12	10	1.91%
First quarter	April 2018 to June 2018	506	52	3	2	0.40%
Second quarter	July 2018 to September 2018	472	19	2	2	0.42%
Third quarter	October 2018 to December 2018	###	Not yet completed	Not yet completed	Not yet completed	Not yet completed
Fourth quarter	January 2019 to March 2019	###	Not yet completed	Not yet completed	Not yet completed	Not yet completed

Reporting Period 2018/19 (Q1 and Q2)

By 31/03/19, 71 case record reviews and 5 serious incident investigations have been carried out in relation to 978 of the deaths included in the information presented in the Table. In 5 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 52 in Q1, 19 in Q2, as shown in the table. Data for Q3 and Q4 are not yet available.

There were 5 patient deaths, representing 0.41% of the patient deaths during the reporting period Q1 and Q2 that were considered likely to be avoidable. These were patient deaths were also identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

In relation to each quarter, this consisted of: 3 deaths representing 0.40% for the first quarter; 2 deaths representing 0.42% for the second quarter as shown in the table. Data for Q3 and Q4 are not yet available.

The numbers of deaths considered likely to be avoidable have been estimated using the Likert avoidability scales in line with the Learning from deaths (LfD) policy and the Incident management policy. Scores of 1-3 indicate those deaths considered likely (ie over 50%) to be avoidable.

Likert avoidability Scale:

- 1 Definitely avoidable
- 2 Strong evidence of avoidability
- 3 Probably avoidable, more than 50:50
- 4 Possibly avoidable, but not very likely, less than 50:50
- 5 Slight evidence of avoidability
- 6 Definitely not avoidable (unavoidable)

Previous reporting period 2017/18 (Q3 and Q4)

By 31/03/19, from Quarters 3 and 4 of 2017/18, 92 case record reviews and 17 serious incident investigations have been carried out in relation to 1130 of the deaths included in the information presented in the Table. In 17 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 52 in Q3, 40 in Q4, as shown in the table.

There were 14 patient deaths, representing 1.33 % of the patient deaths during the reporting period Q1 and Q2 that were considered likely to be avoidable. These were patient deaths were also identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

In relation to each quarter, this consisted of: 4 deaths representing 0.72% for the Q3; 10 deaths representing 1.91% for Q4 as shown in the table. Data for Q1 and Q2 were presented in last year's Quality Accounts.

The numbers of deaths considered likely to be avoidable have been estimated using the Likert avoidability scales in line with the Learning from deaths (LfD) policy and the Incident management policy. Scores of 1-3 indicate those deaths considered likely (ie over 50%) to be avoidable.

Likert avoidability Scale:

- 1 Definitely avoidable
- 2 Strong evidence of avoidability
- 3 Probably avoidable, more than 50:50
- 4 Possibly avoidable, but not very likely, less than 50:50
- 5 Slight evidence of avoidability
- 6 Definitely not avoidable (unavoidable)

Summary of lessons learnt

The lessons learnt summarised below relate to all patient deaths which were reviewed as part of this process. We have included examples of good practice and areas for improvement; it should be noted that these do show differences in care for our patients and we continue to work to ensure that patient care is consistent and of high quality. During 2018/19, we developed a Learning lessons from near misses, serious incidents and deaths communications plan to help us better define our processes and stakeholders with the objectives:

- Staff use the learning from serious incidents and deaths to improve care and prevent further patient /staff harm
- Staff can describe the learning from a recent near miss, incident, serious incident, or never event.

- Staff know that they can receive practical and emotional support following a serious incident and how they can access this.

Some of our approaches include:

- Newsletters: Patient safety weekly and monthly bulletins, Divisional newsletters, safety alerts, quarterly Complaints, Litigation, Incidents, PALS and Safety report
- Meetings: Clinical innovations and standards committee, Mortality surveillance group, Hospital Mortality review groups, Hospital Clinical performance & patient safety committees, Serious incident review panel (SIRP), Divisional Quality Safety Boards
- Events: Learning from incidents and near misses event, Audit and quality days, trainee doctors, nursing, AHP induction.

Advance Care Planning

The Learning from deaths (LfD) process has helped us to understand where we have areas for improvement, so that we can target these for specific focus. At Barnet Hospital we set up a quality improvement project to improve Advance care planning (ACP), which is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

We have a growing population of frail patients who are frequent users of healthcare services. When discussing their place of death, the majority report that they would like to die at home, although statistically most deaths occur in hospital. Initially we reviewed a cohort of patients over one month to understand where and how we could improve the ACP process. Our interventions included adding ACP to the Board round, increasing training and identifying ACP champions, using ACP stickers to assist recording of the correct information, and enhancing CMC (Co-ordinate my care) training and access. On the pilot ward advanced care planning increased from 39% to ~78%, and this was expanded to 6 further wards. The results showed that six-months later 75% of these patients had remained in the community in their place of discharge. We showed that advanced care planning on the ward leads to more patients ending life in their preferred place of care and with reduced transfers of care.

2017/18 (Q3 and Q4)

Patient care

- Care thoughtful and appropriate
- Develop a clear document for repositioning patients with a raised BMI who have a new tracheostomy.
- Fluid balance charts should be used when monitoring a patient's fluid balance.
- Staff worked well together to gain access as the patient was difficult to cannulate.
- Attention paid to pressure area care.

Communication

- Anticipating early or rapid complications of disease process such as hydration and nutrition, as well as carer support for a dying patient.
- Communication with family not documented in the notes.
- Discussion with next of kin was hampered by the fact that the patient did not want them to know what was going on.
- Documentation of resuscitation drugs and printouts of rhythms and names of clinicians involved in care, clear in notes
- Excellent involvement of medical and surgical teams, appropriate decisions
- Excellent sepsis management
- Excellent repeated attempts and discussions with family.
- Excellent documentation of final discussion and DNAR decision making
- Frequent discussion with family

- Good communication with family
- Good nursing care documentation
- No Documentation of care after death and communication (or attempts to communicate) with relatives and coroners
- Patient's hospital passport was mislaid
- Very clear documentation of numerous conversations with family members.
- When the patient expressed their wish to stop active/life-prolonging treatment, this was respected and acted upon

End of Life care

- Better documentation of events post-death, such as discussions with the family, whether the GP was informed and if any further action was taken.
- Ensuring all involved in the patient's care have been informed of the death.
- Consider earlier referral to Palliative care
- Family involved in end of life discussions.
- Good discussion with family about end of life care.
- Lack of recognition of the importance of obtaining independent interpreting services

Training

- Improve training for emergency management of the deteriorating patient ventilated via tracheostomy
- Improve training on 'red flag' signs in patients ventilated via tracheostomy.
- Update training on the use of capnography
- Increase staff knowledge relating to the management of a child with pyrexia of unknown origin by the provision of formal training.
- There was a lack of adequate staff knowledge of the effects of Amiodarone particularly when administered as a bolus

Treatment pathways

- Create a pathway for all dialysis inpatients at Barnet Hospital
- Deprivation of Liberty Safeguards (DOLs) not in place
- It could have been acknowledged earlier that the patient was deteriorating with a high likelihood of dying and so treatment could have been appropriately limited
- Oral care not well documented in nursing notes and oral care plan not triggered on admission
- Thorough capacity assessment with MDT involvement.

2018/19 (Q1 and Q2)

Patient care

- Excellent management of an aplastic anaemia crisis
- Good care and timely decision making
- Medication should not be given orally to a drowsy patient
- Rapid timely access to very senior clinician input.
- Staff were slow to act on poor oral intake
- The patient was placed appropriately in a high visibility bed on the ward.
- The patient received a weekend medical review and appropriate action was taken.
- The patient's acute deterioration was immediately recognised by nursing staff
- Timely second opinion and legal advice
- Well planned and conducted best interests meeting

Communication

- Excellent documentation of communication with the family
- Good communication regarding nutrition and attempts to maximise oral intake
- Good communication with next of kin following admission to ITU
- Good cooperation between hospital teams
- MDT meeting held to discuss concerns, well documented, all MDT & community involved.

- Post-take ward round documentation could have been more detailed
- Regular review by multi professional team and joined up multi professional approach throughout admission.

End of Life care

- Clarity of visiting hours ie relaxing visiting hours in the case of a terminally dying patient so family can stay with patient in last hours
- Early involvement of palliative care, however this was not communicated well to the whole team involved which caused some confusion
- Excellent palliative care plan providing support to patient and family, with spiritual needs taken into account
- Improve end-of-life care planning for patients with severe long-term conditions
- Need for better community resources to support end of life care at home
- There was poor end of life care in the final hours, as there is little documentation and limited medical review

Treatment pathways

- Clarify the reporting of intraoperative deaths within the incident policy
- VTE management complex but decision making process clearly documented at each point

Description of actions taken during 2017/18 (Q3 and Q4)

The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From October 2017 to March 2018, we identified 15 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

ID	FinYear	Quarter	Likert Avoidability
2017/25733	2017/18	Q3	3. Probably avoidable, more than 50/50
2017/29402	2017/18	Q3	3. Probably avoidable, more than 50/50
2017/29762	2017/18	Q3	3. Probably avoidable, more than 50/50
2017/29969	2017/18	Q3	2. Strong evidence of avoidability
2018/1325	2017/18	Q4	3. Probably avoidable, more than 50/50
2018/4182	2017/18	Q4	3. Probably avoidable, more than 50/50
2018/1569	2017/18	Q4	2. Strong evidence of avoidability
2018/5773	2017/18	Q4	2. Strong evidence of avoidability
2018/11183	2017/18	Q4	2. Strong evidence of avoidability
2018/3607	2017/18	Q4	3. Probably avoidable, more than 50/50
2018/7350	2017/18	Q4	2. Strong evidence of avoidability
2018/6728	2017/18	Q4	2. Strong evidence of avoidability
2018/6737	2017/18	Q4	2. Strong evidence of avoidability
2018/8069	2017/18	Q4	2. Strong evidence of avoidability

Following investigation, each serious incident report contains a detailed action plan that is agreed with our commissioners and shared with the relatives. These actions are reviewed so that we have assurance that they are implemented. We have reworded some of the actions, so that our patients and their families are not identifiable.

- Amend the current ICU guideline for repositioning patients, to include that patients who have a high BMI and a new tracheostomy and who require repositioning should have four staff members involved in the procedure (including the nurse managing the tracheostomy).
- Clarify that the medical FY1 doctor overnight is to be viewed as Supernumerary and must not be asked to review acute or deteriorating patients without support.
- Complete a medication risk assessment for Amiodarone.

- Consider whether all wards should combine nursing and medical notes.
- Develop a business case to seek funding to explore the development of an electronic solution which would aid interpretation of plotted measurements on the GAP/GROW (Foetal development chart) and in turn clinical management is currently being finalised for presentation to the Technology Board.
- Develop a communication decision tool with suggested strategies and contact information for staff to support their decision making and clinical history taking when dealing with patients and families where there are communication difficulties.
- Develop a GAP/GROW (Foetal development chart) workbook of case studies as part of training improvement
- Develop an appointment system to ensure an effective process for following up women who do not attend for planned CTG scans.
- Develop clear criteria identifying the appropriate waiting time for transfer of women following induction with the Cooks' balloon and this information will be incorporated into the Maternity escalation policy as part of the maternity red flag triggers.
- Develop links with the Infectious diseases team in order to produce training for paediatric staff focusing on the following areas:
- Develop Multidisciplinary simulation training specifically relating to care of a child with SVT including the administration of Amiodarone.
- Devise an action template for staff shortages to ensure that patients at risk are prioritised.
- Highlight and escalate displaced patients of concern at the bed meeting, with a list of outliers for daily review.
- Emphasise the importance of communication cancellations of antenatal appointments to the midwife
- Ensure all patients that are reported as having chest pain (regardless of the history) have a new ECG and have this reviewed by an FY2 doctor or registrar.
- Ensure all women booked under midwifery led care have their appointment booked and sent to them by the community midwife. In the event that they do not attend, this will be followed up by the community midwifery team.
- Ensure that if a patient is unpredictable, a behavioural chart will be completed daily.
- Ensure the Enhanced Care Assessment form is available on all wards
- Ensure there is an adequate supply of critical drug stickers with the prescriptions charts and with the critical drugs poster clearly visible for all prescribers to see with the correct process of identifying critical drugs.
- Explore a solution for accessing ice or a suitable alternative in the Emergency Department.
- Explore the possibility of increasing the referral rate from Barnet hospital to the Fetal Medicine Unit at Royal Free hospital, focusing particularly on women who require increased surveillance.
- Have a permanent medical FY2 rotated in on the weekends who will conduct a daily Ward Round.
- Highlight the availability of interpreting services within the Trust
- Identify patients at handover and safety huddles that are at risk and who will be responsible for the patient safety that day.
- Implement weekend consultant-led ward rounds on the Ward
- Incorporate the learning from this death into training
- Introduce a consistent 24 hour cover, which will help provide a better point of contact, particularly for outlier medical patients, and also ensure the on take FY1 doctor continues with clerking rather than being pulled to see ward patients.
- Offer to share a copy of the final report and a face to face meeting with the patient/carer/ relative to feedback the findings of the investigation at a 'being open' meeting.
- Organise the schedule for ICU doctors to receive training on how to use the new ICU ultrasound machines.
- Place a safety alert regarding critical medications on to the Trust screensaver.
- Prepare a continuous programme for staff to simulate the scenario of management of the deteriorating patient.
- Present the case at the governance meeting to share learning
- Provide a clear process when access to the CCTV room is required out of hours.
- Reiterate the importance of safeguarding patient information during the safety briefing.

- Remind all staff of the importance of using capnography monitoring for tracheostomy patients
- Remind staff about speaking up at safety huddles when patients have a triggering PAR/NEWS score.
- Remind staff about the need for comprehensive documentation and consideration of the use of a scribe to record events.
- Review and update the guidance on ultrasound scan to include clearer guidance for sonographers as to what to report on the scan report if a scan falls within the extremes of normal limits for fetal growth measurement parameters.
- Review and update the Transfer Checklist to ensure there is an escalation prompt/ process for nursing staff to follow to ensure patients get a medical review prior to transfer if they have a PAR score of 3 and above.
- Review ICU discharge policy to reflect that complex ICU patients should not be stepped down to wards at night.
- Review safeguarding processes
- Review the feasibility of implementing weekend safety huddles as part of the current Quality Improvement work on the Safety Huddles initiative of the NHS Improvement Maternal and Neonatal health safety Collaborative
- Review the guideline for women who fail to attend antenatal visits in the community or in hospital and include additional actions for the follow-up of women who are having on-going blood pressure profile assessments in the Day assessment unit.
- Review the medical rota to ensure there are adequate medical staff covering the medical wards on the weekend.
- Set up a working group to review the pathway for escalating for a clinical review and the criteria for triggering the emergency bleep calls.
- Share a copy of the report with staff involved and ensure they reflect on what could have been done differently and include this in their appraisals.
- Share learning via CLIPS report (Complaints, Litigation, Incidents, PALS and Safety)
- Submit an ICU business case recommending the purchase of three new multi-modal ultrasound machines.
- Triage calls made to Hospital at Night Coordinators as routine or urgent by asking the caller. All urgent calls to record SBAR (Situation / Background / Assessment / Recommendation) on a separate sheet and record outcomes based on a doctor's feedback.
- Undertake an audit on the use of MEOWS (mother's early warning score) charts.
- Update guideline for the Induction of labour including pre-labour rupture of membranes at term guideline
- Update the risk relating to Nursing Shortages
- Ward Manager to liaise with PARRT and organise a learning session for nursing team about deteriorating patients and escalation processes.
- Write the protocol recommending use of ultrasound imaging for all invasive procedures carried out on ICU. This should incorporate the radiology LocSSIPs (Local Safety Standards for Invasive Procedures) for invasive procedures.

Description of actions taken during 2018/19 (Q1 and Q2)

The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From April 2018 to September 2018, we identified 4 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

ID	FinYear	Quarter	Likert Avoidability
2018/11594	2018/19	Q1	2. Strong evidence of avoidability
2018/15356	2018/19	Q1	3. Probably avoidable, more than 50/50
2018/18956	2018/19	Q2	3. Probably avoidable, more than 50/50
2018/21527	2018/19	Q2	2. Strong evidence of avoidability

Following investigation, each serious incident report contains a detailed action plan that is agreed with our commissioners and shared with the relatives. These actions are reviewed so that we have

assurance that they are implemented. We have grouped the actions into broader themes here, so that our patients and their families are not identifiable.

- Arrange simulation of adult emergency call situations in ward areas (including scenarios with patients displaying confusion)
- Develop guidance on the use of bed and chair alarms and the checks to undertake to ensure the equipment is safe for use.
- Develop a protocol for safe transfer of confused patient after 8pm
- Ensure and document attendance of ward nursing staff at escalation and use of the SBAR (Situation, Background, Assessment, Recommendation) training
- Ensure staff attend refresher training on how to take lying and standing blood pressures
- Ensure that monthly audits are undertaken to determine the accuracy of documentation on the NEWS 2 observation chart.
- Establish a 12 midnight huddle where Registered Nurses (RN) go through each patient's notes and documentation with HCAs and also discuss patients at risk of deterioration or/ and patients who require escalation.
- Facilitate discussion and training about the use of CPAPs in ED
- Offer to share a copy of the final report and a face to face meeting with the patient/carer/relative to feedback the findings of the investigation at a 'being open' meeting.
- Present the case at the governance meeting to share learning
- Remind staff about using the "P" function on ECGs and audit to check understanding
- Share a copy of the report with staff involved and ensure they reflect on what could have been done differently and include this in their appraisals.
- Share the learning via CLIPS report (Complaints, Litigation, Incidents, PALS and Safety)
- Update ECG audit template to include signatures and monitor results.

Description of proposed actions to take during 2018/19

Actions from quarter 3 and 4 reviews when they are completed will be taken forward during 2018/19 and reported on in next year's Quality Accounts.

Assessment of the impact of the actions taken

For each patient death that was considered likely to be avoidable, an investigation was undertaken and the actions to prevent recurrence of the incident were recorded (these actions have been detailed above). These actions are logged on our Risk Management system Datix, and are monitored by the hospital Clinical performance & patient safety committee and Clinical standards and innovations committee (CSIC) to ensure completion and compliance.

In addition, a number of actions are also reviewed by our commissioners, providing external assurance of our processes. This ongoing external review has been completed to the satisfaction of our commissioners. This will include a review of audits undertaken that provide evidence that the action continues to be implemented.

2.3 Reporting against core indicators

This section of the report presents our performance against 8 core indicators, using data made available to the trust by NHS Digital. Indicators included in this report, shows the national average and the performance of the highest and lowest NHS trust.

Areas covered will include:

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

This information is based on the most recent data that we have access to from NHS Digital and the format is presented in line with our previous annual reports. In future annual reports we will look to standardise the information produced, including time period examined.

Summary hospital-level mortality (SHMI)

Indicator:

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

Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	Royal Free Performance Jul 16 - Jun 17	Royal Free Performance Jul 17 - Jun 18	National Average Performance Jul 17 - Jun 18	Highest Performing NHS Trust Performance Jul 17 - Jun 18	Lowest Performing NHS Trust Performance Jul 17 - Jun 18
0.853 (Lower than expected)	0.9053 (as expected)	0.8777 (lower than expected)	0.8351 (lower than expected)	1.0 (as expected)	0.6982 (lower than expected)	1.2572 (higher than expected)

The SHMI score published in this report has been calculated by NHS Digital and uses finalised HES data for the financial years 2014-15, 2015-16, 2016-17 and 2017-18. NHS Digital have indicated that they believe there is a shortfall in the number of records in the HES data for discharges in the reporting period October 2015 – September 2016 for Royal Free London NHS Foundation Trust (provider code RAL). This has the potential to either under or over represent performance against this indicator and as such the report should be viewed with caution, however it should be noted that the Royal Free London NHS Foundation Trust participates in the HSCIC NHS Choices / Clinical Indicator sign off programme whereby data quality is reviewed and assessed on a monthly and quarterly basis.

No significant variance between the data held within Trust systems and data submitted externally has been observed.

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

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

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

The latest data available covers the 12 months to June 2018. During this period the Royal Free had a mortality risk score of 0.8351, which represents a risk of mortality lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked 9th out of 131 non-specialist acute trusts.

The Royal Free London NHS Foundation Trust has taken the following actions to improve the mortality risk score, and so the quality of its services:

- A monthly SHMI report is presented to the trust Board and a quarterly report to the Clinical Performance Committee. Any statistically significant variations in the mortality risk rate are investigated, appropriate action taken and a feedback report provided to the trust Board and the Clinical Performance Committee at their next meetings.

Patient deaths with palliative care code

Indicator:

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

Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	Royal Free Performance Jul 16 - Jun 17	Royal Free Performance Jul 17 - Jun 18	National Average Performance Jul 16 - Jun 17	Highest Performing NHS Trust Performance Jul 16 - Jun 17	Lowest Performing NHS Trust Performance Jul 16 - Jun 17
25.4%	25.6%	34.2%	40.8%	33.8%	59.5%	14.3%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from NHS Digital.

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level is included as a contextual indicator to the SHMI indicator. This is on the basis that other methods of calculating the relative risk of mortality make allowances for palliative care whereas the SHMI does not take palliative care into account.

Last year the Royal Free London NHS Foundation Trust intended to take the following actions to improve this percentage, and so the quality of its services, by:

- Presenting a monthly report to the trust board and a quarterly report to the clinical performance committee detailing the percentage of patient deaths with palliative care coding. Any statistically significant variations in percentage of palliative care coded deaths will be investigated with a feedback report provided to the trust board and the clinical performance committee at their next meetings.

This year there has been an increase in the percentage of deaths with palliative care coding so that it is now above the national average performance, with the Royal Free London NHS Foundation Trust ranking 36th out of 132 non-specialist acute trusts.

Patient reported outcome measures scores (PROMS)

Indicator:

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. PROMS measure health gain in

patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009. The table below shows the scores for the adjusted average health gain, which is the casemix-adjusted average gain in health from pre- to post-operative.

Royal Free Performance 2014/15	Royal Free Performance 2015/16	Royal Free Performance 2016/17	Royal Free Performance 2017/18	National Average Performance 2017/18	Highest Performing NHS Trust Performance 2017/18	Lowest Performing NHS Trust Performance 2017/18
Indicator: Groin hernia surgery IS THIS STILL INCLUDED? NOT IN ONLINE DATASET						
Low Number rule Applies	Low Number rule Applies	0.05				
Indicator: Varicose vein surgery – IS THIS STILL INCLUDED? NOT IN ONLINE DATASET						
Low Number rule Applies	0.12	0.11				
Indicator: Total hip replacement (EQ-5D Index)						
0.74	0.43	0.42	0.41	0.46	0.55	0.36
Indicator: Knee replacement surgery (EQ-5D index)						
0.68	0.31	0.32	0.299	0.34	0.40	0.25

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

This data has been reviewed and when we compare our clinical data with the data produced by the National Joint Registry (NJR) and National Hip Fracture Database (NHFD) there are no concerns regarding our performance which shows good care and above average performance. Therefore it appears that the data is related to patient's mismatched expectations regarding their condition post-operative. To address this we have a Joint School, where patients are informed of what to expect post-surgery and can manage their expectations of pain and mobility.

The Royal Free London NHS Foundation Trust has taken the following actions to improve the score, and so the quality of its services, by:

- obtaining data of actual number of procedures undertaken to compare with figures
- reviewing where pre-operative questionnaires are completed

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

Emergency readmissions within 28 days

Indicator:

The percentage of patients 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.

Please note that this indicator is currently suspended by NHS Digital with the intention that they will produce it again from summer 2018 onwards. As a result the trust has provided the latest available data to 2016/17. Internally the trust review it's 30-day emergency readmission rates for elective patients as part of its board key performance indicators.

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	National Average Performance 2016/2017	Highest Performing NHS Trust Performance 2016/2017	Lowest Performing NHS Trust Performance 2016/2017
Patients aged 0 to 15 years old					
9.93%	10.1%	5.2%	6.4%	3.3%z	10.5%
Patients aged 16 years old or over					
9.5%	8.5%	8.3%	10.6%	5.5%	10.6%

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

The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care. The table above demonstrates that the 28 day readmission rate at Royal Free London NHS Foundation Trust compares favourably with the rate amongst the 136 non-specialist providers in England; with a lower than average readmission rate observed at Royal Free London Foundation NHS Trust in both paediatric and adult cohorts.

The relative risk of emergency readmission within 28 days of previous discharge provides further evidence that the Royal Free London Foundation NHS Trust performs better than expected given its casemix and patient profile; the relative risk is 9.8% below (better than) expected. Standardised for both casemix and patient demographics this is the 8th lowest relative risk of any non-specialist English provider.

The Royal Free London NHS Foundation Trust has taken the following actions to improve the score, and so the quality of its services, by:

- carefully monitoring the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low or reducing rate of readmission is seen as evidence of good quality care. (In relation to adults the re-admission rate is lower (better) than the peer group average)
- undertaking detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's and identifying the underlying causes of readmissions

Responsiveness to the personal needs of our patients

Indicator:

The trust's responsiveness to the personal needs of its patients during the reporting period. This is the weighted average score of 5 questions relating to responsiveness to inpatient personal needs from the national inpatient survey (score out of 100).

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/17	Royal Free Performance 2017/18	National Average Performance 2017/18	Highest Performing NHS Trust Performance 2017/18	Lowest Performing NHS Trust Performance 2017/18
68.6	69.9	68.3	67.1	68.1	85.0	60.5

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

The NHS has prioritised, through its commissioning strategy, an improvement in hospitals responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is just below the national average and 2016/17 performance.

The Royal Free London NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Developing site-based experience strategies that identify local issues for patients
- Continuing to deliver and monitor the patient experience strategy goals of cancer and dementia:
 - Cancer experience
 - Commenced the cancer clinical practice group across all tumour types where cancer patient experience will be a key focus
 - Established a cancer CNS community of practice for all cancer nurses
 - Piloting a new app which will gather real-time patient experience metrics split by tumour site
 - Dementia experience
 - 2 elderly care wards (8 West and 10 North) have undergone dementia friendly refurbishment
 - Publication of RFL Dementia Handbook for carers
 - 100 members of staff joined Chickenshed theatre company to complete an innovative study day in advanced comms for dementia
 - Over 600 members of staff have completed specialist CAPER Anchor training

Friends and Family test (Staff)

Indicator:

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Royal Free Performance 2015	Royal Free Performance 2016	Royal Free Performance 2017	Royal Free Performance 2018	National Average Performance 2017	Highest Performing NHS Trust Performance 2017	Lowest Performing NHS Trust Performance 2017
72%	75%	74%				

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

Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. The trust performs better than the national average on this measure.

The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Undertaking activities to enhance engagement of staff have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends.
- Implementing a world class care programme embodying the core values of welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our world class care programme anticipates even greater clinical and staff engagement.

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

Venous thromboembolism (VTE)

Indicator:

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

NHS Digital publish the VTE rate in quarters and this is presented in the table below.

Royal Free Performance Oct 15 - Dec 15	Royal Free Performance Oct 16 - Dec 16	Royal Free Performance Oct 17 - Dec 17	Royal Free Performance Oct 18 - Dec 18	National Average Performance Oct 17 - Dec 17	Highest Performing NHS Trust Performance Oct 17 - Dec 17	Lowest Performing NHS Trust Performance Oct 17 - Dec 17
97.1%	96.6%	95.9%	95.9%	95.3%	100.0%	76.08%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from NHS Improvement data collection.

The Venous Thromboembolism (VTE) data presented in this report is for the period October 2018 to December 2018.

Venous Thromboembolism (VTE) results in many hospital deaths which are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed for risk of VTE.

The Royal Free performed better than the 95% national target, achieving 95.9%, the same as Q3 in 2016/17.

The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

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

<https://improvement.nhs.uk/resources/vte-risk-assessment-data-q3-201718/>

C difficile

Indicator:

The rate per 100,000 bed days of cases of C Difficile infection that have occurred within the trust amongst patients aged 2 or over.

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	National Average Performance 2016/2017	Highest Performing NHS Trust Performance 2016/2017	Lowest Performing NHS Trust Performance 2016/2017
17.8	21.0	21.3	66.1	37.6	0	157.5

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

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

Royal Free London NHS Foundation Trust performance was worse than the national average during 2017/18. However, very few of these infections have been attributed to lapses in care by the trust.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve the score, and so the quality of its services, by:

- The trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code. Delivery of educational programmes, comprehensive antibiotic policies, good bed management with early isolation of symptomatic patients and enhanced environmental cleaning.
- The microbiology, infection, prevention and control and pharmacy teams continue to perform Clostridium difficile ward rounds to ensure that all elements of the care and treatment of patients with C. difficile are being appropriately managed.
- The trust C.difficile 'action log' incorporates activity across the trust and is driven through the fortnightly divisional lead/C.diff action group.
- Learning from antimicrobial audits has provided evidence for a revised patient prescription chart with enhanced antimicrobial section. This has now been rolled-out across the trust and elements are being audited to focus on embedding as best practice.

Patient safety incidents

Indicator:

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

	Royal Free Performance Oct 14 - Mar 15	Royal Free Performance Oct 15 - Mar 16	Royal Free Performance Oct 16 - Mar 17	Royal Free Performance Oct 17 - Mar 18	National Average Performance Oct 17 - Mar 18	Highest Performing NHS Trust Performance Oct 17 - Mar 18	Lowest Performing NHS Trust Performance Oct 17 - Mar 18
(a)	5,734 (34.7)	5,915 (36.5)	6,549 (39.1)	6,527 (38.8)	4,713 (40.9)	1,828 (14.9)	2,100 (158.3)
(b)	43 (0.75)	26 (0.44)	33 (0.20)	24 (0.14)	17 (0.15)	0 (0.0)	4 (4.34)

Every six months, NHS Improvement publishes official statistics on the incidents reported to the National Reporting and Learning System NRLS. These reports give NHS providers an easy-to-use summary of their current position on patient safety incidents reported to the NRLS, in terms of patient safety incident reporting and the characteristics of their incidents. The information in these reports should be used alongside other local patient safety intelligence and expertise, and supports the NHS to deliver improvements in patient safety.

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the NRLS.

NHS Improvement regards the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported a similar volume of incidents per 1,000 bed days between Oct 2017 and Mar 2018 (38.8) compared to the national average (40.9).

The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- 1) Launching our Patient safety Clinical Practice Group (CPG) , which is initially focussed on embedding Local Safety Standards for Invasive Procedures (LocSSIPs). The LocSSIPs are safety checklists for procedures that are undertaken outside theatres eg biopsies and some injections.
- 2) Developing its patient safety culture, supporting the Trust goals of: zero never events, reducing avoidable deaths and zero avoidable hospital-acquired infections. We have focussed on improving our risk assessment processes for those most serious incidents and continue encouraging staff to report incidents. We have developed our safety learning and communications plan, that supports us

providing timely feedback to staff on the outcomes and learning resulting from incident investigations. This is underpinned by safety events, newsletters, blogs and visits to ward areas.

We have robust processes in place to capture incidents, and increase our reporting by an average of 9% year on year. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts.

All incidents resulting in severe harm or death undergo additional scrutiny at our weekly, site-based Serious incident review panels (SIRP). These multi-disciplinary panels are led by each hospital's medical director and they review all moderate harm or above incidents to determine level of harm, level of avoidability and level of investigation required. They also provide scrutiny of the final reports to ensure that the actions address the root causes identified in the investigations.

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

Part three: review of quality performance

3.1 Overview of the quality of care in 2018/19

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2018/19 against indicators and national priorities selected by the board in consultation with our stakeholders.

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 and to show key performance indicators that are requested by the Royal Free London NHS FT Board.

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
Section 1: Patient safety	<ul style="list-style-type: none"> • Summary hospital mortality indicator (SHMI) • Hospital standardised mortality ratio (HSMR) • Methicillin-resistant staphylococcus aureus (MRSA) • C. difficile Infections
Section 2: Clinical effectiveness	<ul style="list-style-type: none"> • Referral to treatment (RTT) • A&E performance • Cancer waits • Average length of stay (elective and non-elective) • 30-day emergency readmission rates for elective patients
Section 3: Patient experience	<ul style="list-style-type: none"> • Friends and family test • Volume of delayed transfers of care (DTOCs) • Cancelled operations not readmitted within 28 days

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	Source
Summary Hospital Mortality Indicator (SHMI)	These measures use routinely collected data to calculate an overall “expected” number of deaths if the trust matched the national average performance. The result is a ratio	Stethoscope, Methods Analytics

and Hospital Standard Mortality Ratio (HSMR)	(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.	
MRSA	The count of meticillin resistant Staphylococcus aureus (MRSA) bacteraemias attributed to the trust.	Datix system
C. Difficile infections	Number of Clostridium Difficile infections reported at the trust	Datix system
C. Difficile Lapses in care	Number of Clostridium Difficile infections due to lapses in patient care	Datix system
RTT Incomplete Performance - % waiting less than 18 weeks	Percentage of patients on the incomplete RTT patient tracking list waiting 18 weeks or less for treatment or discharge from referral.	Cerner system
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.	Cerner system
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.	Infoflex system
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.	Infoflex system
31 day wait diagnosis to treatment	Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.	Infoflex system
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.	Infoflex system
Average length of stay (non-elective and elective)	Mean length of stay for all inpatients based on whether their mode of admission was elective or non-elective. This includes patients with a 0-day length of stay.	Stethoscope, Methods Analytics
30-day re-admission rate following elective or non-elective spell	Number of emergency re-admissions within 30 days of discharge as proportion of total discharges following an elective admission And	Stethoscope, Methods Analytics

	Number of emergency re-admissions within 30 days of discharge as a proportion of number of discharges following an elective admission	
Friends and Family IP, A&E and maternity scores	The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP, A&E and maternity friends and family tests. (Neither Likely or not likely excluded from responses)	To be confirmed
Volume of delayed transfer of care (DTOCs)	This is the number of bed days lost in a month to patients who are awaiting a transfer of care to social or NHS community care.	Cerner system
Cancelled operations	Volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and day-case operations.	Cerner system

Notes on the charts

This year the presentation of the data is the same as the previous Quality Account. Two chart types are now used: control charts and funnel plots. Only where appropriate funnel plots are unavailable have we used a standard bar chart to show Royal Free London performance benchmarked against other providers.

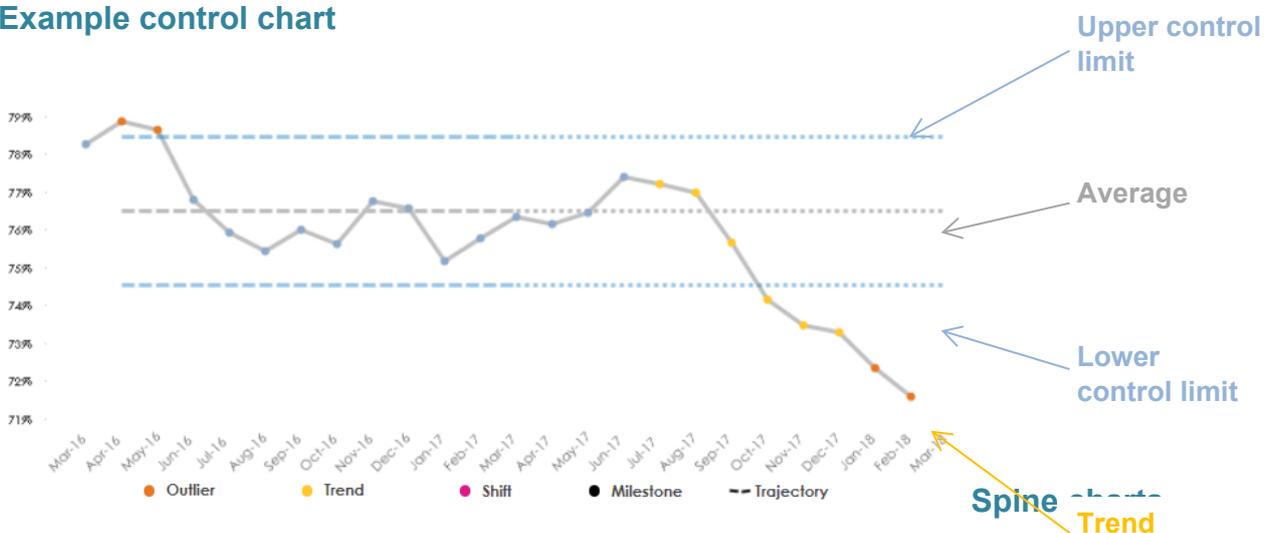
Control charts

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).¹

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



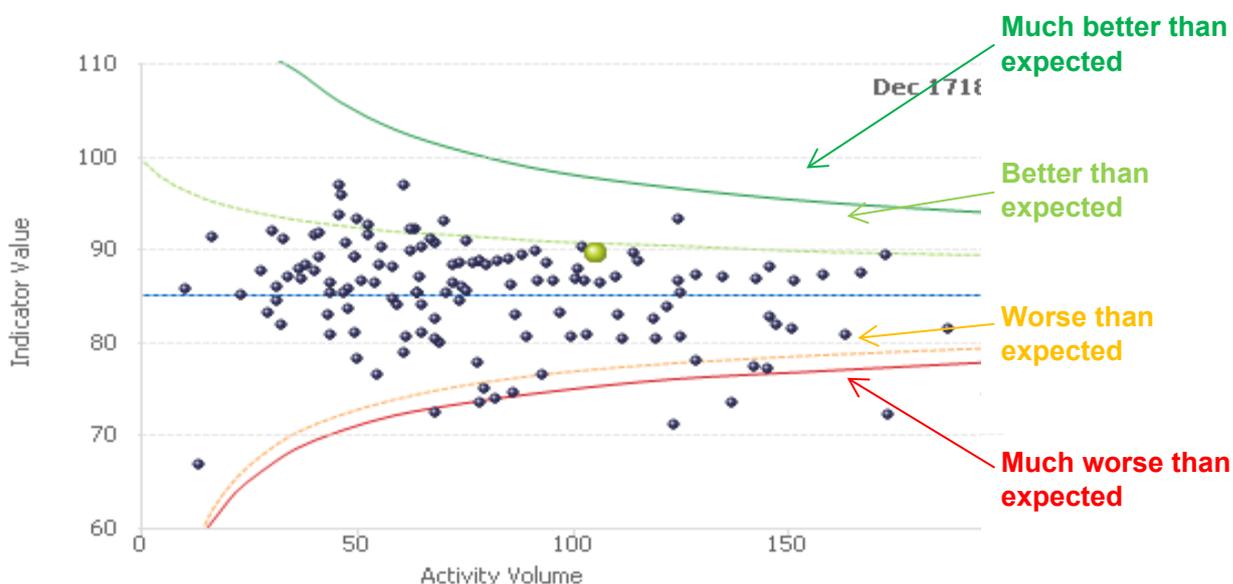
¹ <http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html>

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.² 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.

² Methods Analytics methodology, 2018

Performance against key national indicators

Section 1: Patient Safety

Summary Hospital Mortality Indicator (SHMI)

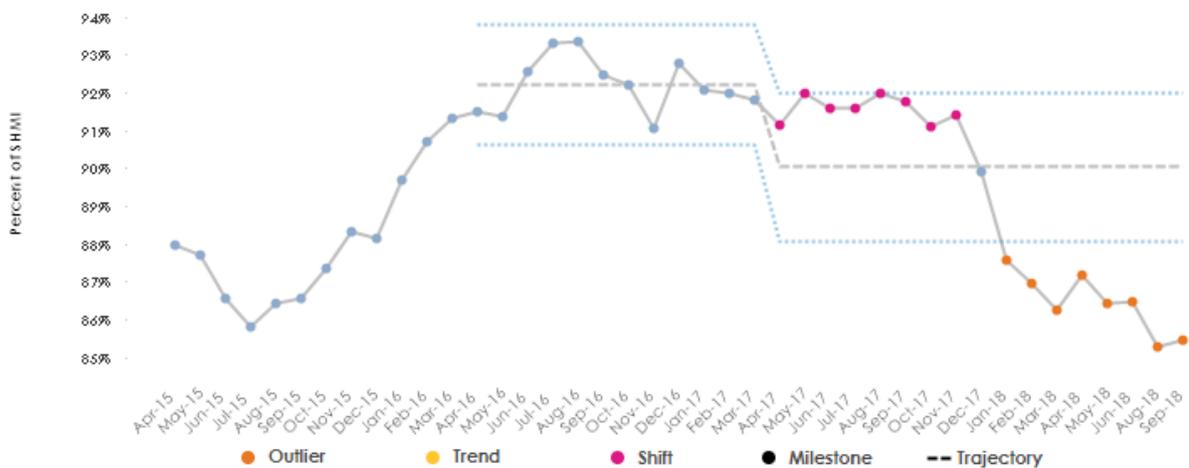
SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. This expression of mortality risk includes all diagnoses groups and mortality occurring up to 30 days post discharge.

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

SHMI data is presented below for April 2015 to September 2018. This shows a recent improvement in the trust's score to a mean of 86.2 or 13.8% better than expected over the months April to September 2018.



Summary Hospital Mortality Indicator

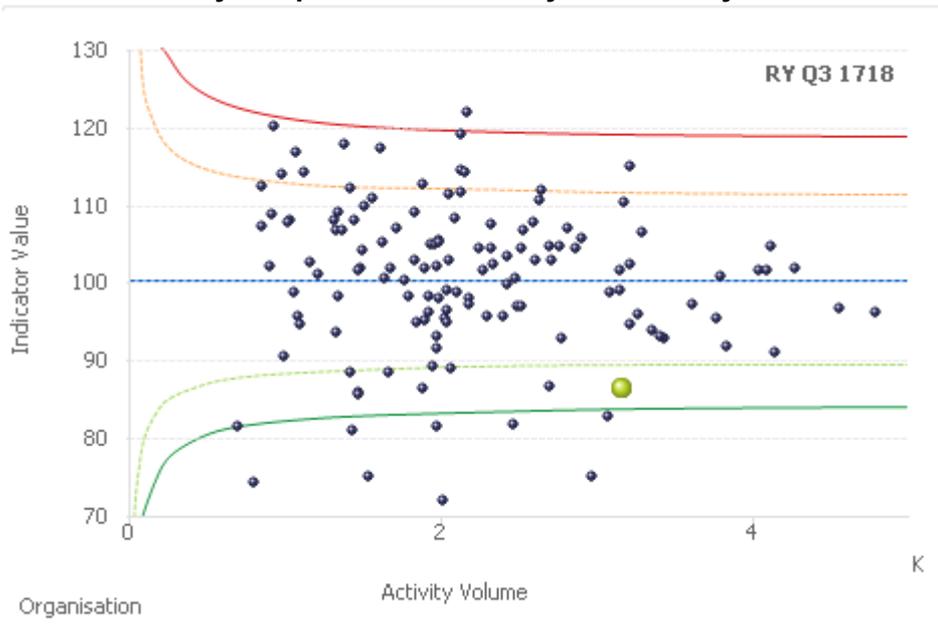


Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Aug-18	Sep-18
91.78%	91.12%	91.42%	89.94%	87.60%	86.99%	86.29%	87.20%	86.46%	86.50%	85.31%	85.47%

Source: Royal Free London NHS Foundation Trust 2015-2018

The chart below shows the Royal Free London SHMI performance compared to all other acute NHS trusts for the rolling year ending Q2 2018/19 (the latest for which information is currently available). The Royal Free SHMI was 9th lowest out of 134 acute trusts and was statistically lower than expected.

Chart: Summary Hospital-level Mortality Indicator by NHS acute trust



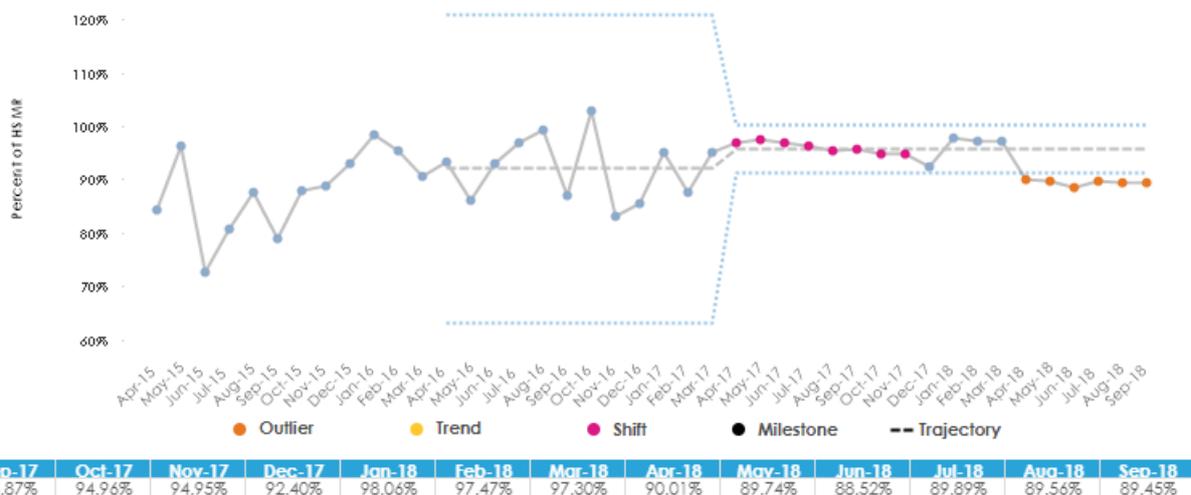
Source: Stethoscope benchmarking tool, Methods Analytics 2019

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 September 2018; our average over the period has been 89 or 9% better than expected.



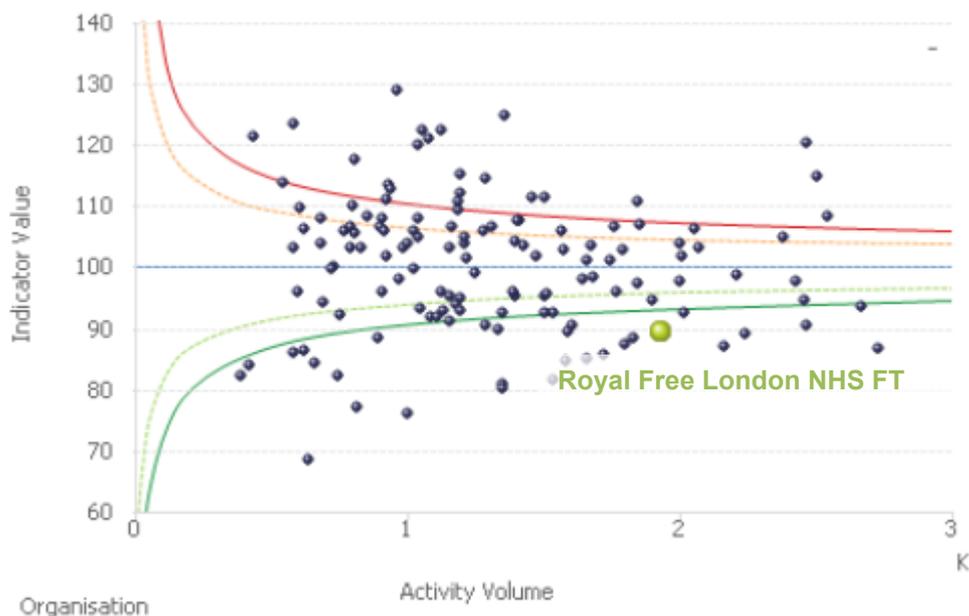
Hospital Standardised Mortality Ratio



Source: Royal Free London NHS FT 2015-2018

However, benchmarking shows that on this measure the Royal Free London is significantly below (better than) the national mean. Previously, we fell within expected limits.

Chart: Hospital Standardised Mortality Ratio by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2019

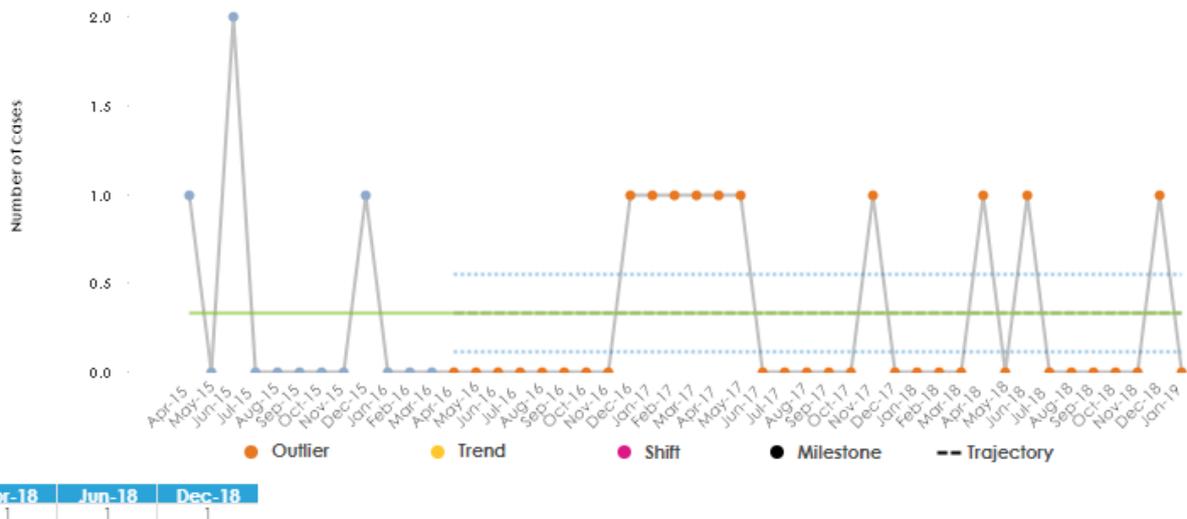
The charts describe the standardised mortality ratio for the 12 months ending 30th September 2018, and shows that the Royal Free London NHS Foundation Trust recorded the 23rd lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 89.46 (where a risk of 100 would indicate mortality exactly as expected for this casemix across England), the reported risk signposts that our mortality risk is 9% below (better than) expected, and that this is statistically significant, in other words unlikely to have occurred by random chance.

Methicillin-resistant staphylococcus aureus (MRSA)

MRSA is an antibiotic resistant infection associated with admission 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.



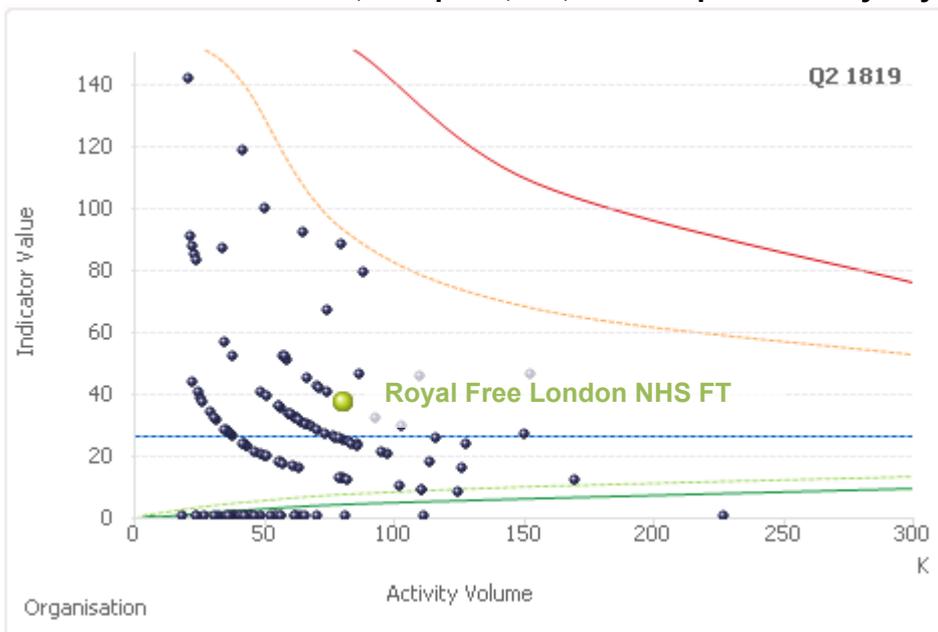
MRSA Bacteraemias



Source: Royal Free London NHS FT 2015-2019

In the twelve months to the end of January 2019 the Royal Free reported 3 MRSA bacteraemias. The chart below shows the Royal Free London Q2 2018/19 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.

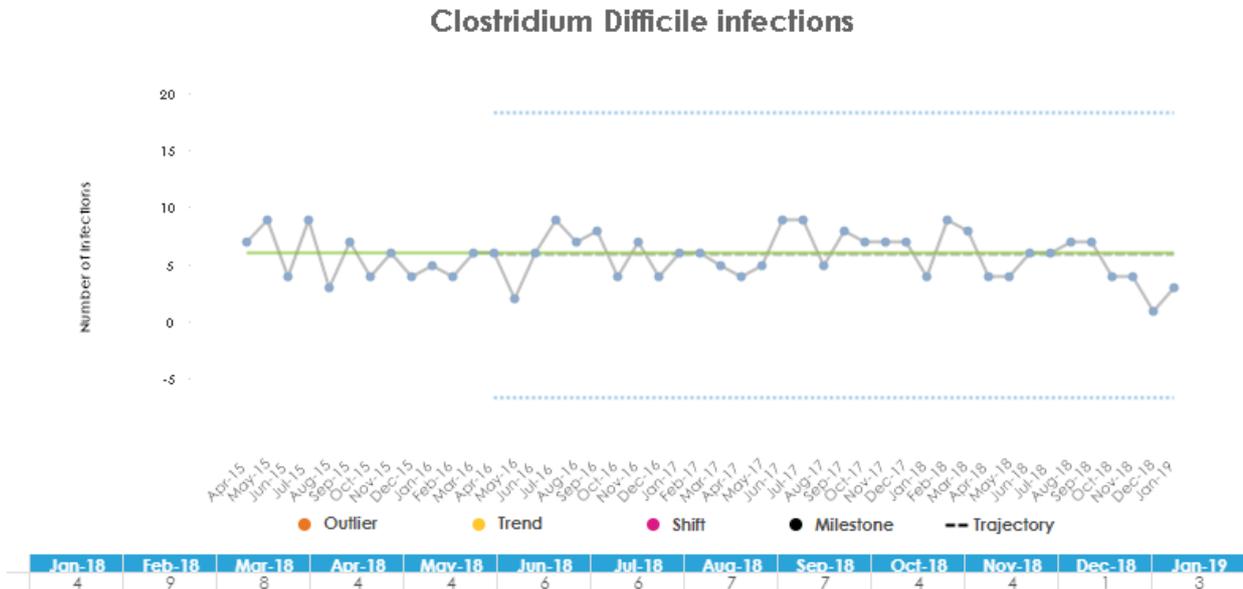
Chart: MRSA bacteraemia, rate per 1,000,000 occupied bed days by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2019

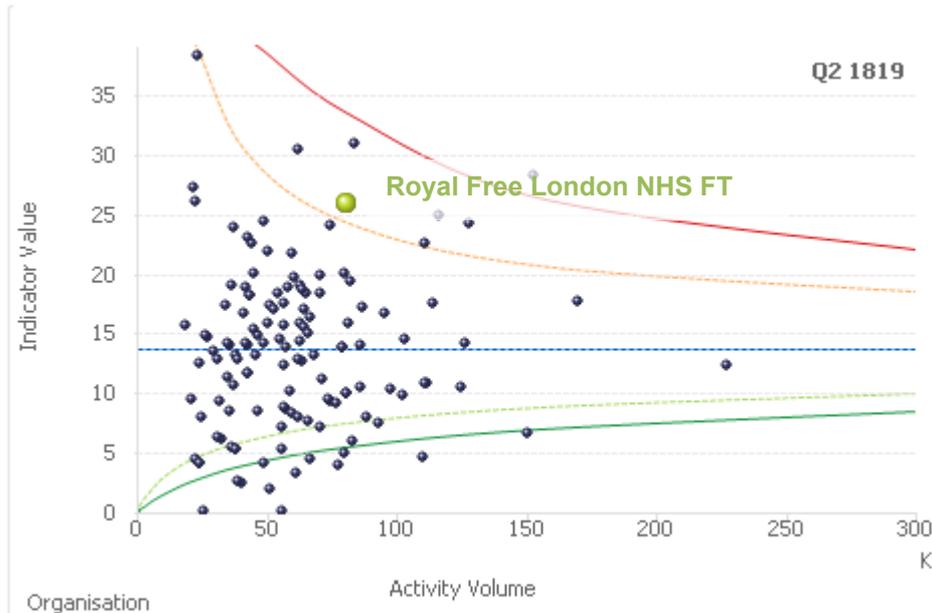
C. difficile

In relation to C. difficile the trust saw little change in 2018/19 from 2017/18 in terms of the rate of infections, with an average of ~5 per month in the 12 months prior to February 2019.



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. This is consistent with previous performance.

Chart: C. Difficile infection rate per 100,000 occupied bed days by NHS acute trust Q2 2018/19

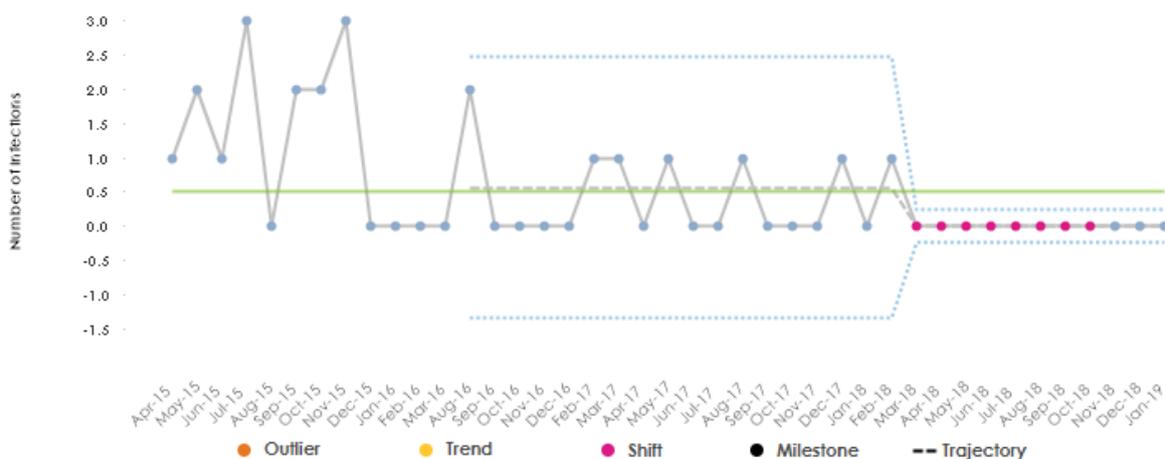


Source: Stethoscope benchmarking tool, Methods Analytics 2019

However, of the 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 1 incident in the 12 months prior to February 2019.



Clostridium Difficile infections from lapses in care



Feb-18

Source: Royal Free London NHS FT 2015-2019

Section 2: Clinical Effectiveness

Referral to treatment (RTT)

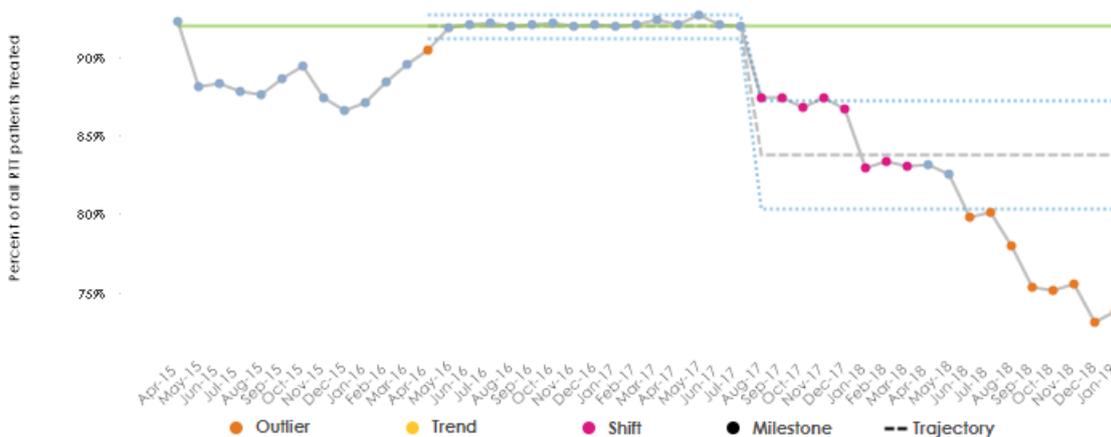
In England, under the NHS Constitution, patients have the right to access consultant-led services within a maximum waiting time of 18 weeks. This is known as referral to treatment (RTT) and we report our performance to the government on a monthly basis.

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 92% should be waiting 18 weeks or less to start treatment. This is the 'incompletes' standard.

As shown in the chart below, However, since August 2017, the trust has failed the standard. Performance in January 2019 was 73.9%.



RTT: % < 18 weeks wait to first treatment



Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
83.0%	83.4%	83.1%	83.2%	82.6%	79.8%	80.1%	78.0%	75.3%	75.2%	75.5%	73.2%	73.9%

Source: Royal Free London NHS FT 2015-2019

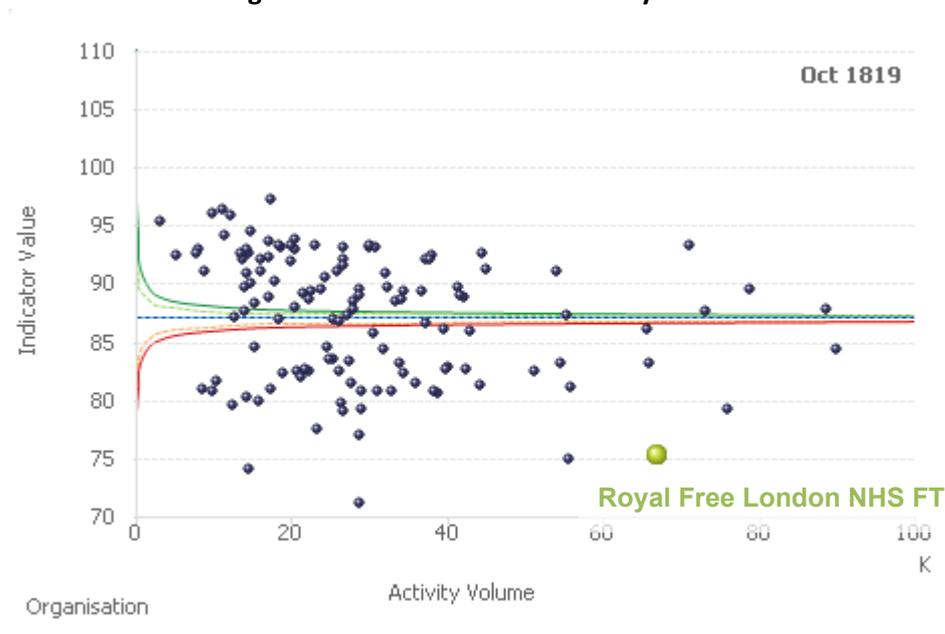
This was primarily a result of improvements the trust made to the way in which it tracks patient pathways using a Patient Tracking List (PTL). During 2018/19 the trust worked on improving the PTL for two main reasons:

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 logic which will be used to construct the new PTL has been written and agreed and we are in the process of agreeing timescales for validation of pathways that will become visible once implemented. It is expected that this exercise will take 12 months, after which we will have an accurate and complete list of the status of RTT pathways.

The chart below shows the Royal Free London October 2018 performance (the latest available data) compared to other NHS acute trusts in England. This shows that our performance was 4th lowest in England.

Chart: RTT % waiting <18 weeks for first treatment by NHS acute trust October 2018/19



Source: Stethoscope benchmarking tool, Methods Analytics 2019

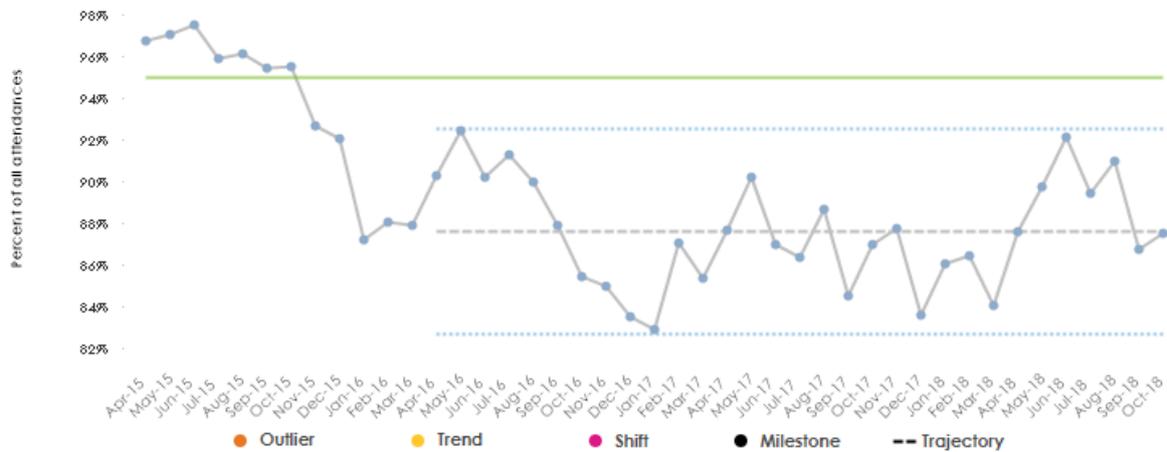
Accident and Emergency performance

The Accident and Emergency Department is often the patient’s point of arrival. The graph below summarises the Royal Free London’s performance in relation to meeting the 4-hour maximum wait time standard set against the performance of 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 December 2018 to January 2019, the Royal Free London NHS FT achieved an average monthly performance of 87.4%. This was not significantly different from average performance in 2017/18.



A&E: % of patients seen within 4 hours



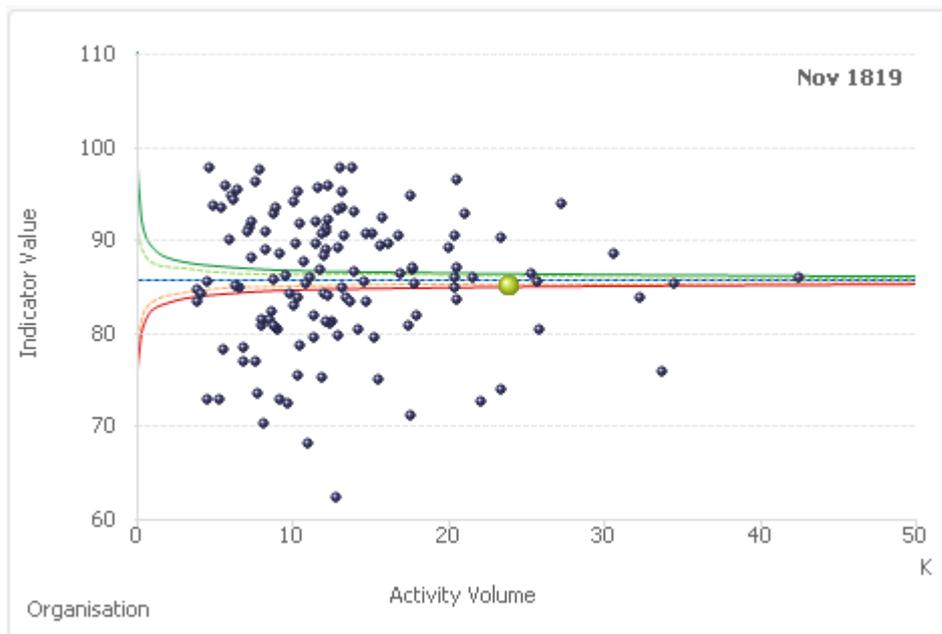
Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
87.0%	87.8%	83.7%	86.1%	86.5%	84.1%	87.6%	89.8%	92.2%	89.5%	91.0%	86.8%	87.5%

Source: Royal Free London NHS FT 2015-2019

Pressure on A&Es has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare. 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.

The chart below shows the Royal Free London November 2018 performance (the latest available data) compared to other NHS acute trusts in England. This shows that our performance was within expected control limits when compared to other Type 1 A&E providers in England.

Chart: Performance against 4 hour A&E standard in November 2018 by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2019

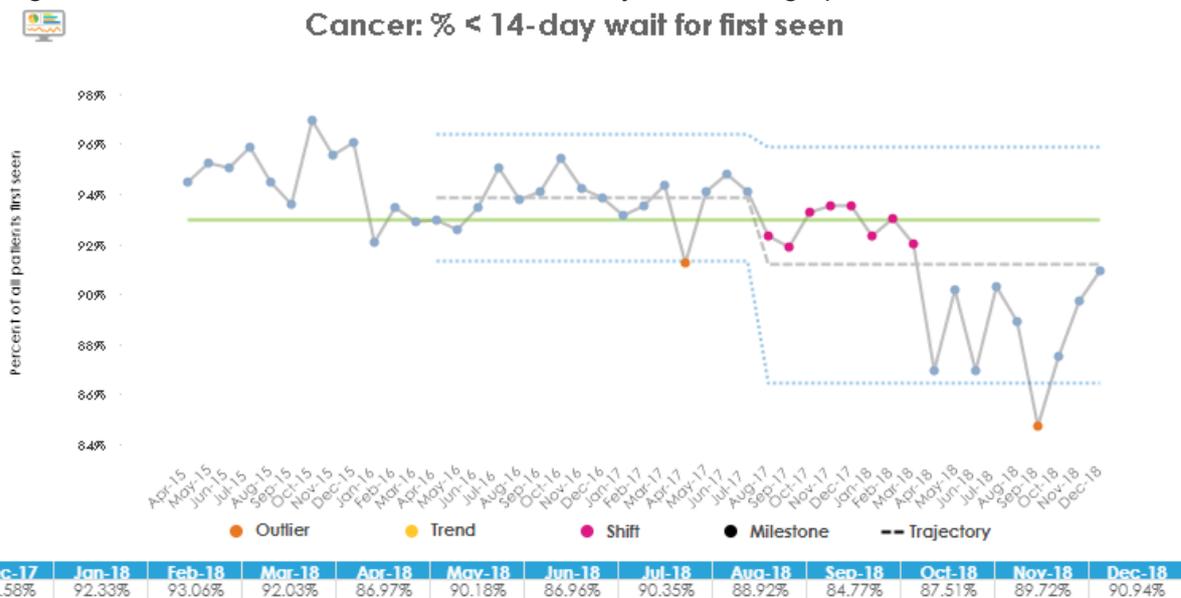
Cancer waits:

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 have begun first definitive treatment within 31 days of the decision to treat and 85% of patients to have begun first definitive treatment within 62 days of referral.

For 2018/19, trust performance has declined against the standard to see at least 93% within 2 weeks from GP referral, achieving an average performance of 89.47%. The main factors influencing below standard performance have been the holiday periods for Easter and summer as well as significant unexpected increases in referral rates in some tumour sites. The trust continues with robust seasonal 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.

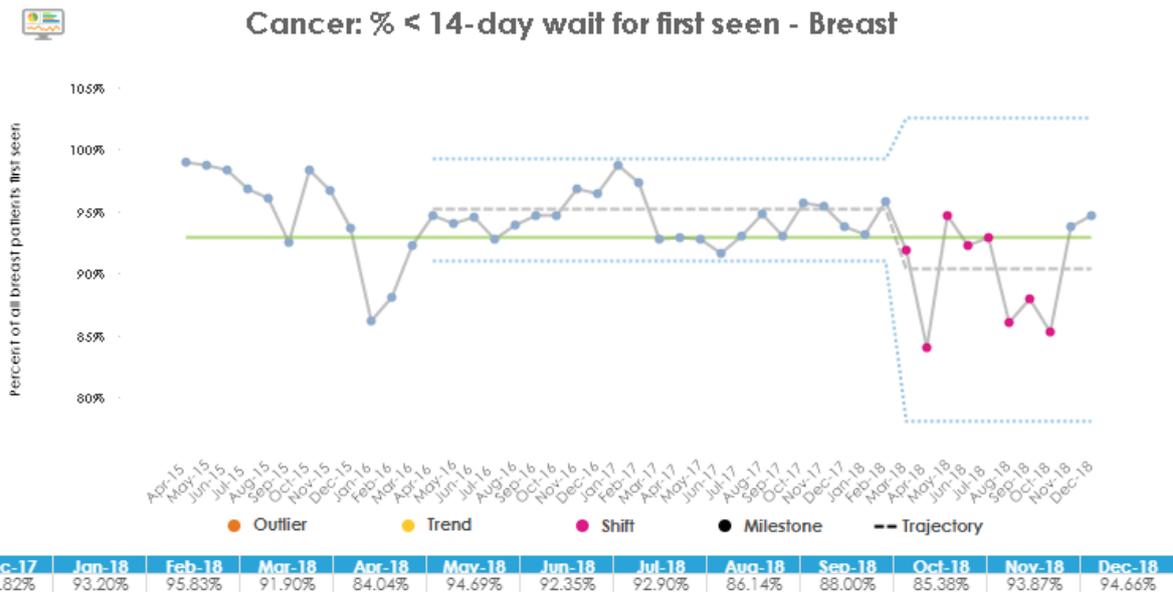
In addition, we have seen performance decline in conjunction with roll-out of the national “paperless” referral system (ERS) which means patients book and can reschedule their appointments without speaking to a member of staff and this limits our ability to encourage patient to attend sooner.



Source: Royal Free London NHS FT 2015-2018

Breast Urgent referral 2 week waits

In 2018/19, the trust saw 81.2% of patients on an urgent (symptomatic) breast referral pathway within 2 weeks, below the national standard.



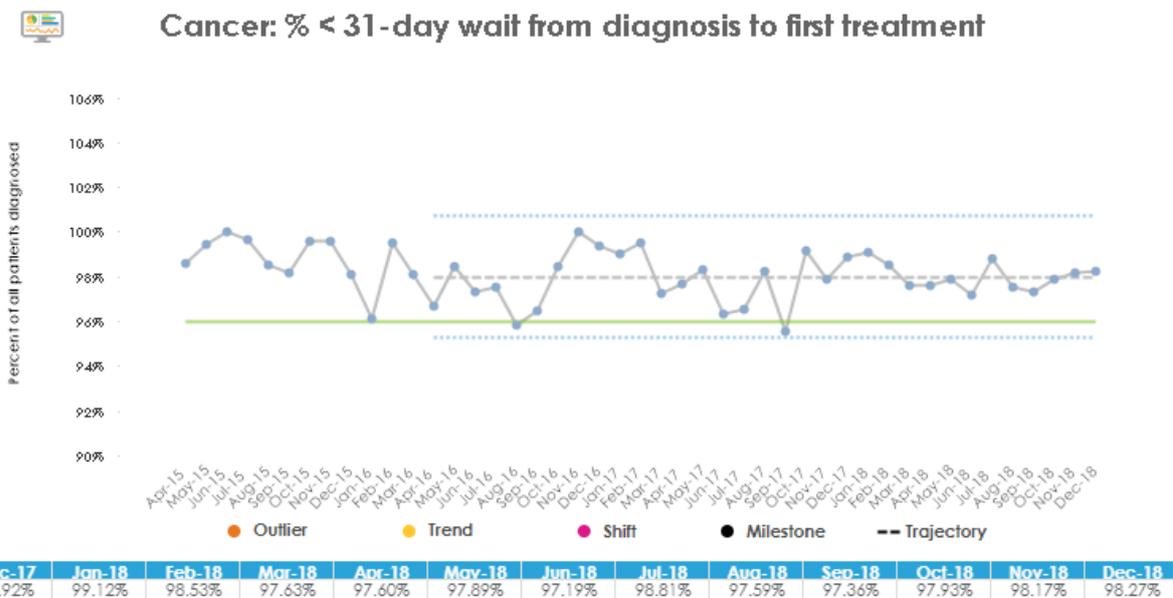
Source: Royal Free London NHS FT 2015-2018

This is discrepant to previous years where we met the standard. The service had undertaken an audit of patients who do not accept an appointment within two weeks and have found many patients are not informed about the urgency prior to referral. The service will now work with CCGs to improve communication with patients prior to referral.

We have also seen performance decline in conjunction with roll-out of the national “paperless” referral system (ERS) which means patients book and can reschedule their appointments without speaking to a member of staff and this limits our ability to encourage patient to attend sooner.

First definitive treatment within 31 days

In 2018/19, the trust met the standard to see 96% of patients within 31 days for their first definitive treatment for cancer, meeting the national standard for the year overall.



Source: Royal Free London NHS FT 2015-2018

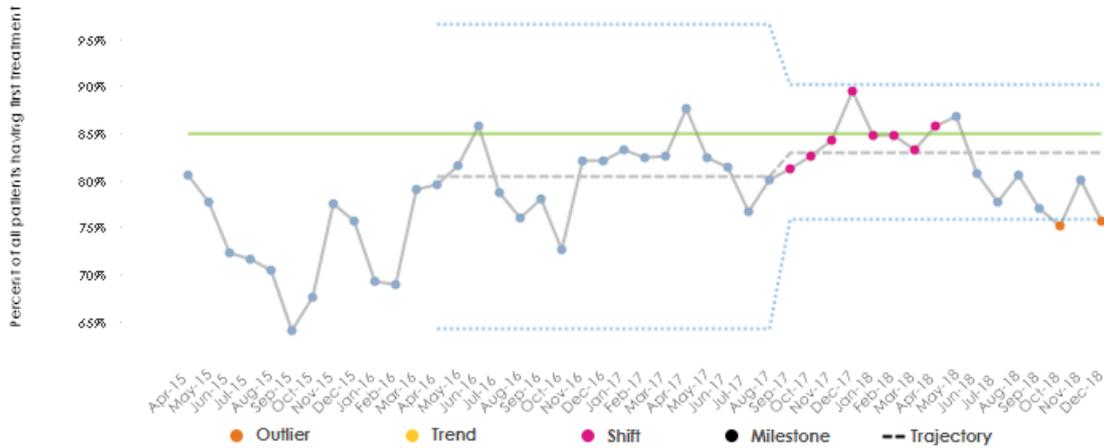
This is similar performance to 2017/18 when we also met the standard.

First definitive treatment within 62 days of an urgent GP referral

The trust did not meet the 62 day standard in 2018/19, with 80% of patients receiving first treatment within 62 days of a GP referral. This represents a slight deterioration on 2017/18 where 82.9% of patients were treated within the standard.



Cancer: % < 62-day wait for first treatment - GP referral



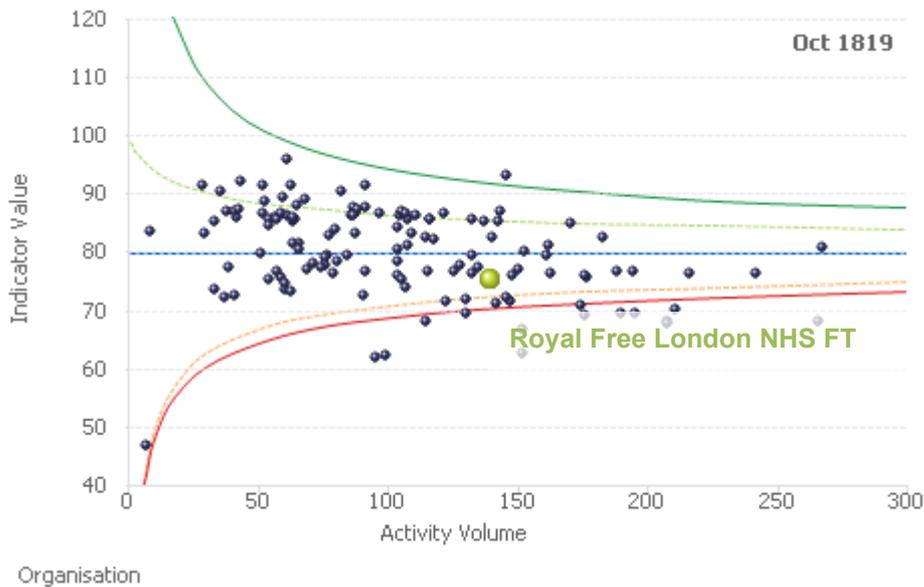
Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
89.52%	84.85%	84.91%	83.33%	85.82%	86.93%	80.74%	77.78%	80.58%	77.11%	75.18%	80.08%	75.81%

Source: Royal Free London NHS FT 2015-2018

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 2019/20 the trust plans to launch a Clinical Pathway Group dedicated to cancer. This will be a large, clinically-led, programme of improvement work using methodology that has been tested and proven in other areas within the trust (e.g. “keeping mothers and babies together”).

When comparing Royal Free London to benchmarks in October 2018 (the latest available data), this suggests that performance did not differ from the national mean by more than can be explained by random chance.

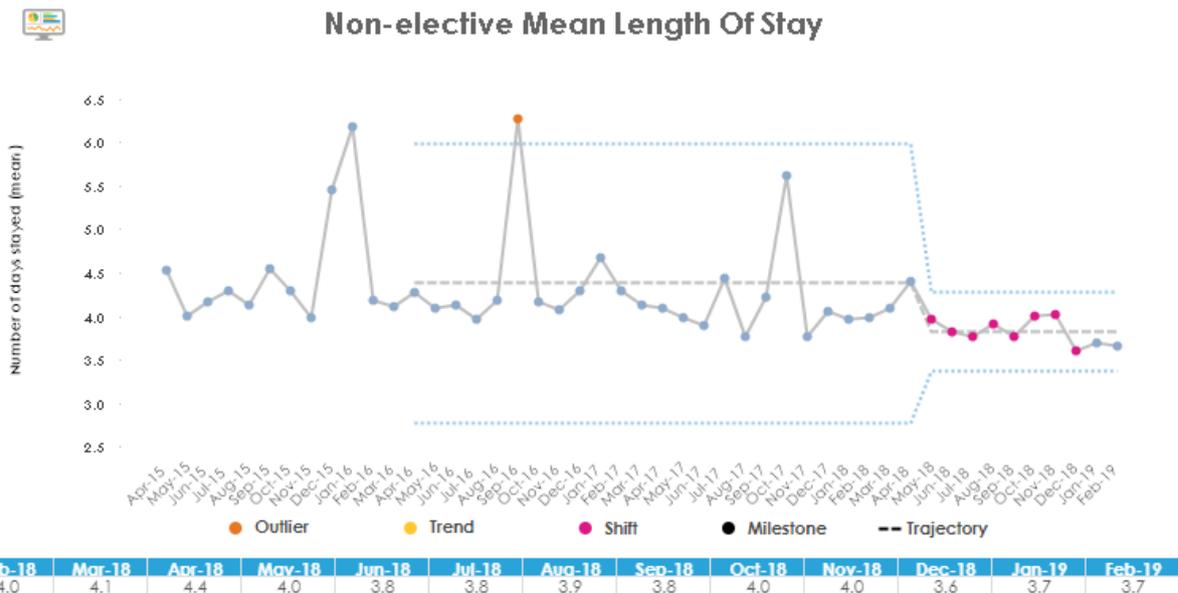
Chart: Cancer 62 day wait for first treatment from GP referral, all acute trusts, October 2018



Source: Stethoscope benchmarking tool, Methods Analytics 2019

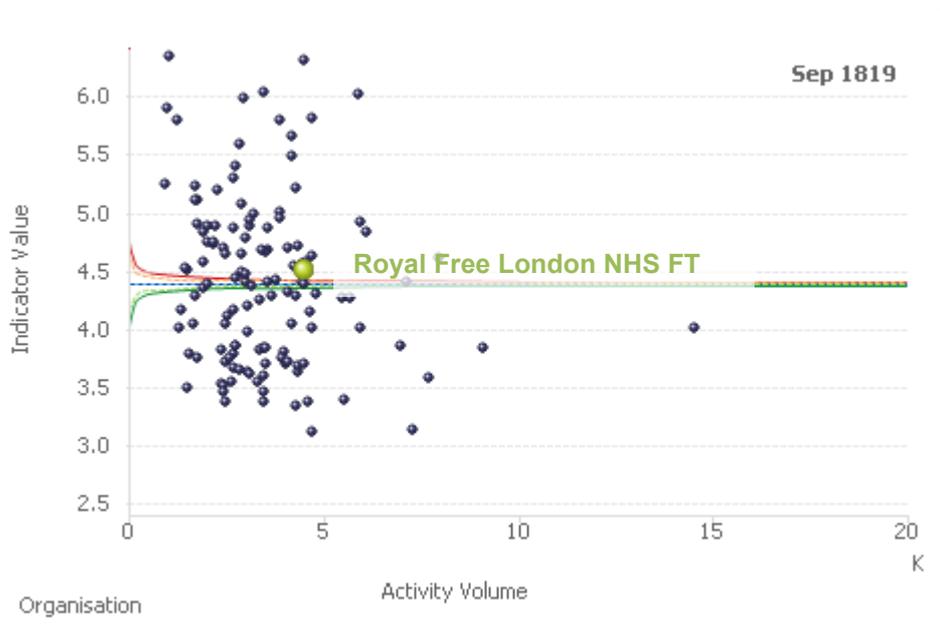
Average length of stay: Non-elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective from April 2018 to February 2019 (the latest available data) shows that the trust average length of stay in the period April to December 2017 was 3.9 days. This is significantly improved from the average length of stay reported in 2017/18 at 5.1 days and you can see from the chart below we had a positive shift in performance in December 2018.



Source: Royal Free London NHS FT 2015-2019

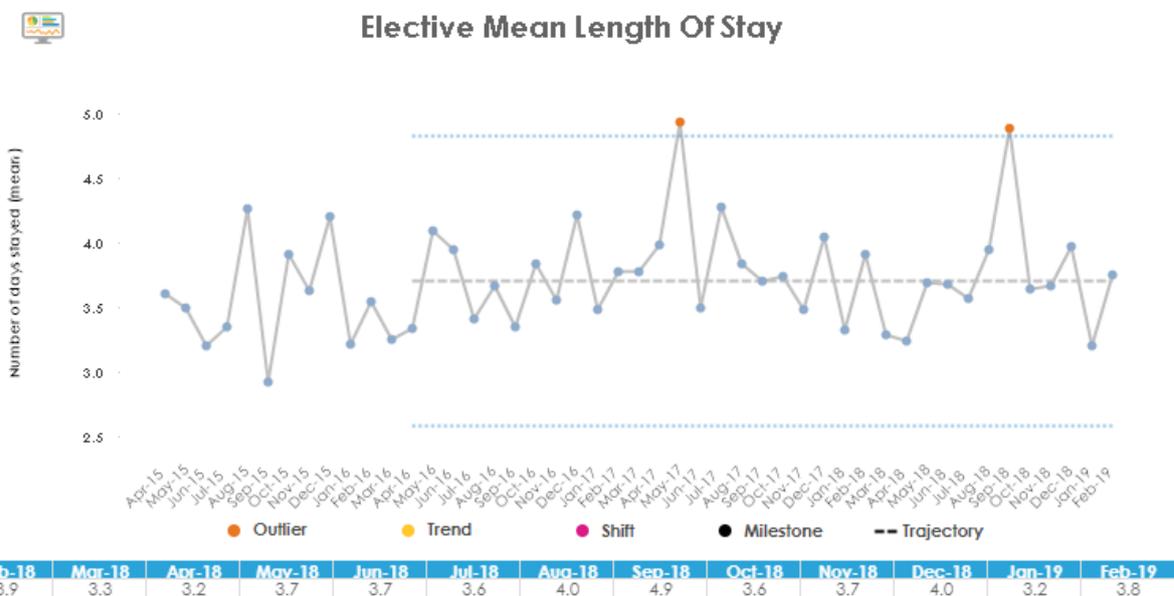
When comparing Royal Free London to benchmarks in September 2018 (the latest available data), this suggests that length of stay was higher (worse) than the national mean by more than can be explained by random chance.



Source: Stethoscope benchmarking tool, Methods Analytics 2019

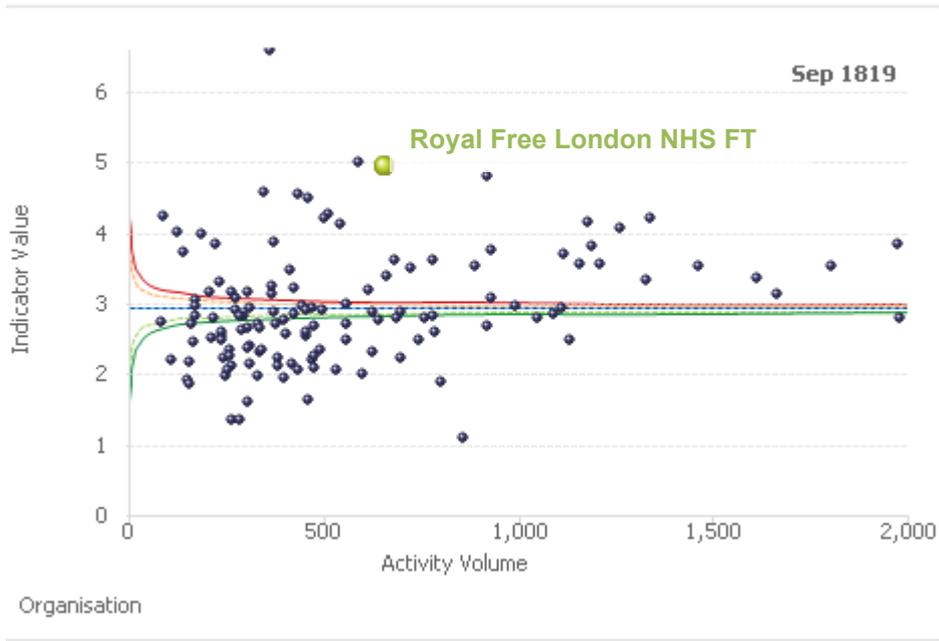
Elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective to February 2019 (the latest available data) shows that the trust average length of stay in the period April 2018 to February 2019 was 3.8 days. This is an improvement on the average length of stay from 2017/18 which was reported at 4.6 days.



Source: Royal Free London NHS FT 2015-2019

When comparing Royal Free London to benchmarks in September 2018 (the latest available data), this suggests that average length of stay was significantly higher (worse) than the national mean by more than can be explained by random chance.

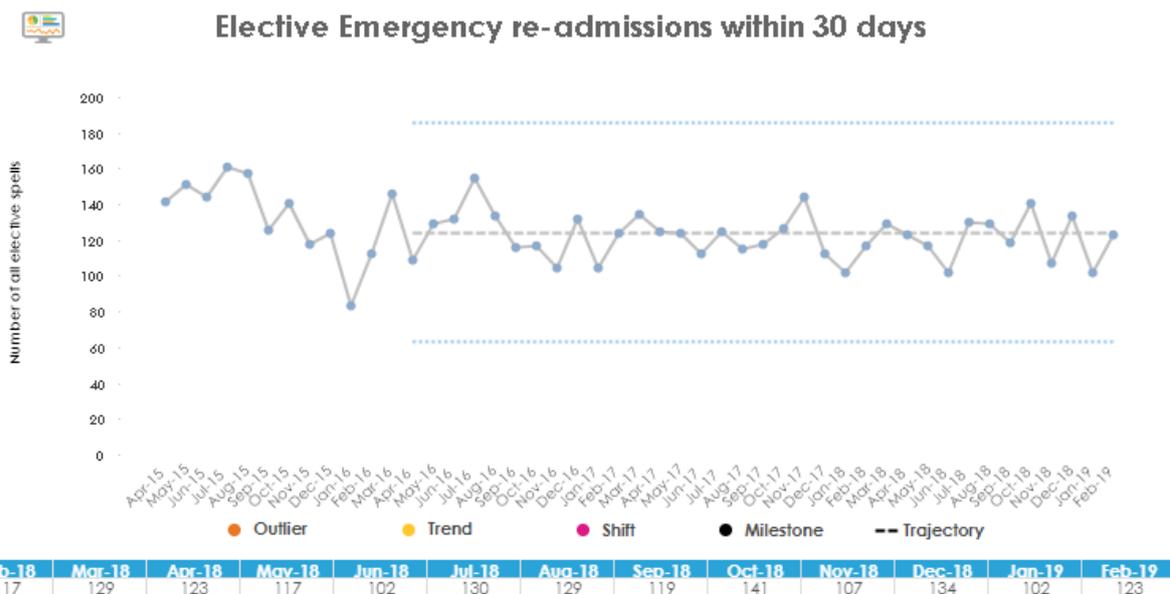


Source: Stethoscope benchmarking tool, Methods Analytics 2019

Emergency re-admissions:

30 day emergency re-admissions following an elective admission

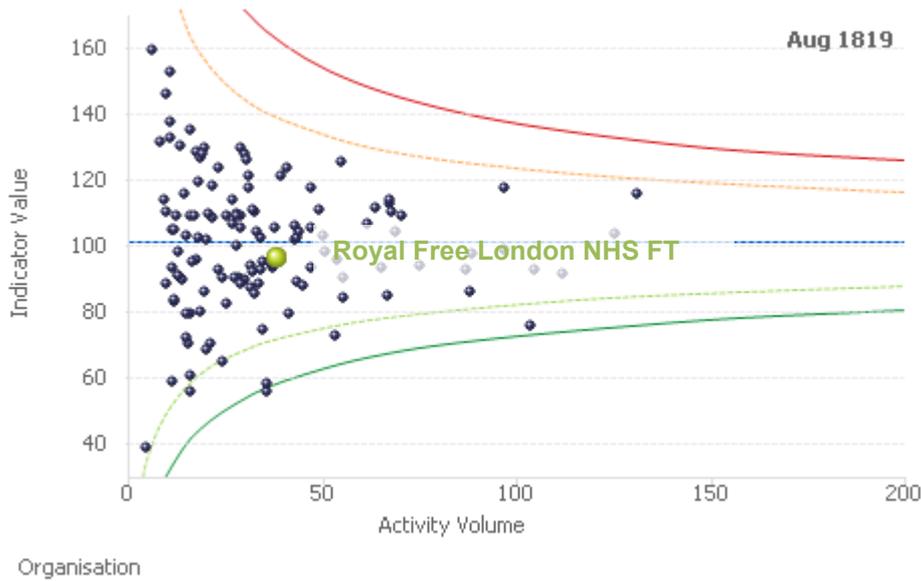
The chart below shows the proportion of patients re-admitted as an emergency following an elective admission in the previous 30 days between April 2015 and February 2019 (the latest available data). The average for April 2018 to February 2019 was 6.5%. This shows that there has been no significant change during this period.



Source: Stethoscope benchmarking tool, Methods Analytics 2018

When comparing Royal Free London to benchmarks in August 2018 (the latest available data), this suggests that average length of stay did not differ from than the national mean by more than can be explained by random chance.

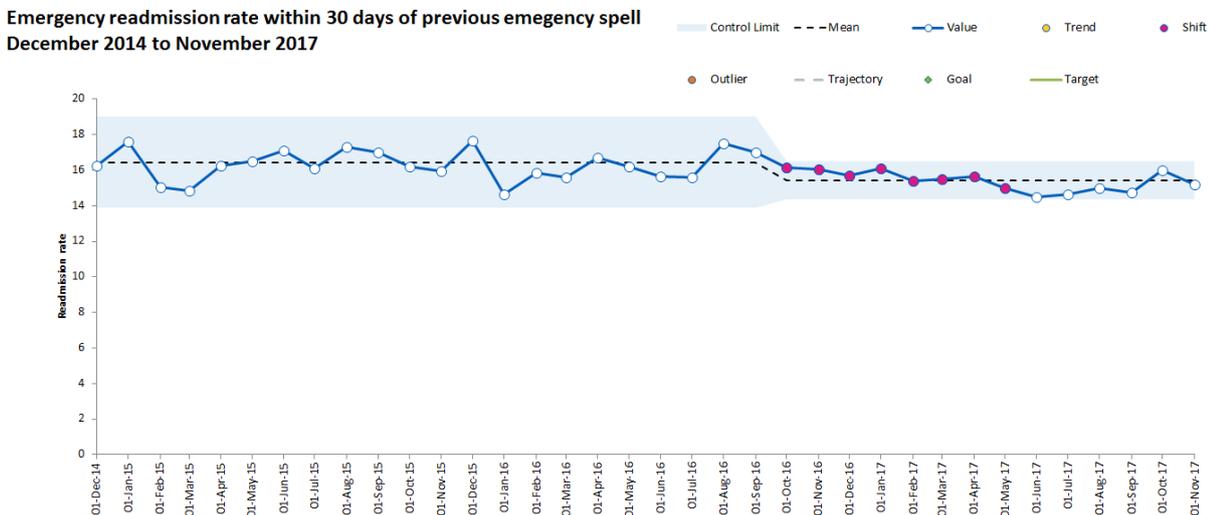
Chart: Emergency re-admissions, percentage within 30 days of an elective admission August 2018



Source: Stethoscope benchmarking tool, Methods Analytics 2019

30 day emergency re-admissions following a non-elective admission

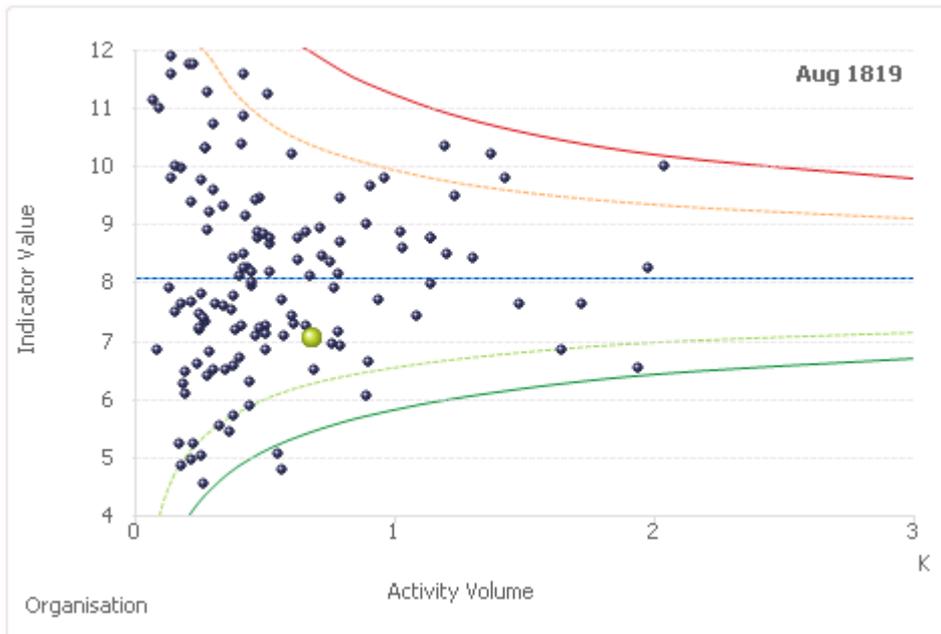
The chart below shows the proportion of patients re-admitted as an emergency following a non-elective admission in the previous 30 days between January 2015 and November 2017 (the latest available data). The average for April 2017 to November 2017 was 15.1%. This shows that there has been no significant change since a reduction that started in October 2016.



Source: Stethoscope benchmarking tool, Methods Analytics 2018

When comparing Royal Free London to benchmarks in August 2018 (the latest available data), this suggests that average length of stay did not differ from than the national mean by more than can be explained by random chance.

Chart: Emergency re-admissions, percentage within 30 days of a non-elective admission Apr-Nov 2017



Source: Stethoscope benchmarking tool, Methods Analytics 2018

Section 3: 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 2015 to January 2019 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 largely maintained since then. The positive shift in performance was driven by improvement at the Royal Free Hospital site, likely to be linked to the opening of the new Emergency Department in 2017.

For all areas we have maintained performance over the last year. Whilst we previously did include benchmarking charts for these measures, NHSE recommends that benchmarking is not used to compare providers due to the flexibility of local data collection methods and variation in local population.



A&E scores Friends and Family Test – positive responses



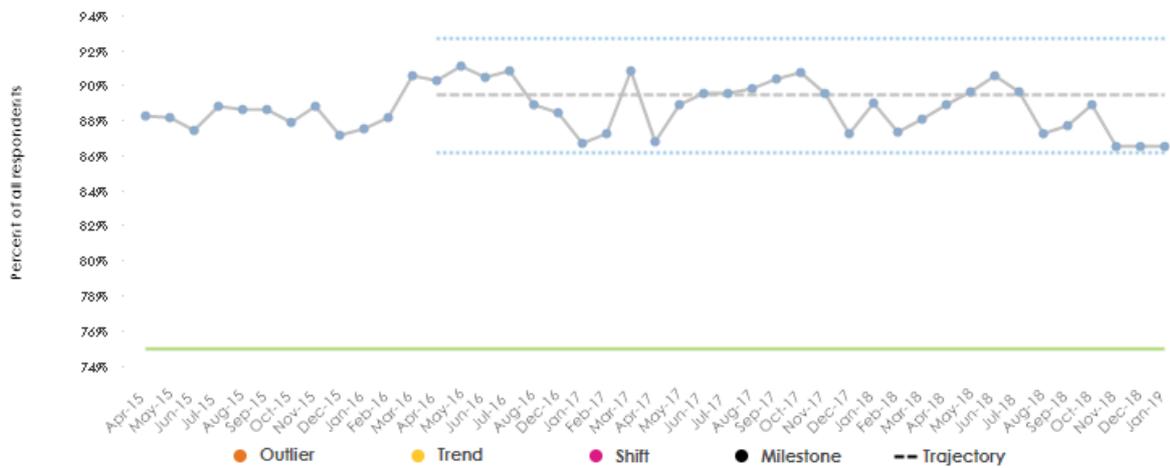
Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
84%	83%	81%	85%	84%	85%	85%	86%	84%	84%	82%	82%	84%

Source: Royal Free London NHS FT 2015-2019

The FFT scores for inpatients have remained compliant and stable over 2018/19. Any variation has been within expected limits.



Inpatient scores from Friends and Family Test – positive responses



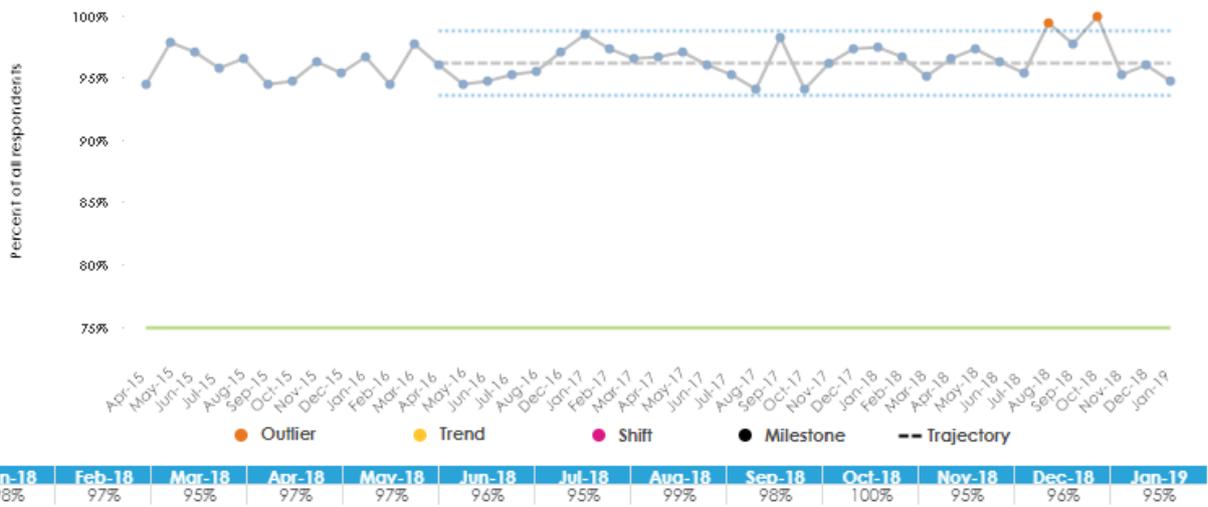
Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
89%	87%	88%	89%	90%	91%	90%	87%	88%	89%	87%	87%	87%

Source: Royal Free London NHS FT 2015-2019

The FFT scores for maternity have remained stable over 2017/18. Any variation has been within expected limits.



Maternity Scores from Friends and Family Test – positive responses



Source: Royal Free London NHS FT 2015-2019

Volumes of delayed transfers of care

This is the number of bed days per month that the trust lost to patients who were waiting for a transfer to social or NHS community care. Over the course of 2018/19, we have seen this number stabilise following a positive shift in performance from April 2017. We have been working closely with our local commissioners and social and community care providers to reduce this rate.

Volume of Delayed Transfers of Care (DIOC)



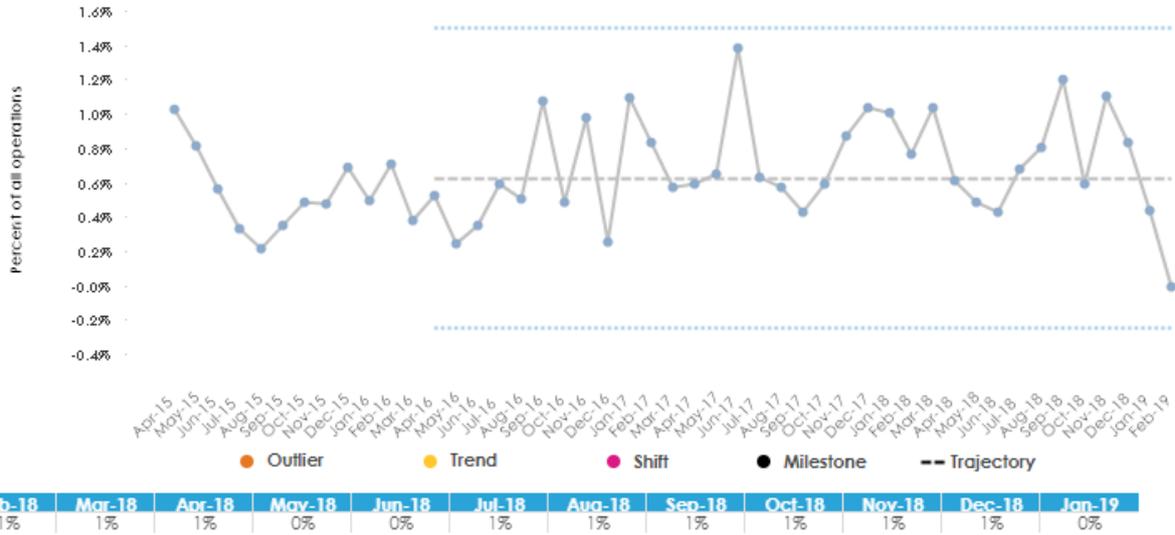
Source: Royal Free London NHS FT 2016-2019

Benchmark information is not available for this measure.

Cancelled operations rate

This is the volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and daycase operations. Over the course of 2018/19, this rate has remained within expected control limits.

Cancelled Operations rate



Source: Royal Free London NHS FT 2015-2019

Benchmark information is not available for this measure.

3.2 Performance against key national indicators

The following indicators are reported in accordance with national indicator definitions.

Indicators of Governance	Target	Q1	Q2	Q3	Q4	
Summary Hospital Mortality Indicator (rolling year average to end of quarter, Q3 and Q4 are unavailable)	<100	87.8	86.8	unavailable	unavailable	
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	>=95%	88.2%	86.4%	86.2%	85.4%	
**C difficile number of cases against plan	18/Qtr	16	22	21	21	
**Maximum time of 18 weeks from point of referral to treatment in aggregate for patients on an incomplete pathways (reported as arithmetic average of months in quarter/year waiting under 18 weeks)	>=92%	92.3%	88.9%	87.0%	83.1%	
Maximum 6 week wait for diagnostic procedures	>=99%	99.5%	98.8%	98.9%	99.5%	
**Cancer: two week wait from referral to date first seen						
All cancers	>=93%	93.6%	92.9%	94.0%	92.4%	
Symptomatic breast patients	>=93%	92.5%	93.7%	95.1%	93.7%	
**All cancers: 31 day wait from diagnosis to first treatment	>=96%	97.5%	96.9%	98.6%	98.4%	
**All Cancer 31 day second or subsequent treatment -						
surgery	>=94%	98.4%	96.0%	98.5%	95.2%	
drug	>=98%	100%	100%	100%	100%	
radiotherapy	>=94%	100%	100%	100%	99.1%	
**All Cancer 62 days wait for first treatment:						
from urgent GP referrals:	>=85%	83.5	79.2%	85.1%	84.4%	

		%				
from a screening service	>=90%	90.3%	96.3%	89.2%	94.2%	
Venous thromboembolism risk assessments	95%	96.6%	95.7%	95.9%	96.4%	

Section 3.4 Our Plans

This section contains an overview on our plans in regards to:

- Implementing seven day services
- Speaking up
- The Care Quality Commission

Seven day 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 Trust showed an improvement in its performance against the standards of the 7 Day services survey in 2018 compared with 2017. The key findings particularly for standards 2 and 8 were as follows:

Standard 2:

- The overall proportion of RFL patients seen and assessed by a suitable consultant within 14 hours of admission was 80% (March 2017 - 56%).
- The overall proportion of Barnet Hospital patients seen and assessed by a suitable consultant within 14 hours of admission was 88%.
- The overall proportion of Royal Free Hospital site patients seen and assessed by a suitable consultant within 14 hours of admission was 73%.

Standard 8:

For RFL Trust as a whole, the overall proportion of once daily consultant or delegated reviews where the patient required a once daily review and received this was 85% on a weekday and 82% on a weekend. Equally, for RFL Trust as a whole where the patient required twice daily reviews and received these was 83% on a weekday and 83% on a weekend.

- 57% of the once daily reviews were undertaken directly by a consultant on a weekday and 36% of these reviews on a weekend.
- 72% of the twice daily reviews were undertaken directly by a consultant on a weekday and 53% of these reviews on a weekend.

In April 2019 the Royal Free London will be undertaking a limited audit of specific specialties in order to meet the Board Assurance requirements for the 7 Day Audit Services. The specialties which will be audited will include those which did not meet the 90% standard for

consultant review within 14 hours of admission (Standard 2). For standard 8 patients on ICU/HDU under the above specialties will be audited as to whether they have had twice daily reviews. The following specialties will be surveyed:

Barnet Hospital	Royal Free Hospital
<ul style="list-style-type: none"> • Cardiology • Emergency Medicine • General Surgery • Paediatric Medicine • Trauma and Orthopaedics 	<ul style="list-style-type: none"> • Acute Internal Medicine • Cardiology • General Surgery • Geriatric Medicine • Infectious Diseases • Oncology • Trauma and Orthopaedics • Vascular Surgery

The audit will cover a sample of emergency patients admitted between 02/04 /2019 and 08/04 /2019.

The completed data will be validated by the Medical Director for the site.

Speaking up



Sir Robert Francis's 'Freedom to Speak Up' review in February 2015 highlighted the need for the creation of the National Guardian and Freedom to Speak up (FTSU) Guardians at every Trust in England as a 'vital step towards developing the right culture and environment for speaking up'.

This strategy sets out the trust's vision for an open and effective speaking up culture and how the outcomes will be measured to ensure that all of our staff feel safe to speak up. Having a healthy speaking up culture is an indicator of a well-led trust. We are committed to promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out. Our Board, Group Executive Committee and Local Executive Committees will support this agenda by:

- Role-modelling our world class care values and behaviours to promote a positive culture

- Providing the resources required to deliver an effective Freedom to Speak Up function; and
- Having oversight to ensure the policy and procedures are being effectively implemented.

Our Freedom to Speak up Guardian and other champions have a key role in:

- Helping to raise the profile of raising concerns in our organisation
- Providing confidential advice and support to staff in relation to concerns they have about patient safety
- Providing confidential advice and support in staff in relation to the way their concern has been handled.

Representatives of the trust are fully engaged with the National Guardian's office and the local network of Freedom to Speak Up Guardians in our region to learn and share best practice.

Our Strategy

The Trust will take the following actions to deliver this vision:

- Increase the level of awareness for all staff so they are clear about what concerns they can raised and how to raise them using the appropriate pathways;
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively;
- Ensure the FtSU Guardian and local speaking up champions are clear about their roles and responsibilities when supporting staff to raise concerns;
- Continue to increase the number of local speaking up champions across all sites, staff groups and backgrounds, so they are representative of the workforce.
- Provide regular communications to all staff (including those permanently employed on a full / part time basis, temporary workers and volunteers) to raise the profile and understanding of how to raise speaking up concerns;
- Communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality;
- Share good practice and learning from concerns raised, through a variety of mediums, with the key aim of fostering openness and transparency such as staff briefings, team meetings, intranet, social media; and
- Actively seek the opinion of staff to assess that they are aware of and are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning.

Outcome and measures

1. Annual staff survey results
2. Feedback from 'go see' visits and Board and Executive walk rounds
3. Feedback from structure walk rounds undertaken by FtSU Guardian and local champions
4. Regular review of speaking up issues being raised through other routes e.g. Datix, counter fraud etc
5. Number of channels available for staff to raise concerns including champions and other internal and external routes e.g. staff side, staff networks, national guardian office, CQC etc
6. Feedback from staff on the speaking up process once the complaint has been investigated
7. Quarterly FtSU updates for all staff via various methods e.g. staff briefings, social media, freepress, intranet etc.
8. Evidence that investigations are factually based and led by someone suitably independent in the organisation, producing a report which focuses on learning lessons and improving care
9. High level findings of cases provided to the Audit Committee on a bi-monthly basis
10. Speaking up policy reviewed annually.

Monitoring

A Freedom to Speak Up Annual Report will be presented to the Board each year by the Freedom to Speak Up Guardian and the Executive Lead for Speaking up which will include:

- An overview of the cases reported and the themes identified;
- Action taken within the last 12 month period;
- Planned action to be taken within the following 12 month period

Care Quality Commission:

In addition to the December 2018 core services inspection, the CQC undertook the Well Led and use of Resources inspection between 8 to 10 January 2019. The trust is awaiting the final report of these inspection.

We anticipate the most recent inspection report for 2018/19 and we continue to improve on areas identified from the previous CQC inspection in February 2016 and have achieved the following improvements in response to the 2016 report during 2018/19. 'should do' and 'Must do' information as used in the current draft.

Completed actions from CQC 2016 Report

Should dos:

Trust wide, arrangements around equipment storage should be reviewed so that shower rooms are not used. At Chase Farm Hospital, this was included in the development of the new building.

Royal Free and Barnet Hospitals should improve the termination of pregnancy pathway; the service was reconfigured with a new clinical guideline and pathway.

The trust should address the compliance with the National Emergency Laparotomy Audit (NELA) at Barnet Hospital; compliance for NELA has now improved.

The trust should introduce the use of POSSUM scoring. We routinely use P-POSSUM scoring in our emergency general surgery and it is a mandatory part of the booking process. However, we don't use CR-POSSUM for elective colorectal surgery and there are no plans or national guidelines for colorectal cancer recommending its use.

At Royal Free Hospital should identify a dedicated bereavement facility for women and families to use in or near the labour ward. A room within the Heath Birth Centre was identified; The Royal Free Hospital charity provided funding for the refurbishment.

Royal Free and Barnet hospital sites should ensure all staff interacting with children have an appropriate level of Safe guarding training. Compliance is >90%

Must dos

Chase Farm Hospital must review the selection criteria for cases at the Chase Farm hospital site; strict selection criteria was reviewed and agreed and is being reviewed periodically.

Nursing staffing levels on the children's ward on the Royal Free site must be improved; additional nursing staff recruited.

Barnet Hospital must address the inconsistencies in mandatory training records for clinical staff in Medicine. Data on MAST training is now only taken from one source.

<p>Chase Farm Hospital must review the selection criteria for cases at the Chase Farm Hospital site; strict selection criteria was reviewed and agreed and is being reviewed periodically.</p>	<p>Trust wide, arrangements around equipment storage should be reviewed so that shower rooms are not used. At Chase Farm Hospital, this was included in the development of the new building.</p>	<p>Royal Free and Barnet Hospitals should improve the termination of pregnancy pathway; the service was reconfigured with a new clinical guideline and pathway.</p>
<p>The trust should address the compliance with the National Emergency Laparotomy Audit (NELA) at Barnet Hospital; compliance for NELA has now improved.</p>	<p>Nursing staffing levels on the children’s ward on the Royal Free site must be improved; additional nursing staff recruited.</p>	<p>The trust should introduce the use of POSSUM scoring. We routinely use P-POSSUM scoring in our emergency general surgery and it is a mandatory part of the booking process. However, we don’t use CR-POSSUM for elective colorectal surgery and there are no plans or national guidelines for colorectal cancer recommending its use.</p>
<p>At Royal Free Hospital should identify a dedicated bereavement facility for women and families to use in or near the labour ward. A room within the Heath Birth Centre was identified; The Royal Free Hospital charity provided funding for the refurbishment</p>	<p>Royal Free and Barnet hospital sites should ensure all staff interacting with children have an appropriate level of Safe guarding training. Compliance is >90%</p>	<p>Barnet Hospital must address the inconsistencies in mandatory training records for clinical staff in Medicine. Data on MAST training is now only taken from one source.</p>

A summary of CQC “Must and should dos”

Annexes

Annex 1. Statements from commissioners, local Healthwatch organisations, Overview and Scrutiny Committees and council of governors

- **Commissioners:**
- **Healthwatch**
- **Overview and Scrutiny Committees**
- **Council of governors**

Appendices

Appendix a: Changes made to the quality report

The views of our stakeholders and partners are essential in developing our quality report.

Our report has changed in response to comments received following the distribution of the draft as follows:

This information will be included in the final report.

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 Tariff (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.
Cardiotocography (CTG)	Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy . The machine used to perform the monitoring is called a cardiotocograph.
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
Never event	Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

NICE: National Institute of Clinical Excellence.	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
Patient at Risk & Resuscitation Team (PARRT).	The Patient at Risk & Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP.
PEWS: paediatric early warning score.	A scoring system allocated to a patient's (child's) physiological measurement. There are six simple physiological parameters: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
SBAR: situation, background, assessment, recommendation.	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.
SHMI: summary hospital-level mortality Indicator.	The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
UCLP: University College London Partners .	UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).
VTE: venous thromboembolism.	A blood clot that occurs in the vein

**London Borough of Barnet
Health Overview and Scrutiny
Committee
Forward Plan May 2019**

Contact: tracy.scollin@barnet.gov.uk

Title of Report	Overview of decision	Report Of (<i>officer</i>)	Issue Type (Non key/Key/Urgent)
15 May 2019			
Quality Accounts 2018-19	Report on the Quality Accounts from NHS Service Providers 2018-19		Non-key
11 July 2019			
Integration Barnet CCG	Update on the two key programmes to support integration locally		Non-key
Suicide Prevention			Non-key
Barnet Hospital update	<ul style="list-style-type: none"> • Planning matters and parking • Patient meals at BH 		Non-key
28 October or 12 December 2019			
Breastfeeding Support Service	Update on co-design work and contract		Non-key
STP Update	Adult Elective Orthopaedic Surgery		Non-key
12 December 2019			
To be allocated			
GP Workload Collection Tool	Update on development from Barnet CCG		Non-key

Title of Report	Overview of decision	Report Of (<i>officer</i>)	Issue Type (Non key/Key/Urgent)
Health Provision Plans for Cricklewood NW2 and impact of Brent Cross South	Barnet CCG		Non-key
Update on surplus land owned by Finchley Memorial Hospital	Community Health Partnerships		Non-key

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