Appendix 1:

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

7. NHS TRUST QUALITY ACCOUNTS 2016-2017

North London Hospice

The Chairman invited to the table:

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

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

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

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

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

However

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

In addition:

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

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

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

The Chairman thanked the North London Hospice for attending.

Central London Community Healthcare NHS Trust (CLCH)

The Chairman invited to the table:

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

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

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

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

However:

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

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

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

The Chairman thanked the CLCH for attending the meeting.

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

The Royal Free London NHS Foundation Trust

The Chairman invited to the table:

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

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

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

However:

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

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

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

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

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