Health and Social Care Scrutiny Sub-Committee Agenda

To: Councillor Carole Bonner (Chair)
Councillor Margaret Mead (Vice Chairman)
Councillors: Kathy Bee, Sean Fitzsimons, Andrew Pelling and Andy Stranack

Reserve Members: Councillors: Sue Bennett, Pat Clouder, Bernadette Khan, Manju Shahul-Hameed, James Thompson and David Wood

Non Voting Co-opted HealthWatch Croydon Member: Gary Hickey

A meeting of the **HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE** which you are hereby summoned to attend, will be held on **Tuesday 16th May 2017** at **6:30pm** in **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

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5 May 2017

PRE MEETING FOR COMMITTEE MEMBERS ONLY:
Room G4 at 6.00p.m.
Committee Members are expected to attend.
If on the day you are delayed or unable to attend please contact Extension 62317 or the Town Hall Reception; Direct Line 020 8760 5525.

Members of the Public are welcome to attend this meeting. If you require any assistance, please contact the Scrutiny Team as detailed above.

AGENDA - PART A

1. Appointment of Healthwatch Croydon Co-Optee

To confirm the appointment of Gary Hickey

2. Apologies for absence

3. Minutes of the meetings on 21 March and 24 April 2017

To approve the minutes as true and correct records (to follow)

4. Disclosure of Interest

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality in excess of £50. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Business Manager at the start of the meeting. The Chairman will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

5. Urgent Business (if any)

To receive notice from the Chair of any business not on the Agenda which should, in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

6. Exempt Items

To confirm the allocation of business between Part A and Part B of the Agenda.

7. Annual Quality Account
South London and Maudsley NHS Foundation Trust (Page 1)

To receive and comment on the draft report of South London and Maudsley NHS Foundation Trust
A presentation will be given at the meeting, which will be available online after 11 May.

8. **Annual Quality Account**
Croydon Health Services NHS Trust (Page 53)

To receive and comment on the draft report of Croydon Health Services NHS Trust.
A presentation will be given at the meeting, which will be available online after 11 May.

9. **[The following motion is to be moved and seconded as the "camera resolution" where it is proposed to move into part B of a meeting]**

That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended.

AGENDA - PART B

None

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South London and Maudsley NHS
NHS Foundation Trust

DRAFT Quality Account for 2016/2017

NB: Report still to be formatted for publishing and will be externally published once contents agreed.

CONTENTS PAGE

Part 1:

Statement on quality from the Chief Executive of the NHS Foundation Trust

The annual quality account report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders.

This year has been an important year in improving the quality of the service we provide to both our patients and carers. We have made a really good start to our Quality Improvement (QI) work. Many staff have already attended training, and a raft of QI projects are now in train across the Trust. In the end, it will be our pursuit of quality and value that will deliver longer term sustainability. Most importantly we are continuing to deliver high quality care to all of the people who use our services. One way in which this is reflected is through external recognition – for example the individuals and teams who were winners in five categories at the recent Royal College of Psychiatrists awards.

Working in close partnership with the people who make use of our services, their friends, families, carers and local communities is key to our ability to support people in achieving the best possible outcomes for themselves. For QI to work within our trust it is key that the partnerships mentioned above run through our improvement projects at all levels of the organisation. It is with this in mind that training for staff has been developed to ensure co-production in this important area.

We recognise that valuing staff is an important feature in providing high quality care and in 2016 we held our first Trustwide staff awards, which was a successful day in recognising the key contributions staff make in delivering quality care.

The CQC carried out week long focussed inspections of both our Acute and MHOA pathways to ensure implementation of the actions plans following the 2015 inspection. At this point we are still awaiting formal written feedback on the outcome of these inspections, however initial verbal feedback has been positive in that identified improvements have been made from the previous inspection. However, we recognise that there are still areas we need to improve which were identified by the CQC and the subsequent action plans that are currently being drafted have helped provide us with an agenda when agreeing our priorities for the upcoming year.

The CQC's publication of its rating and full report can be found at the following website:
http://www.cqc.org.uk/provider/RV5

To our best knowledge the information presented in this report is accurate and I hope you will find it informative and stimulating.

Dr Matthew Patrick
Chief Executive Officer

A summary of successes and developments in 2016/2017

AREA	SUCCESS/DEVELOPMENTS
Care Quality Commission (CQC)	➢ Sustained the overall Inspection rating of 'Good' given in 2015. ➢ Acute and MHOA compliance inspections demonstrated improvements as a result of action plans.
ICT/Technology	➢ SLaM's Chief Information Officer (CIO) was ranked 55th in the UK top 100 Chief Information Officers
Research	➢ The Pioneering research registration scheme has had over 10,000 patients agree to be contacted to participate in research. Following the "*Consent for Contact*" (C4C) programme. ➢ SlaM was rated top mental health trust in the country for recruiting patients to clinical studies in October 2016 by National Institute for Health Research (NIHR) and Clinical Research Network (CRN).
Awards/Creditations	➢ In September 2016, the Director of the NIHR Maudsley Biomedical Research Centre won the prestigious "*Katon Research Award*" from the Academy of Psychosomatic Medicine. ➢ In October 2016, Forensic inpatient services won six awards in the Koestler Trust Awards. The awards were for art work done by service users from River House. ➢ The PiCup Clinic is shortlisted for the 2017 HSJ Value in Healthcare Awards. The awards are for NHS services that responded to the NHS' drive to improve the cost effectiveness of its care. The service is nominated for two awards. ➢ Seven researchers received prestigious "Senior Investigator Awards" from NIHR research wing of NHS. ➢ Organisers of the Schwartz Round won award for the Best Academic Poster at Points of Care Foundation's annual Schwartz Community Conference. ➢ In June 2016, the ward manager at Acorn Lodge inpatient children's unit was shortlisted for Nurse of the Year in the prestigious Nursing Times Awards. ➢ A SLaM pharmacist won UKCPA Patient Safety Award for their pilot scheme. It was for work in pharmaceutical care of patients on

	"*psychotropic*" medication in an acute hospital. ➢ Local Care Record won an award at eHealth Insider (EHI) Award held in September 2016. The category was "*Best use of IT to support integrated health care services*". The service joins up patient records between GP practices in Lambeth and Southwark with Guy's & St Thomas', KCH and SLaM. ➢ The National Adult Outpatient Neurodevelopmental Clinic won the "*Outstanding Health Services*" award at the Autism Professionals Awards held in March 2017 (National Autistic Society's).
External Organisations	➢ Public Health England (PHE) are working to promote NHS being tobacco free and they have encouraged NHS to follow SlaM, as SlaM is one of the first mental health trusts to be smoke free
24 hour crisis Line	➢ The SLaM 24 hour crisis helpline was one of the top ten most read stories in the "Mental Health Today" (MHT). The MHT is a guide to understanding and achieving the best in mental healthcare.
Other	➢ The Bethlem Hospital's new Gallery and Museum space in the original hospital administration building was shortlisted down to the last 4 for the national museum of the year award.

Table one: A summary of successes and developments in 2016/2017

…..and what we can do better.

We need to improve in the areas that the CQC inspectors judged to require further improvement in their last two visits, whilst the Trust is awaiting the final version report the areas raised verbally included;

Improve staff levels and vacancies, a reduction in prone restraint, individualised care planning.

All these have been translated into quality priorities for 2016/17.

Trust Activity

During 2016/2017 the Trust provided or subcontracted more than 255 services including inpatient wards, outpatient and community services, as well as serving the communities of south London, we provide more than 53 specialist services for children and adults across the UK including perinatal services, eating disorders, psychosis and autism.

SlaM has reviewed all the data available to them on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2015/2016 represents £321 million generated from the provision of relevant health services by SlaM for 2016/2017.

Part 2: Priorities for Improvement and statements of assurance from the Board

Our priorities for improvement for 2017/2018

Over the last year we have listened to feedback from service users, their families, carers, staff, local Healthwatches, staff, Council of Governors as well as commissioners and regulators. A Trust Quality priority setting event was held on the 22nd February 2017 with all our stakeholders. This feedback alongside feedback from CQC focused visits in January and March 2017 as well as Trust information from complaints, serious incidents and audits has helped us to identify our future priorities.

Quality Improvement

Over the last year the Trust has seen a drive to improve the quality of care we provide and the implementation of the Trust Improvement strategy by using Quality Improvement methodology. The Trust has made a really good start to our Quality Improvement work with many staff now trained in QI methodology. It is this pursuit of quality and value that will deliver longer term sustainability.

Mission Statement

Our long term vision is to create and sustain a culture of continuous quality improvement

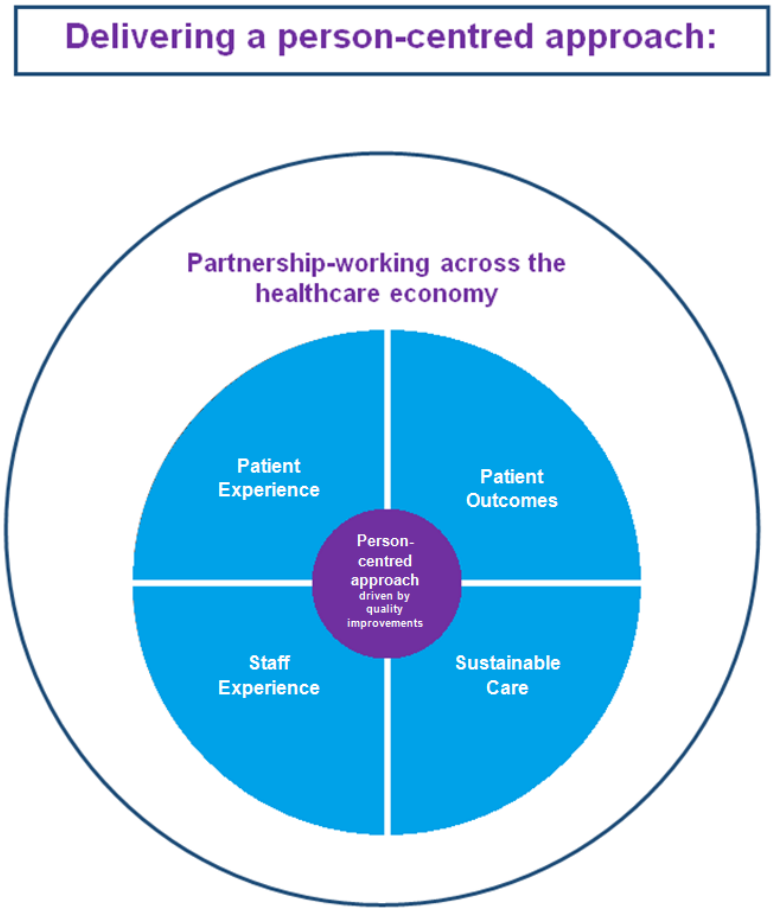
How we plan to do it

We aim to become an organisation with a culture of improvement that is based on service users, carers, staff and key partners working together. We want to improve **outcomes** and experiences for all people who use our services, and improve the **value** of the care we provide.

This is a bottom up approach, not top down. The programme will support staff to learn and use quality improvement methods, involving and engaging **everyone** in thinking about how to improve services.

Trust Improvement strategy

The aim of the Trust improvement strategy is to deliver the Right Care in the Right Place at the Right Time with the Right Value. This will be achieved through delivering a person centred approach, improving safety, experience, outcomes and delivering balanced budgets within agreed time frames. The strategy is outlined in the graph below.



Graph one: Trust Improvement Strategy

The quality indicators below align to both the Trust Improvement strategy outlined above and the nationally set areas of patient safety, clinical effectiveness and patient experience.

Quality Priorities 2017/2018

The priorities for 2017/2018 have been arranged under three broad domains which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be reported on in next year's Quality Accounts.

Quality Priorities 2017/18

Domain	Trust Improvement Strategy	Aim	Quality Indicator	How progress will be monitored
Patient Safety	Patient Experience	Reducing Violence	Reducing restrictive interventions; Inpatient areas Reduction of 50%	QSC, Board, Performance monitoring reports, STSC
	Patient Experience		Baseline: year 16/17 874 Violence and aggression reduction of 50% Inpatient areas 1819 Baseline: Year 16/17	QSC, Board, Performance monitoring reports, STSC
	Staff Experience	Staffing Levels	>50% wards reduction of average inpatient ward breaches per month Baseline: 20 wards	QSC, Board, Performance monitoring reports
Clinical Effectiveness	Patient Outcomes	A reduction in mortality for people with severe mental health problems	Further develop electronic systems to improve delivery of care (eOBs) across all Trust service areas. >50% of all Adult inpatient wards Baseline: 2 wards	QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare project Board
	Patient Outcomes		Ensure clinical and non-clinical staff have received level 1 physical health awareness training across all Trust service areas. Target 65% Baseline 0%	QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare Committee LEAP Education

				and training
	Patient Outcomes		Inpatients and patients of early intervention services will have 90% or greater rates for each metabolic screening parameter and where indicated, interventions. Target 90% Baselines(taken from YTD CRIS data extract financial year April 16 - March 17) Inpatients 77% metabolic screening, 60% intervention EI 52% metabolic screening, 61% intervention Patients with psychotic illnesses in longer term follow up (CPA) will have 65% or greater rates for screening / intervention rates. Target 65% baseline 41% metabolic screening, 51% intervention	QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare Committee LEAP Education and training
Patient Experience	Patient Experience	Ensure Family and carer engagement	75% of identified carers in all Trust service areas will have been offered a Carers Engagement and Support Plan. Baseline: 0 (new form) Performance Measurement TBC by Trust lead Cath Gormally	QSC, Board, Performance monitoring reports, Quality Dashboard, Carer and Family strategy meeting
	Patient Experience	Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate	10% reduction in admissions in Trust Inpatient Services. Reduction in admissions from 8 to 7 per day	
	Patient Experience		30% reduction in Length of stay (LOS) in Trust Inpatient services. Reduction in LOS from 45 days to 30 days	

	Patient Experience	To ensure that service users are involved in the planning of their care and there are personalised care plans.	>89% of service users will state that they feel involved in their care in all Trust service areas. Baseline 89% Source: Pedic	QSC, Board, Performance monitoring reports, Quality Dashboard
Staff Experience	Staff Experience	To improve structures and processes that facilitate positive staff experience.	Increase of 5 % of staff reporting the organisation **definitely** takes positive action on health and well being. (CQUIN) Baseline: 25% in 2015 staff survey Decrease of 5% of staff saying they have felt unwell in the last 12 months as a result of work related stress (CQUIN) Baseline: 43% 2015 staff survey	QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly) Staff survey

Table two: Quality Priorities 2017/2018

Care Quality Commission (CQC); Inspection September 2017 Results and Actions

SLaM is required to be registered with the CQC and its current registration status is registered, without condition. In 2016/2017 SLaM has participated in special reviews or investigations by the Care Quality Commission relating to the following areas; MHOA and Acute pathway. SLaM is currently awaiting the final report and findings which may result in a change in the grid below, which is the current overall and service specific ratings following the results of the comprehensive inspection of some of our services by the CQC in 2015.

SLaM has made the following progress by 31st March 2017 in taking such action outlined in table 2. The CQC has not taken enforcement action against SLaM during the period 2016/17.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community mental health services for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Forensic inpatient/secure wards	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good

Table three: Care Quality Commission Inspection Results

Following recent CQC visits, the table below is a summary of the quality improvement work currently being undertaken.

Area of Improvement	Actions undertaken
Staffing	• E- rostering redesign • Assessment days reviewed and changed. • Media and recruitment campaigns • Development of Band 4 Assistant practitioner role job • Staff retention initiatives implemented.
Food	•New menu introduced •Implemented interactive meal times •new catering contract •Forensic wards – Activity of daily living kitchen
Reducing Restraint	• The Trust has developed a reducing restrictive interventions three year strategy • The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014) • Continued roll out of violence reduction programme called 'Four Steps to Safety'
Environment	Above national average in PLACE scores in: • Cleanliness • Condition, appearance and maintenance • Privacy, dignity and wellbeing
Privacy and Dignity	• Vistamatic windows programme • Variety of daily activities and individual goal setting.
Creating and sustaining a culture of continuous Improvement	Since the CQC inspection in 2015 we have appointed the Institute of Healthcare Improvement and an internal Quality Improvement Team to support us all in our drive to improve the quality of everything we do, with transformation projects now taking place at a local ward and team level.

Table four: CQC Actions

Audit

Participation in National Quality Improvement Programmes

National quality accreditation schemes, and national clinical audit programmes are important for a number of reasons. They provide a way of comparing our services and practice with other Trusts across the country, they provide assurances that our services are meeting the highest standards set by the professional bodies, and they also provide a framework for quality improvement for participating services.

The national clinical audits and national confidential enquires that SLaM participated in, and for which data collection was completed during 2016/2017, 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. During that period SLaM participated in 100% of national clinical audits and 100% of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that SLaM participated in, and was eligible to participate in during 2016/17 are listed below:

- The 5 national, Prescribing Observatory for Mental Health - POMH-UK audits:
    - Use of sodium valproate
    - Prescribing for substance misuse: alcohol detoxification
    - Prescribing antipsychotic medication for people with dementia
    - Monitoring of patients prescribed lithium
    - Rapid tranquilisation
- The CQUIN 2016/17 Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- The national confidential inquiry into suicide and homicide by people with mental illness

The national clinical audits that SLAM participated in for which data collection was completed during 2016/17, are listed below.

The reports of six national clinical audits were reviewed by the provider in 2016/2017 and SLaM intends to take the following actions to improve the quality of healthcare provided [description of actions].

POMH-UK audits

Participation in the five Prescribing Observatory Audits (POMH-UK) managed by the Royal College of Psychiatrist's Centre for Quality Improvement

SLAM pharmacy has collected and submitted data for the 2016-17 POMH-UK audits, as required.

- Use of sodium valproate
- Prescribing for substance misuse: alcohol detoxification
- Prescribing antipsychotic medication for people with dementia
- Monitoring of patients prescribed lithium
- Rapid tranquilisation

Below is a summary of the findings from those audits:

i) Use of sodium valproate

NICE recommends that valproate should not routinely be prescribed for women of childbearing age. In addition to this, all patients prescribed valproate should have an annual physical health check. In 2015, the trust participated in the national POMH-UK audit of valproate prescribing for bipolar disorder. Results of the audit were reported by POMH in March 2016.

Overall, the rate of prescription of valproate for women of childbearing age was found to be higher in SLaM than in the average national sample (33% vs 8%). Physical health monitoring was evident for more patients prescribed valproate in SLaM than the national average.

ii) Prescribing for substance misuse: alcohol detoxification

Results of this national audit showed that patients admitted to a SLaM in-patient unit for alcohol detoxification are more likely to have their physical health monitored compared with the national average. However, assessment for Wernicke's encephalopathy and prescription of parenteral thiamine was lower in SLaM than in the national sample.

iii) Prescribing antipsychotic medication for people with dementia

NICE guidance recommends against the routine use of antipsychotics for patients with dementia. When considering an antipsychotic the risks must be discussed with the patient and their carers. In addition, antipsychotic use should be regularly reviewed and the indication documented in the patient's notes.

The trust recently participated in a national audit of the prescribing of antipsychotics for patients with dementia. The results showed that the rate of antipsychotic prescription in dementia was comparable with the average national sample. The indication for antipsychotic prescription was documented for the majority of SLaM patients. Medication reviews were evident for a higher proportion of patients in SLaM than in the average national sample. However, discussions of the risks of antipsychotics use were not evident for many patients in SLaM.

iv) Monitoring of patients prescribed lithium

Patients prescribed lithium must have their renal and thyroid function tested before starting lithium and at least every 6 months whilst maintained on treatment. Lithium plasma levels should be monitored at least every 6 months.

Results of the 2016 national audit showed that renal and thyroid function tests were completed before lithium initiation for more patients in SLAM than in the national average. However physical health and plasma level monitoring was evident for fewer SLAM patients during maintenance treatment than in the national sample.

v) Rapid Tranquilisation

Results of the 2015 audit showed that whilst prescribing for rapid tranquilisation was consistent with trust guidance physical health monitoring after administration of parenteral medication was

not evident for all patients. The trust has submitted data for the 2016 national audit of rapid tranquilisation. Results are due to reported by POMH later this year.

In the meantime, we have analysed data locally for a sample of patients who received medication for rapid tranquilisation. There appears to have been an improvement in physical health monitoring, when loosely defined as eyesight observations. However, physical health monitoring as recommended by NICE and the trust guidelines is still poor.

Data for this audit were collected from ePJS. It is possible that as previously suggested, physical parameters are recorded on MEWS chart, which are then not available on ePJS. The introduction of eOBS (electronic MEWS) will improve availability of information on ePJS,

vi) CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2016/17

The Trust participated in data collection and entry onto the NHSE online Webform Portal from December 2016 to February 2017. Confirmation was received from the Royal College of Psychiatrists. Results from the audit are pending.

Results received in 2015/16

National CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2015/16

During December 2015 and January 2016, the Trust collected and entered (onto the NHSE online Webform Portal) data for the National CQUIN audit. The Trust was assessed against the following parameters:

1. Smoking status
2. Lifestyle (including exercise, diet, alcohol and drugs)
3. Body Mass Index
4. Blood pressure
5. Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
6. Blood lipids

Performance against the CQUIN is presented as a single percentage figure for each provider, calculated on the basis of the following:

a) The denominator will be the total number of patients in the sample.

b) The numerator will be the total number of patients in the sample for whom there was documented evidence that:

- they were screened for all six measures listed in the CQUIN guidance during their inpatient stay; and

- where clinically indicated, they were directly provided with, or referred onwards to other services for interventions for each identified problem (with thresholds for intervention being as set out in NICE guidelines).

The data submitted to NHSE is outlined below:

Standard/Indicator	CQUIN SLAM I/P Q4 15/16 Target= 90% (*n*=100)
Monitoring of physical health risk	
Monitoring of smoking	99%
Monitoring of BMI	95%
Monitoring of glucose control	93%
Monitoring of lipids	89%
Monitoring of blood pressure	99%
Monitoring of 5 risk factors in those with established cardiovascular disease	N/A
Assessment of physical activity	43%
Assessment of diet	96%
Assessment of substance misuse	97%
Monitoring of alcohol consumption	97%
Intervention offered for identified physical health risks	
Intervention for smoking	97%
Intervention for BMI >/= 25kg/m2	85%
Intervention for abnormal glucose control	96%
Intervention for elevated blood pressure	88%
Intervention for physical activity	100%
Intervention for diet	91%
Intervention for substance misuse	81%
Intervention for alcohol misuse	67%

Table five: CQUIN Indicator 4a results

vii) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The Trust participated in the NCISH. Data for the NCISH reviewed suicide data over a 10 year period (2004-2014). Following a themed review of suicides in SLAM which was completed in 2015/16, a number of recommendations have been implemented, including:

- The launch of a new Risk Assessment Tool on ePJS

- Audits on the management of self-harm have been completed (the findings are outlined below in the Trust Clinical Audit Programme)

- Audits on carers' assessments and care plans have been completed.

Trust Clinical Audit Programme

The reports of 25 local Trust wide clinical audits have been completed in 2016/17 and where relevant, have been reviewed by the appropriate Trust committees for the development of actions to improve the quality of health care provided. A summary of some of the key audits are outlined below.

- **Management of Violence and Aggression: Physical Interventions**

The audit provided insight into practices of physical restraint within inpatient services. Most physical restraints were carried out on men; service users from BME backgrounds; and service users being treated under the MHA.

Physical restraints were mostly prompted by service user to staff aggression. Much of the behaviour which led to the restraint did not have a 'trigger' as such and was thought to be related to the service user being unwell at the time of the incident. However, where triggers were identified these centered around the themes of: medication, other services, property/ items and leave. These themes may be important areas for consideration in taking steps to reduce violence and aggression in inpatient settings.

The Trust is currently developing a 'Reducing Restrictive Interventions' Strategy which will provide a framework for clinical services in the reduction of the use of restraint, prone restraint and seclusion.

The 4-Steps to Safety violence reduction programme continues to be rolled out across the in-patient services.

- **Missing persons' policy for detained patients (AWOL) and informal patients**

An audit was completed in 2016 to assess compliance with the Trust Missing and Absent Persons' policy for detained patients (AWOL) and informal patients, 2015; and to identify any deficiencies in care and make recommendations to address these.

- Care provision was good in respect of reporting the incidents on DATIX, completing risk assessment, recording the AWOL Forms 1 and 2, and reporting patients as missing to the police.

- There was room for improvement for informing the police of high risk informal patients who had gone missing.

- The audit found key focus for improvement needed to be given to the documenting of leave care plans on EPJS and fact finding reports being completed for C Grade incidents.

The report recommended that leave care plans should be documented and updated as and when necessary in line with Trust policy, as well as improved documentation of risk assessments. The documentation of risk assessments is expected to improve with the new Risk Assessment Tool which was launched on EPJS in January 2017.

The completion of fact finding reports for Grade C incidents is also expected to improve since the launch of the electronic fact finding report on DATIX in April 2016.

- **Seclusion of Service Users**

This report focuses on examining the use of seclusion, compliance of staff to procedures and policy within the SLaM Seclusion Policy version 7(2015) and NICE Violence Guideline (2005). Authority to seclude a service user who is an inpatient has long been recognised as a necessary element in dealing with patients who pose a risk of significant harm to others and staff.

Overall, compliance with policy standards was lower than the performance from the previous audit.

- There was high compliance around the authority to initiate seclusion, doctors attending reviews after seclusion was initiated, and medical reviews being completed within 30 minutes of seclusion being initiated.
- Most of the service users had a risk assessment completed within the current spell at the time of the incident, and documentation for care plans were adequately evidence on EPJS.
- The characteristics of the seclusion rooms showed high compliance policy standards.
- More than half of the informal patients were assessed under the Mental Health Act shortly after being placed in seclusion.
- The emergency team was contacted for half of the incidents leading to seclusion.
- Care plans were formulated or updated for just over half of the incidents after seclusion was terminated or following decisions to continue seclusion.
- Service users were rarely informed of the reason for being placed in seclusion.
- Patient observations were inconsistent for all services users.

The report puts forward a number of recommendations aimed to improve the use of seclusion in compliance with the Trust policy. These include regular refresher training for staff; and improved documentation around the duration of seclusion, service user activities and physical observations on ePJS and seclusion forms. Furthermore, evidence of communication with service users regarding the reasons for initiating seclusion also needs to improve.

- **Self-Harm: Longer Term Management**

The NICE Clinical Guideline for Self-Harm: Longer Term Management details the management of single and recurrent episodes of self-harm and the longer term psychological treatment. The 2016 audit was undertaken to provide assurance that standards detailed in the NICE clinical guideline were being adhered to and where compliance was not met, recommendations were made to improve the care provided to service users.

- Care provision was good in respect of assessments of needs and risks, including for older adults and children.
- However, some room for improvement was identified with regards to documenting coping strategies, psychosocial and occupational functioning, and the need for dependent treatment.
- There were also gaps in identifying significant relationships that could affect the level of risk, and long term risks.
- There was high compliance with documentation around care plans and risk management plans.
- Psychological interventions for self-harm was offered for all patients and where appropriate pharmacological intervention alongside this.
- Gaps were highlighted in documentation regarding service user skills, strengths and assets, and employment.
- There were also gaps in documentation regarding occupational rehabilitation.

Following the report, there has been further promotion of the NICE guideline (2011) to psychiatric liaison nurses and doctors in training of recommendations and workshop / training sessions.

The report also recommendations the consideration of service user and carer involvement in training to address assessment of coping strategies, protective factors and roles of carers. There should also be improved understanding between liaison teams and occupation therapists of how to assess and address occupational health needs in the liaison setting.

- **Use of MCA and DOLs audit**

This audit assessed the current compliance with the Mental Capacity Act Policy (May 2015).

- Compared to the previous audit, the report found that fewer service users had a capacity assessment on admission.
- The most common reason for capacity assessments was for medication and treatment.
- There was little documented evidence of how service users were helped to make the decision as independently as possible.
- Best interest meeting documentation was variable, however there were high records of family/carer involvement.

- Staff awareness of the use of MCA and DoLS was high.

Further work in the Trust needs to be done to ensure capacity assessments are completed for all admissions. The report also recommends that service users should be encouraged to make decisions as independently as possible and this should be documented on ePJS.

- **Informal Patient Experience of Admission**

The audit assessed compliance with the Leave for Informal Patient Policy (2016) and if the rights detailed in the 'Being an Informal Patient' leaflet (2016) were being upheld.

- In a majority of cases, patients were allowed to leave the ward when they wanted, and where they were not, reasonable explanations were given.
- Where treatment was refused, this decision was mostly respected.
- A low percentage of service users were aware of their leave care plans.
- The leave poster was displayed on all of the wards visited; however it was not always positioned for obvious sighting.
- It was also found there were variations in the versions of posters being used among the wards.

The report recommends that staff should ensure informal inpatient service users are aware of their leave care plans, and wherever possible be involved in the care planning.

CAG leads have also been advised to check the correct Trust Informal Patient poster is clearly displayed on wards.

- **Food Satisfaction Survey**

An audit was completed in 2016 to ascertain patient satisfaction with catering and food provision offered to patients in inpatient services. The audit found:

- The monthly menu display board on the Acute wards was not clear in both content or visually.
- While patients appeared to overall enjoy the food, they stated that the quality of the meal was not always consistent.
- Patients were satisfied with portion sizes.
- There was a poor response regarding access to menu choices except for Forensic services, where patients stated they had both access to a menu and always received what they ordered.

- CAMHS patients were less satisfied than the rest of the organisation.

The outcome of the audit will be considered in future tendering processes.

Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by the South London and Maudsley NHS Foundation Trust (SLaM) for the reporting period, 1 April 2016 - 31 March 2017, that were recruited during that period to participate in research approved by a research ethics committee was 2337**.**

Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5 % of SLaM income in 2016/2017 is conditional on achieving quality improvement and innovation goals agreed between SLaM and any person they entered into an agreement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The value of these payments for 2016/17 was £5.6m.

Further details of the agreed goals for 2016/2017 and for the following 12 month period are available electronically at http://intranet.slam.nhs.uk/cquins/default.aspx.

Hospital Episode Statistics Data – HES

SLaM submitted records during 2016/17 to the Secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

	In-Patients - SUS data Apr 2016/ Feb 2017	Out-patients and Community –MHMDS Apr 2016/ Feb 2017 (provisional)
NHS No	98.2%	99.3%
GP Practice code	99.8%	98.1%

Table six: The percentage of records relating to patient care which included the patient's NHS No and GP practice code.

Information Governance

The trust's submission for the annual NHS Information Governance Toolkit for 2016-17 demonstrated **91% compliance** with national health and social care information governance standards (all Level 2 or above), which is satisfactory compliance. SLaM annual submission was independently assessed by internal audit with a reasonable assurance outcome.

The Trust is undergoing a digital transformation programme and has implemented a revised Information Governance Operating Model and continued to implement improvements around information governance compliance with national standards and key legislation. All IT staff were trained according to the CoBIT (Control Objectives for Information and Related Technologies) governance framework. The trust closely followed the publication of the new Caldidcott Review and the CQC data security review. The recommendations from these national reviews were incorporated in the overall IG action plan. The Local Care Record has been launched with trust's partnerhip. The LCR (Local Care Record) provides timely and secure sharing of relevant patient information between care professionals to support direct provision of care within King's Health Partners, and GP practices in Lambeth and Southwark. The trust joined the NHS Digital careCERTassure programme to develop and implement a robust cyber security programme. The information governance team developed new expertise around privacy, cyber security and risk management. The information risk assurance process was reviewed and updated. The IG team have implemented a dashboard for effective and timely monitoring of IG reviews, investigations and compliance reviews.

The Trust continues to provide clear, concise and up-to-date notification material to service users to ensure they are sufficiently information about the way their personal data is utilised with opportunities to opt-out of any scheme if they wish to do so.

Assurance around Information Governance is regularly presented to relevant IG Committees chaired by the Caldicott Guardian, the CCIO (Chief Clinical Information Officer) and the Chief Information Officer. The Board receives quarterly and annual updates on levels of assurance.

Payment by Results Clinical Coding

SLaM was not subject to payment by results clinical coding audit by the National Audit Office during the 2016/2017 financial year. Focus remains on improving the data completeness and accuracy of the Mental Health Clustering Tool which may become the payment by results currency in mental health. The Clinical Information System has built in alerts to remind clinicians that a mental health cluster has expired.

Improving Data Quality

SlaM will be taking the following actions to improve data quality:

- Clinical Academic Groups will be working collaboratively with the Business Intelligence and Performance Management teams to improve their data quality.
- Introduction of modern information reporting toolsets to improve access to information
- The Quality Improvement Initiative has raised awareness for the need ensure better data capture.
- Improved design of reports promotes the use of information for service improvement
- Data Quality of Mental Health Services Data Set (MHSDS) and other external submissions are routinely checked prior to the submissions.

National indicators 2015/2016

NHS Outcome Framework Indicators

SlaM is required to report performance against the following indicators:

3. Care Programme Approach (CPA) 7 day follow-up
2. Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)
3. Re-admission to hospital within 28 days of discharge

Care Programme Approach (CPA) 7 Day follow- up

Follow up within seven days of discharge from hospital has been demonstrated to be an effective way of reducing the overall rate of death by suicide in the UK. Patients on the care programme approach (CPA) who are discharged from a spell of inpatient care should be seen within seven days.

National Target	SlaM 2014/15	SlaM 2015/16	SlaM 2016/17	National Average 2016/17	Highest Trust % or Score 2016/17	Lowest Trust % Score 2016/17
Not specified (formerly 95%)	97.4%	**96.99%**	**97.1%**	96.2% (Q3)	100%	28.6%

Table seven: Seven day follow-up

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2016/17 published at the time of writing the quality account available at www.england.nhs.uk/statistics

SlaM considers that this data is as described for the following reasons: There continues to be a strong operational and performance focus on this indicator within the Trust.

The Trust performance continues to be comparable with previous years.

Access to Crisis Resolution Home Treatment (Home Treatment Team)

Home treatment teams provide intensive support for people in mental health crisis, in their own home. Home Treatment is designed to prevent hospital admissions and give support to families and carers.

The indicator here is the percentage of admissions to the Trust's acute wards that were assessed by the crisis resolution home treatment teams prior to admission.

	National Target	SlaM 2014/15	SlaM 2015/16	SlaM 2016/17	National Average 2016/17	Highest Trust % or Score 2016/17	Lowest Trust % Score 2016/17

Number of admissions to acute wards that were gate kept by the CRHT teams	95%	91.5%	**95.9%**	96.5%	98.7 (Q3)	100%	76.0%

Table eight: Access to crisis resolution
The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2016/17 published at the time of writing the quality account available at www.england.nhs.uk/statistics

Note that Psychiatric Liaison Nurse assessments of patients in Emergency Departments are included in the gatekeeping performance figures for previous years.

SlaM considers that this data is as described for the following reasons: SlaM failed to achieve the 95% standard in Quarters 1 and 2. In October the development of the Assessment and Referral Centre (ARC) and standardisation and development of the Home Treatment Teams has led to significant improvements and the thresholds have been met in Quarters 3 and 4.

SlaM intends to take the following actions to improve this indicator score, and so the quality of its services, by further development and embedding of the acute care pathway reconfiguration that has occurred in the financial year.

Re-admissions

The table below provides the emergency readmissions rate within 28 days for adult acute patients. The Health and Social Care Information Centre (HSCIC) has not published results for 2015/16 at the point of writing.

Readmissions to hospital within 28 days of discharge

	SlaM 2014/15	SlaM 2015/16	SlaM 2016/17
Patients readmitted to hospital within 28 days of being discharged	3.95%	2.7%	Pending

Table nine: Readmissions to hospital

Pending: The data is measured on discharges for the financial year. 28 days after the end of the year has to elapse to allow data capture of any readmissions for patients discharged at the end of the financial year. The data is then checked.

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

The routine monitoring indicator for readmissions for Mental Health contracts and Clinical Commissioning Groups (CCG) is readmissions within 30 days. The Benchmarking Network for Adult Mental Health report 2014/15 reports that, using a weighted population, the Trust had a 4.5% emergency readmission rate in comparison a national mean of 8.7% for emergency readmissions within 30 days.

SlaM intends to take the following actions to improve this indicator score, and so the quality of its services: To be completed once results are available

Service Users Experience of Health and Social Care Staff

	SlaM 2015/2016	SlaM 2016/2017	Highest Trust % or Score 16/17	Lowest Trust % or Score 16/17
Service users experience of Health and Social Care Staff	7.6	7.5	8.1	6.9

Table ten: Service Users Experience of Health and Social care Staff

SlaM considers that this data is described for the following reasons:

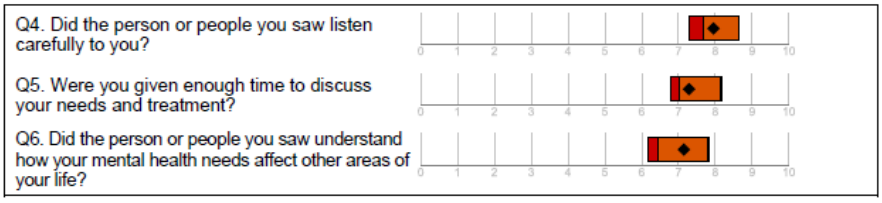
The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2016, overall SlaM scores for this section were about the same as other mental health Trusts. The average Health and Social Care Worker section score for SlaM patients was 7.5 with other Trusts performing in a range of 6.9 to 8.1. This is a slight decrease from the 2015 SlaM responses which gave an average score for this section of 7.6. However, two out of three questions maintained the same score as 2015 (Q4 and Q6).

Survey of people who use community mental health services 2016
South London and Maudsley NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Health and social care workers							
S1	Section score	7.5	6.9	8.1			
Q4	Did the person or people you saw listen carefully to you?	7.9	7.3	8.6	198	7.9	
Q5	Were you given enough time to discuss your needs and treatment?	7.3	6.8	8.2	199	7.6	
Q6	Did the person or people you saw understand how your mental health needs affect other areas of your life?	7.1	6.2	7.8	190	7.1	

Survey of people who use community mental health services 2016
South London and Maudsley NHS Foundation Trust

Health and social care workers



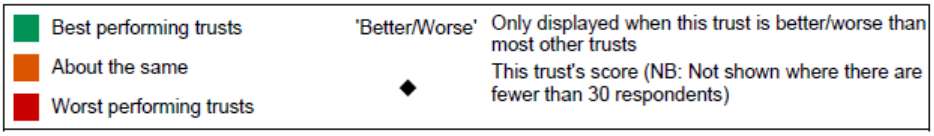


Table eleven: Survey of people who use community mental health services 2016

SlaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ensuring service users are involved in the planning of their care and co-producing a consensus statement for involvement in own care and taking forward a programme plan to deliver on the Trust's Patient and Public Involvement Strategy.

Core Indicators

NHS Improvement was formed in 2016 (replacing the previous Foundation Trust regulator Monitor). NHS Improvement published the Single Operating Framework with effect from October 2016. The framework replaced Monitor's Risk Assessment Framework and introduced new measures whilst discontinuing others or changing thresholds. The Quality Account guidance advises that the indicators included in both of these frameworks should be reported here.

Indicator	SlaM 2016/17	National Target	National Target Met
1. Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	89.7%	75%	✓
2. Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	99.3%	95%	✓
3. Care Programme Approach (CPA) 7 Day follow- up	97.1%	Not specified (formerly 95%)	✓
4. Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	96.5%	95%	✓

5. People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Pending	50%	
6. Data Completeness, Mental Health: identifiers – NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code	98.9%	97%	✓
7. Data Completeness, Mental Health: outcomes (for patients on CPA) – accommodation and employment status	57.4%	50%	✓

Table twelve: Core Indicators

Indicators 1 and 2 are based on collated monthly internal Trust reporting, NHS Digital (formerly Health and Social Care Information Centre) will publish full year performance later in 2017/18.

Pending: First Episode Psychosis waiting time – March data being validated and due for submission to NHS England before the end of April. Performance, following a failure to meet 50% in Quarter 1, has been in excess of the target and the Trust's recovery trajectory. For the rest of the financial year.

The indicator percentage of CPA patients with a review in 12 months is not specified within the Single Oversight Framework. The Trust continues to monitor this internally through performance reviews.

The indicator for Meeting commitment to serve new psychosis episodes by early intervention teams indicator has been replaced by the Early Intervention in Psychosis standard.

Delayed Transfers of Care

The indicator 'minimising delayed transfers of care' for mental health trusts is not included in the Single Oversight Framework but the indicator was selected for quality report assurance so therefore is included in the Quality Account.

Note: The month of March is currently being validated with clinicians and agreed with social care prior to its submission to NHS England on 24 April 2017. Quality assurance audit has so far taken place for data covering April to February.

Patient safety incidents resulting in severe harm or death

The Trust records all reported incidents on a database, in order to support the management of, monitoring and learning from all types of untoward incident. In addition patient safety incidents are uploaded to the National Reporting and Learning Service (NRLS) for further monitoring and inter-Trust comparisons. The NRLS system enables

patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.

The process of reporting Trust data to the NRLS and NRLS publication of national data is retrospective by nature. For the latest bencharked data, SlaM reported:

NRLS Data Q3-Q4 15/16	SLAM 15/16	Average for Mental Health Trusts	Highest Trust % or Score 15/16	Lowest Trust % or Score 15/16
Reported Incidents per 1000 bed days	23.18	42.02	85.06	14.01
Percentage of incidents resulting in severe harm	0.3%	0.4%	2.3%	0.0%
Percentage of incidents reported as deaths	0.4%	1.0%	5.2%	0.1%

NRLS Data Q1-Q2 16/17	SLAM 16/17	Average for Mental Health Trusts	Highest Trust % or Score 16/17	Lowest Trust % or Score 16/17
Reported Incidents per 1000 bed days	22.05	46.02	88.97	10.28
Percentage of incidents resulting in severe harm	0.3%	0.4%	2.9%	0.0%
Percentage of incidents reported as deaths	0.4%	1.1%	10.0%	0.1%

Table thirteen: NRLS (National Reporting and Learning Service) Data

Duty of Candour 2016/2017

Since April 2016, the following measures have been taken regarding duty of candour:

1. A Learning Lessons Half Day event took place at the Ortus on 19.04.17 with over 40 attendees.
2. The PALs service has produced a video aimed at staff which gives advice on how and when to use the duty of candour.
3. The Practical Guide to Structured Investigations training continues to provide education on how and when to use the duty of candour.
4. The Patient Safety intranet website provides practical advice and duty of candour document templates for staff.

5. The mandatory Datix (Trust Incident reporting system) fields for the recording of Duty of Candour were updated in March 2016 and continue to be used and monitored. The entries regarding duty of candour on Datix have been used to inform a re-audit.
6. A re-audit of the duty of candour was conducted and completed in April 2017. Initial findings indicate that since the previous audit in July 2014, the following is to be noted:

Positive points

- Verbal, face to face and written communication was much improved with service users and family (82.5%).
- Apologies are being given more often for both sympathy and admission of responsibility.
- Most cases do record asking the family if they had any questions for the investigation (80%).

Areas for improvement

- Minutes with the service user / family / carer were not recorded for the majority of pre-investigation meetings and required items were not recorded.
- 17.2% of SI cases recorded an offer to meet the service user / carer / family and feedback the investigation, which appears to have slightly decreased from the previous audit.

Part 3: Review of quality performance 2016/2017

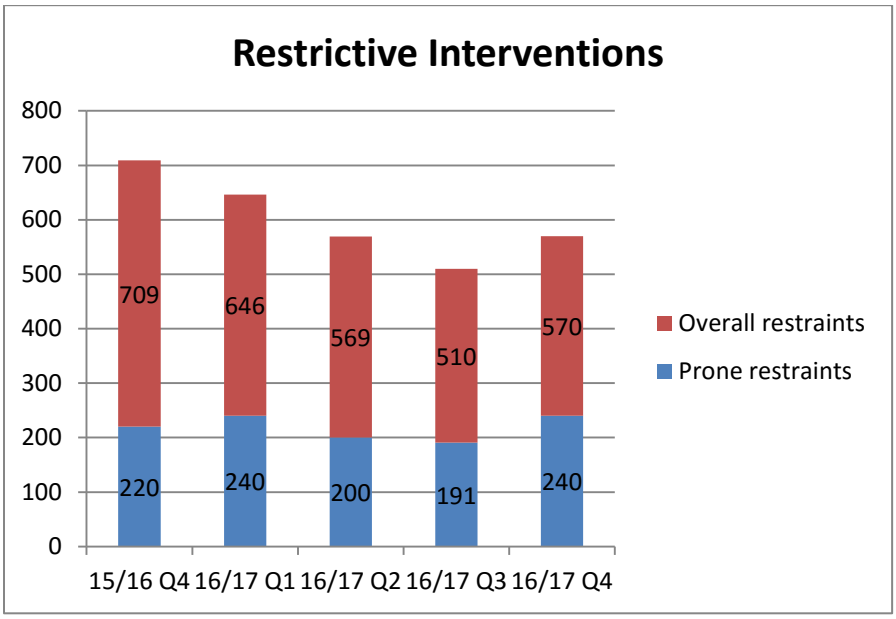
Review of progress made against last year's priorities

Our 2016/2017 quality priorities were selected after consultations with stakeholders and staff from our services. The following summarises progress made against each priority over the year.

Priority One – Patient Safety: Reduce the use of restrictive interventions applied to service users

Target	Reduce any use of restraint that includes prone restraint by 20%. Baseline: 220 in Q4/2017
Measure	Datix incidents in Q4/2016
Headline	**This was not achieved.** Datix incidents in Q4/2017 showed 240 restraints which included prone restraint. Overall, the number restraints in the Trust have decreased by

19.6%. However, the number of prone restraints have increased by 9.1%



Graph two: Restrictive Interventions

In Quarter 4 2015/16, 31% of all reported restraints were prone. Although the overall number of restrictive interventions used has reduced, 42.1% of the reported restrained in Quarter 4 2016/17 are prone. The overall data may suggest that in general, the management of violence and aggression has improved as well as reporting of restraint as per recommendation by the CQC following the comprehensive inspection in 2015.

The Trust internal audit on physical interventions in 2016 found that prone restraint was no longer the most common position used, compared to the findings of the audit completed in 2012.

A three year strategy to reduce restrictive interventions has been developed by the Trust and will be ratified in 2017. The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014) and other relevant national guidance including NICE guideline NG10. The strategy delivery is monitored by the Trust Safe and Therapeutic Services Committee.

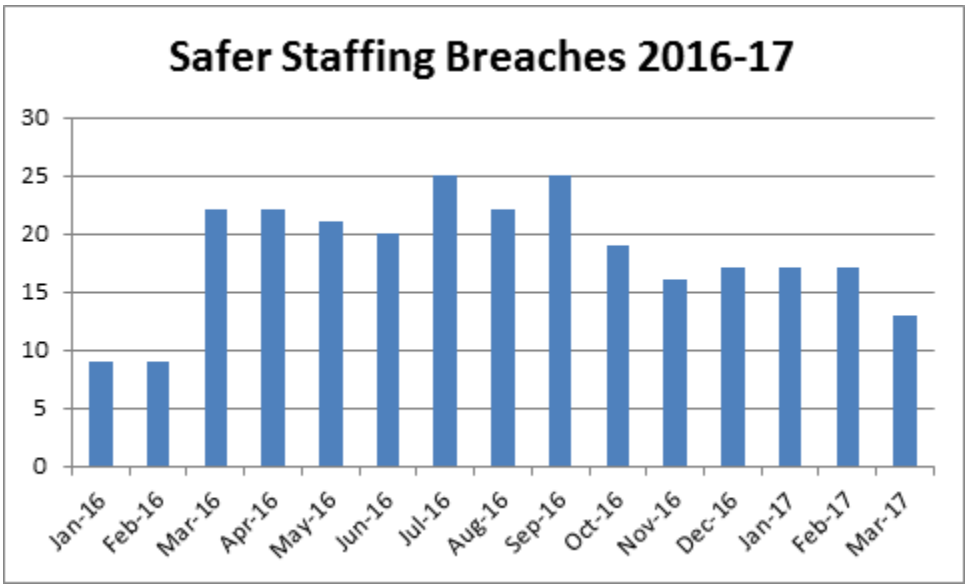
As part of this strategy the trust is in the process of implementing a violence reduction programme called 'Four Steps to Safety' which is being delivered collaboratively with Devon Partnership NHS Trust and is sponsored by the Health Foundation.

The Four Steps to Safety project is a system for safer care and uses a series of evidence based clinical interventions which are implemented using quality improvement methods. The project aims to reduce the levels of violence and aggression by 50% across all inpatient wards achieving better and safer care for the patients and better, safer working environment for the staff. An important part of the project is to enable clinical staff to embed a system of care which is proactive, rather than reactive.

This work was designed and is delivered in partnership with people with lived experience of inpatient services. The programme is being delivered to 48 inpatients wards across the trust and is due to be completed by September 2017.

Priority Two – Patient Safety: Safer staffing

Target	To reduce the number of wards breaching agreed Trust minimum safe staffing levels by 30%. Baseline: 15 Wards
Measure	Safer staffing monthly returns – Safecare
Headline	**We did not achieve this target** Between April 2016 and March 2017, the average number of wards with staff breaches per month was 20.



Graph three: Safer Staffing Breaches June 2016 – March 2017

Process and system improvements Recruitment and Retention

The Trust has worked hard to increase its presence across London and the country. We have attended RCN recruitment Fairs and hosted successful open days at the Bethlem, Kent, Maudsley and Lewisham.

We have had a timetable of monthly assessment centres for Band 5 nurses where we have seen a month on month increase in attendance due to our advertising campaigns in the Metro/Evening Standard and local newspapers.

We have also had a Learning Disability conference to showcase and celebrate the Trusts Learning Disability nurses. It was a widely promoted event. We invited university students and many were expressed an interest to work for the Trust once they qualified.

Nationally, a scheme has been developed to create band 4 Nursing Associate roles, trained at Foundation degree level. Whilst the Trust watches this development with interest, as currently defined, these roles appear better suited for acute general Trusts than Mental Health organisations.

Therefore, in partnership with the other two mental health Trusts who comprise the South London Partnership – Oxleas and South West London and St Georges, an agreement has been reached to take a common approach to the development of band 4 Assistant Practitioners (AP) staff to work in inpatient care areas.

Assistant Practitioners will receive robust training with our partner University LSBU, including an initial two week course focusing on mental health practice and then complete a Foundation degree level course via day release for 18 months.

The first cohort of 12 students from SlaM embarked on this course; the first two 'step up' weeks have been completed.

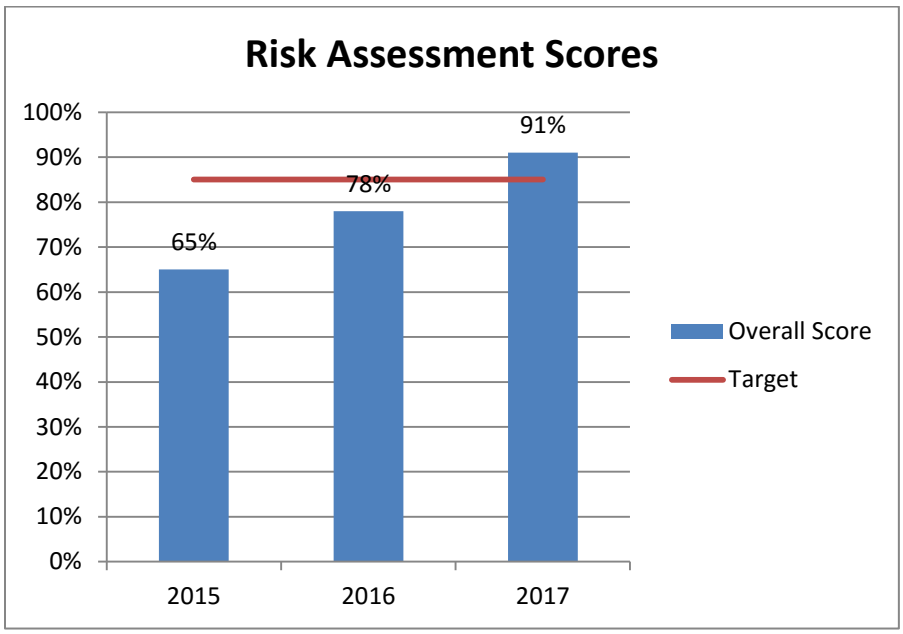
The effect of changes in the workforce will be monitored by seeking service user and staff feedback, and monitoring indicators including complaints and compliments and incident data.

Erostering:

Ward managers regularly attend e –roster efficiency meetings; here they discuss the best practice methods in order to plan staff shifts six weeks in advance. This reduces the level of agency staff. The process and systems within erostering requires continual improvement including building capacity within the team to roll out the SafeCare system across the trust.

Priority Three – Patient Safety: Risk Assessments

Target	85% of service users in in-patient services and community service users under CPA will have a full risk assessment completed for each in-patient admission or CPA review. Baseline:78%
Measure	This will be measured through clinical audit in Q4/ 2017.
Headline	**We achieved this target** The audit sample taken from Q4 achieved 90.8% Inpatient services achieved 95.6% Community services achieved 85.7%



Graph four: Risk Assessment Scores 2015 - 2017

Since 2015, the completion of risk assessments has increased by 26%.

Over the summer of 2016 the trust undertook a comprehensive review and redesign of the electronic PJS which has helped to ensure the risk assessment process is streamlined, understood and standardised across all clinical services. Completion of risk assessments is audited on a monthly basis and escalated to CAG leadership on a quarterly basis as a governance monitoring structure.

In January 2017, the new Risk Assessment tool went live on ePJS, replacing the previous Brief Risk Screen, Full Risk Screen and Risk Plan. In-patient services were given a 4 week transition period ending in March 2017, and community services were given a 20 week transition period which will end in June 2017.

All clinical staff have to complete risk assessment training every three years as mandatory training and with the development of the new risk assessment template and a standardise audit tool, training is currently being roll out to all clinical staff in our inpatient settings to reflect this.

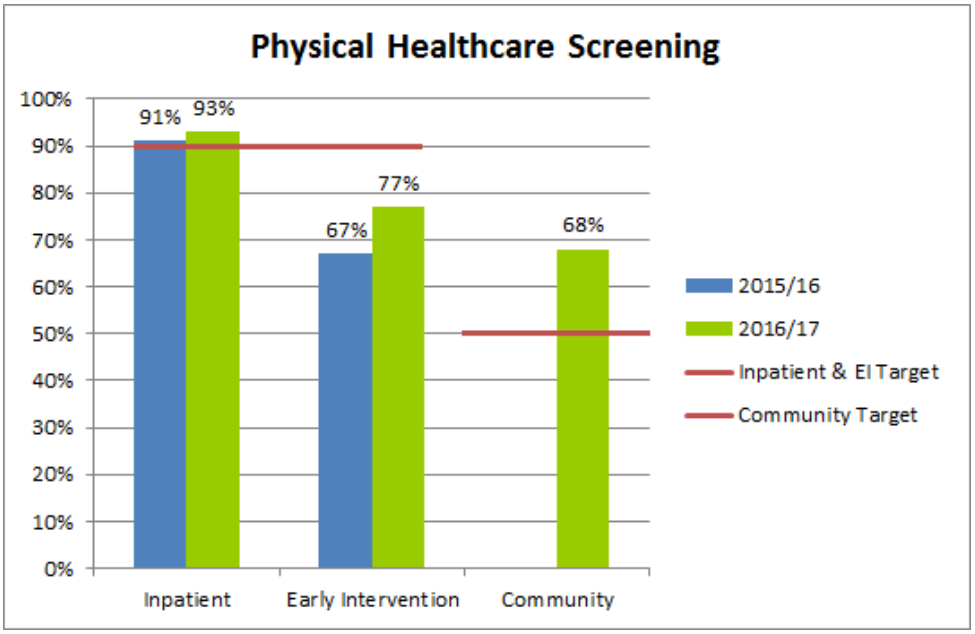
To ensure we are identifying and mitigating against risks associated with individual patients all patients have a full risk assessment within four hours of admission. Risk assessments are reviewed weekly at ward rounds and clinical review meetings, or as required in the case of an event during the patient's stay on the ward. Collaborative risk assessment and management has also been integrated into the inpatient group treatment programme.

The 2017 internal audit found the new Risk Assessment Tool was already in use in 49.4% of the sample.

Priority Four – Clinical Effectiveness: Physical healthcare screening

Target	90% of both in-patients service users and early intervention service users. 50% of community service users on CPA audited will have had an assessment of each of the key cardio metabolic parameters; Smoking status; Lifestyle (including exercise, diet alcohol and drugs); Body Mass Index; Blood pressure; Glucose regulation and Blood lipids. They will be offered interventions based on need. Baseline:85.4% Inpatients; Community Zero baseline(new scope)
Measure	Audit for CQUIN submission in Q4/2017 Baseline: Inpatients 85.4%, Community (no baseline,- new priority)
Headline	**We partially achieved this target.** The audit sample taken from August/September Q2 patients achieved 79.3% Inpatients 93%, EIP 77% and Community 68%

In 2016/17, the CQUIN target for physical healthcare excluded Early Intervention service users from the sample. An internal audit was completed to include Inpatient, Early Intervention and Community patients.



Graph five: Physical Healthcare Screening

The internal audit showed improvements in the completion of screening since the previous year and interventions offered.

Priority Five – Clinical Effectiveness; Care planning

Target	>89% of service users will state that they feel involved in their care.
Measure	This will be measured through the patients survey results in response to the question 'Do you feel involved in your care?' Baseline Figure: 89%
Headline	**We achieved this target.** 89% of service users state that they feel involved in their care (n=10,628) (89.08% to 2dp).

The Trust will maintain and improve on this target by co-producing a consensus statement for involvement in own care and taking forward a programme plan to deliver on the Trust's Patient and Public Involvement Strategy.

Priority Six – Clinical Effectiveness; Developing electronic systems to improve the delivery of care

Target	50% of inpatient teams using electronic observations in practice (eobs); technology to enable paper free patient observations. Baseline: 0 Wards.
Measure	No. of wards using eobs
Headline	**We did not achieve this target** 2 wards are using eObs (Johnson and ES2). AL1 has completed training and is ready to start using the new system. 6 more wards are being trained and will be prepared to start implementation in May 2017.

Technical Development

The developers are working towards fully replacing the physical health chart currently being used trust wide to record physical health observations, MEWs, with a digital tool.

They have alongside this work, been making some improvements to some of the functionalities on the system being piloted on ES2 and Johnson unit. The latest release in March, saw some useful additions to the system that both improve its user friendliness as well as the

effectiveness in improving the process of recording and accessing meaningful data and alerts that contribute to timely clinical decision making. The full replacement of the paper chart is expected to be complete by the end of April, a slight delay from earlier projection.

Wards implementing eObs:

ES2 and Johnson PICU wards are no longer considered to be pilots wards as eObs is now fully established into the ward routine and the system is used regularly to carry out physical health observation. Both wards played a significant role in influencing the changes and further developments that have been made to the system since the pilot started almost a year ago.

The latest upgrade to the software has significantly improved the system usability resulting in a noticeable increase in the rate of observations completed, especially on ES2 which is the ward that has been using the system the longest. This increase is following an initial slump which was partly due to system usability issues staff were experiencing. In terms of device/system safety, no adverse events have been reported since both wards started using the electronic system and neither ward have ever had to resort back to paper recording due to system failure.

Graphs six and seven: Trends electronic physical health observations in pilot wards

Integrating QI methodology with the roll-out of eObs.

AL1, older adults unit is the first ward to be trained to use QI methodology in its implementation of eObs. The ward manager and a nominated champion had the three days QI training from the Institute of Healthcare Improvement (IHI) followed by a the whole team training on e-Observation and the new physical health tool, NEWS. The ward is also allocated additional support from the QI team to guide them through the process of setting up their PDSAs and measures to monitor improvement. AL1 is now ready to go live once IT support is in place. The learning from their implementation of eObs using QI methodology will be useful for the roll-out to the rest of the trust..

Trust Roll-Out

The Ladywell site in Lewisham, is half-way through the training and preparation for eObs implementation. It is anticipated that up to 80% of staff in each ward will be trained by the 28th April before implementation can go ahead. Subject to the progress of the software development, Implementation will start from the first week of May 2017.

The next site to implement eObs will be the Maudsley following successful implementation in Ladywell.

Phase two of eObs

The second phase of eObs will be focused on developing the mental health observation tools and the enhancement of the task management functionalities on the system.

This is expected to start from June while the physical health aspect is being rolled out.

Priority Seven – Patient Experience; Reducing the number of Acute out of area treatments

Target	A 40% reduction in the number of adult patients admitted to external providers (overspill). Baseline Figure: Yearly average of 46.1
Measure	This will be measured in monthly performance meetings and data extracted. Complaints data will also be monitored.
Headline	**We did not achieve this target.** Average number of admissions/ transfers to private overspill beds: 2015/16 – 46.1 2016/17 – 40.7 There has been an improvement in the last year, but only a 13.3% reduction.

In November 2016 the Acute care CAG published it's two year plan.

In essence the plan is to control admissions into beds and reduce the length of stay through systematic sustained quality improvements, thereby eliminating the need for overspill and improving the patient experience.

	2015/16	2016/17
Average for the year (external plus McKenzie)	46.1	40.7

Table fourteen: Overspill averages 2015 to 2017

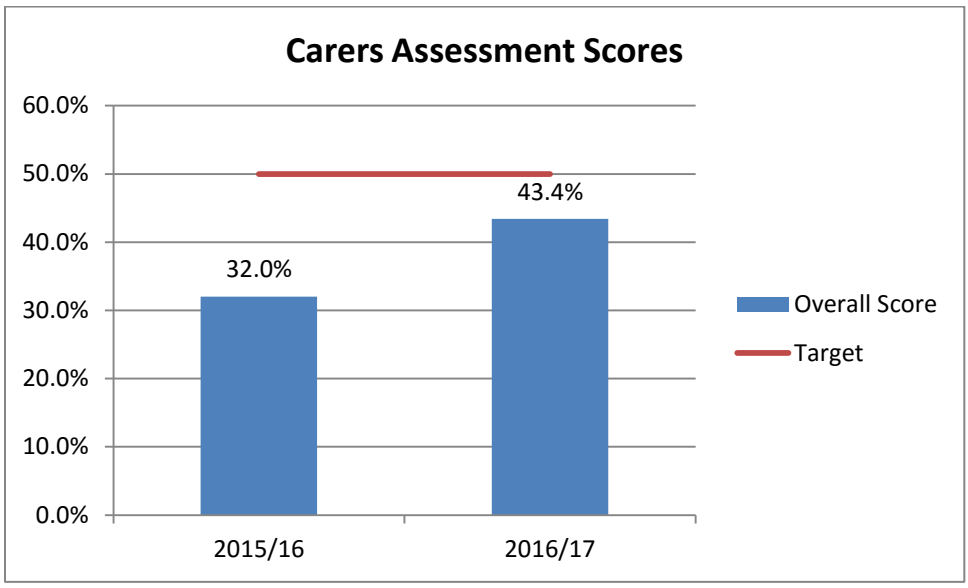
The Trust intends to reduce the average length of stay from 45 days to 40 days, which in turn will contribute to preventing external overspill.
Throughout 2017/18, through a series of quality improvement projects we aim to further reduce the average length of stay to 35 days.

Getting the average length of stay to 35 days and creating four acute wards for each borough (as well as the PICU provision and the early intervention ward) will allow the wards to run at 85%, with a target four hour wait time for admission.

In 2018/19 we plan to further decrease the length of stay to 30 days. Once this is achieved the CAG executive believe that this will be a good time to further review the skill mix of staff on the wards.

Priority Eight – Patient Experience; Carer's assessments and associated care plan

Target	>50% of identified carers will have been offered a carers' assessment and a carer's care plan. Baseline Figure: 32%
Measure	This will be measured through internal audit.
Headline	**We almost achieved this target.** The internal audit achieved 43.4% 43.4% of identified carers were offered a carers' assessment.



Graph eight: Carer Assessment Scores 2015-2017

The previous audit undertaken in 2016 showed performance in offering carers' assessments was 32% and an action plan was sought to address this poor performance and achieve a target of 50% by April 2017.

A key challenge of this work has been to design an assessment tool which was tailored for the needs of mental health carers but also complied with the Care Act and was able to be developed on the ePJS system. Following involvement from carers and staff, a 'carers' engagement and support plan' was developed on ePJS and went live at the end of November 2016 and the old forms were removed. This tool enables staff to assess the presenting needs of the carer, offer advice, information and support and share the support plan with the carer. The tool has links to the four borough local authority forms and guidance on how to access a formal carers' assessment under the Care Act if one is indicated. Staff feedback on the forms has also been encouraged and received and will be used to make further design improvements.

In order to have local leadership and ownership of carers' assessments, each CAG nominated a carers' lead to help to develop the tool and to champion carers' assessments in the CAGs to facilitate an improvement in performance. The initial launch of the forms was, in general, positively received by staff and since the end of November 2016, approximately 300 carers' engagement and support plans have been completed.

However, the current Trust-wide position of patients on CPA with an identified carer offered a carers' assessment is 42.5%. 6.3% of the assessments completed used the new form. Carers' assessments and care planning will continue to be a quality priority in 2017/18, and further work will be completed to promote the use of the new Carers' engagement and support form.

Priority Nine – Clinical Effectiveness- Quality of environments and food within in-patient services

Target	Patient Led Assessments of Care Environments (PLACE) and Food audit scores will achieve overall > 89.95%. Baseline 89.95% (food)
Measure	PLACE audit reports and hotel services Spot Light reports will be monitored and reviewed.
Headline	**We achieved this target.** The Trust scored 95% overall for the PLACE audits. The food audit score was lower than the previous year and equal to the national average (88.07%). However, all other audit scores were higher than the national average.

	Cleanliness	Food	Condition, Appearance & Maintenance
Trust Score 2016	99.26%	88.07%	97.84%
National Average 2016	98.06%	88.07%	93.37%
% above National Average	1.20%	0.00%	4.47%

Table fifteen: PLACE audit scores 2016

We involved our service users in assessing the quality of our care environment as part of the PLACE inspection between February and June 2016.

A team made up of service users, staff and an external assessor from another trust inspected 40 of our wards.

We have exceeded national averages in every PLACE assessment area except 'food', and are taking action to address this. Having changed menus, we currently maintain the national average for food. We are looking to improve this by refining our current catering and domestic food contracts and moving to fully cooked fresh food in Spring 2017.

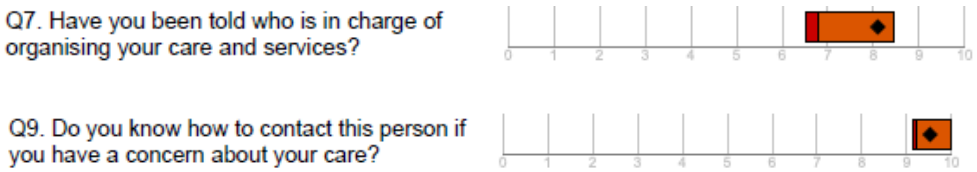
The patient environment and the settings in which we deliver our clinical services is a clear factor in good healthcare delivery. Through PLACE assessments we demonstrate a clear commitment to delivering a well maintained, clean and safe environment for everyone who uses our services.

National patient survey of people who use community mental health services: SlaM report 2016

The national patient survey was returned by 206 SlaM patients giving a response rate of 26%; this is slightly lower than the national average response rate of 28% for all mental health trusts. SlaM performed 'about the same' as all other trusts nationally for every question in the 2016 survey of people who use community mental health services and therefore 'about the same for each separate survey section.

SlaM's highest three performing questions are as follows:

Section 2: Organising care



Section 7: Treatments

Graph nine: SLAM's patient survey highest three performing questions

The three questions where the Trust had the greatest increase in performance in 2016 compared to 2015 are providing help or advice with finding support for finding or keeping work (+11.2%), knowing who to contact out of office hours if you have a crisis (+10.1%) and being involved as much as the service user wanted to be in discussing how their care is working (+4.6%).

National Staff Survey 2016 – Results

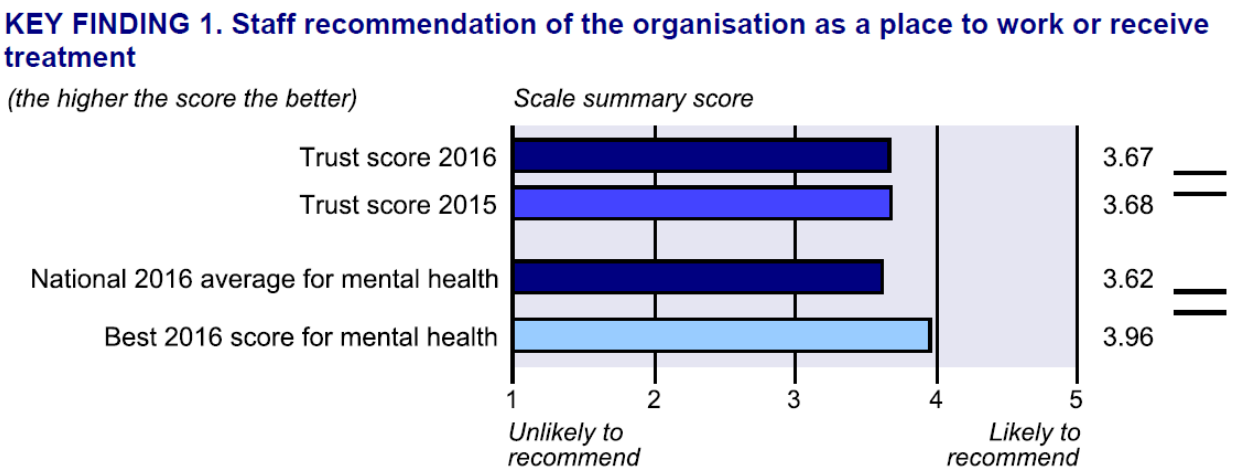
1832 staff at South London and Maudsley NHS Foundation Trust took part in this survey. This is a response rate of 40% which is below average for mental health/ learning disability trists in England, and compares with a response rate of 38% in this trust in the 2015 survey.

Number of Staff recommending the Trust

In the 2016 survey, SLAM performed slightly lower to the year before on the question 'would staff recommend the trust as a place to work or receive treatment?'. SlaM performed slightly above the national average on this question. The SLAM Trust score for this question was 3.67 compared to the national average score of 3.62 for other mental health trusts.

		Your Trust in 2016	Average (median) for mental health	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	72%	72%	72%
Q21b	"My organisation acts on concerns raised by patients / service users"	74%	74%	72%
Q21c	"I would recommend my organisation as a place to work"	58%	56%	59%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	61%	59%	60%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.67	3.63	3.68

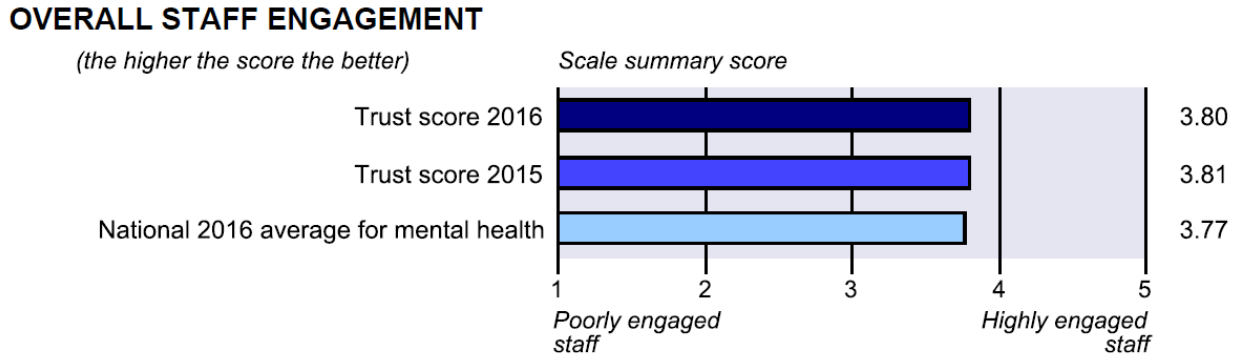
Table sixteen: National staff survey results



Graph ten: National staff survey results – key finding 1

Overall Staff Engagement

The Trust score for overall staff engagement has gone down marginally to **3.80** (3.81 in 2015). This is higher than the national average for all mental health/learning disability Trusts which was 3.77.



Graph eleven: National staff survey results – overall staff engagement

Key Findings – overall Trust

The following are the top five ranking scores for the Trust compared to Mental Health Trusts in England:

- Percentage of staff appraised in last 12 months.
  Trust Score: 93% National Average: 89%

- Effective use of patient/ service user feedback (scale summary score).
  Trust Score: 3.82 National Average: 3.70

- Percentage of staff/ colleagues reporting most recent experience of violence
  Trust Score: 95% National Average: 93%

- Percentage of staff able to contribute towards improvement at work
  Trust Score: 76% National Average: 73%

- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (the lower the score the better)
  Trust Score: 53% National Average: 55%

The following are the lowest five ranking scores for the Trust compared to Mental Trusts in England:

- Percentage of staff satisfied with the opportunities for flexible working patterns
  Trust Score: 51% National Average: 59%

- Percentage of staff experiencing discrimination at work in the last 12 months
  Trust Score: 20% National Average: 14%

- Organisation and management interest in and action on health and wellbeing (Scale summary score)
  Trust Score: 3.56 National Average: 3.71

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
  Trust Score: 78% National Average: 87%

- Percentage of staff reporting food communication between senior management and staff
  Trust Score: 30% National Average: 35%

The following is the area where the experience of staff has improved on the previous annual survey:

- Percentage of staff working extra hours (the lower the score the better)
  Trust Score 2016: 76% Trust Score 2014: 81%

- Percentage of staff experience physical violence from staff in last 12 months (the lower the score the better)
  Trust Score 2015: 3% Trust Score 2014: 5%

The following is the area where the experience of staff has deteriorated most on the previous annual survey:

- Percentage of staff appraised in last 12 months
  Trust Score 2016: 93% **Trust Score 2015: 96%**

Workforce Race Equality Standard

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
  White **Trust Score 2016: 24%** **Trust Score: 2015: 23%**

  BME **Trust Score 2016: 27%** **Trust Score 32%**

Over the past year following on from the previous Staff Survey we have been actively engaging with and supporting the development of the new BME network. This has included the development of a “Tackling Snowy White Peaks” Working group following on from a network event where Roger Kline presented his findings on his research into Snowy White Peaks in the NHS.

The group has been looking at particular issues and themes and have developed a “Reflect and Review” checklist to be used before any formal investigation is undertaken. This will enable managers to take a step back and look at whether there are better alternatives than formal action.

A review of disciplinary investigation outcomes has been conducted on those staff involved in a formal disciplinary process and from a Black African background as there were are a greater proportion going through formal disciplinary processes. It is recognised that the Reflect and Review checklist may assist in ensuring that staff are only taken through a formal process where there is no alternative.

We are presently scoping the implementation of a programme of inclusive leadership which helps organisations think about the impact and implications of unconscious bias. It is intended that we may be in a position to conducting a trial or pilot later in the year.

In the previous Staff Survey report it was highlighted that the Trust was is in the worst 20% in terms of the percentage of staff who experience physical violence from other staff. In September 2016 the Chief Executive wrote an open letter to all staff reminding them of the need to report any incidents of unacceptable behaviour from other staff and to use the mechanisms already available to escalate any matters. It is positive to see a reduction in these reported in the 2016 survey which is also identified as one of the most improved areas but there is still further work to do to make this zero.

At a local level, each CAG and Directorate will again be asked to develop an Action Plan in relation to the responses in the staff survey. This should be based on the requirements identified within the report for their specific areas as some CAGs may need to develop and improve approaches to particular themes. There will need to be regular updates on progress through the CAG HR Business Partners. It is important that local issues are identified and staff are given the opportunity to work towards their resolution and for the CAGs to reassure their staff that they have heard the feedback and are addressing it.

We need to ensure we maintain our areas where we have scored in the top 20% of mental health and learning disability Trusts.

We will need to continue to reinforce the importance of the new annual performance review (appraisal) process which commenced in 2015. We have updated the ratings guide and redesigned the recording form. The performance review process allows an open dialogue about what is good and what needs to improve.

We have seen a reduction in the overall percentage appraisal scores which is a little disappointing and although the score is higher than the national average and a good achievement we need to strive to ensure this is better than the 96% in the previous year over the forthcoming year. We have introduced a new learning development system which will also provide the platform to record and report on appraisals over the forthcoming year.

SlaM Equality Information and Objectives

The Trust published its annual equality information in January 2016. This includes 2016 Trust-wide equality information that provides information on the demographic profile of the Trust's service users and the experience of service users with different protected characteristics.

We also continue to publish local ethnicity reports for Croydon, Lambeth, Lewisham and Southwark. These provide information on the ethnicity of service users accessing 11 of the Trust's services and the experience of service users of different ethnicities in each borough.

The Trust has developed new CAG equality objectives for 2017-20. A high-level summary of these is provided below:

- **Acute Care CAG:** To improve access and experiences for service users with learning disabilities in acute wards.
- **Addictions CAG:** To improve access to substance misuse services in Wandsworth for men who have sex with men.

- **Behavioural and Developmental Psychiatry CAG:** To improve the physical health of Black and Minority Ethnic service users in forensic inpatient services.
- **Child and Adolescent Mental Health CAG:** To improve access and experiences for Asian and Black girls in CAMHS community services.
- **Mental Health of Older Adults and Dementia CAG:** To achieve earlier access to memory services in Lambeth and Southwark for Black service users.
- **Psychological Medicine and Integrated Care CAG:** To improve access and outcomes for Black service users in Lewisham Improving Access to Talking Therapies [IAPT] service.
- **Psychosis CAG:** To ensure equitable access to early intervention services for people aged 35 and over**.**

Annex 1

NHS Croydon CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG Joint Statement on South London and Maudsley NHS Foundation Trust's Quality Account

Council of Governors reply to the Quality Accounts 2015/2016

Healthwatch Southwark, Lambeth and Bromley & Lewisham's response to SlaM NHS Foundation Trust's Quality Accounts for 2016/2017

Annex 2
To be updated with 17/18 dates

Statement of Directors' Responsibilities In Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16;
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to May 2016, including
  - Papers relating to Quality reported to the Board over the period April 2015 to May 2016;
  - Feedback from commissioners dated 24/05/2016
  - Feedback from Governors 20/05/2016
  - Feedback from local Healthwatch organisations 18/05/2016
  - The Trusts complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Quarters 1, 2, 3 and 4 2015/2016
  - 2015 national patient survey results
  - 2015 national staff survey results
  - The head of internal audit's annual audit opinion over the Trust's control environment dated 18/05/2016
  - CQC quality and risk profiles published throughout the year

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
  The performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and,
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Roger Paffard
Chair
South London and Maudsley NHS Foundation Trust

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust

Glossary

Acute Out of Area Treatments (OATs)	An Acute Out of Area admission is when a service user is admitted to an Acute inpatient ward which is located outside of the funding CCG's (See Clinical Commissioning Group entry) area.
Adult Mental Health Model (AMH)	The Adult Mental Health Model (AMH) is a the model used within SlaM to treat people with mental illness, the model focusses on preventing illness and taking a holistic approach to treatment i.e. physical, social and mental health care.
Biomedical Research Centre (BRC)	The Biomedical Research Centre (BRC) is a research centre formed by the National Institute for Health Research (NIHR) (see National Institute for Health Research entry). The Maudsley BRC is in partnership with SlaM, the Institute of Psychiatry, Psychology and Neuroscience at King's College London. The BRC has a number of research themes including Bioinformatics and statistics.
Care Programme Approach (CPA)	The Care Programme Approach (CPA) is a type of support that a person might receive or be offered if they have mental health problems or complex needs. The Care Programme Approach is inclusive of: an assessment of needs, a care plan, regular review of your needs and the care plan and a Care Co-ordinator.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) is a health and adult social care regulator in England. The CQC inspects services based on five Key Lines of Enquiry, these are: safety, effectiveness, caring, responsiveness and well-led.
CareCERTassure	Cyber security programme led by NHS Digital to improve cyber defences in line with Cyber Essentials Plus scheme. SLaM is an early adopter.
Chief Clinical Information Officer (CCIO)	Deputy Medical Director for Information
Clinical Academic Group (CAG)	SlaM is divided into "Clinical Academic Groups". Services fall into particular CAGs depending on who they treat and what treatment they provide. The Trust's CAGs are as follows: **Addictions:** provides community services to adults with drug and alcohol disorders. **Behavioural and Developmental Psychiatry (BPAD):** Provides Forensic and neurodevelopmental services to adults. **Child and Adolescent Mental Health Services (CAMHS):** Provides a range of mental health services for children and young people. **Mental Health for Older Adults (MHOA):** Provides services to those either: over the age of 65 with dementia (see Dementia entry) or severe and complex mental health needs or under the age of 65 who develop dementia **Mood, Anxiety and Personality (MAP):** Provides services for adults who experience mood, anxiety and personality difficulties. **Psychological Medicine (Psych Med):** Provides crisis and triage services to adults. Psych Med also provides specialist services i.e. Mother and Baby unit and Eating Disorders Service. **Psychosis:** The largest CAG within SlaM provides services to adults experiencing Psychosis.
Clinical Commissioning Groups (CCG)/Commissioner	A Clinical Commissioning Groups (CCG) (also known as Commissioners) "are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area." (*About CCGs, NHS Clinical Commissioners*). SlaM is commissioned by Croydon, Lambeth, Lewisham and Southwark CCG.
Control Objectives for Information and Related Technologies (CoBIT)	IT governance and management framework which covers risk management, assurance and audit, data security, governance and governance
Commissioning for Quality and Innovation (CQUIN)	Commissioning for Quality and Innovation (CQUIN) is a payment framework whereby quality improvement goals are linked to financial reward.

Datix	Datix is the incident reporting system which SLaM uses for the recording of incidents and complaints.
Electronic Observation Solution (eOBs)	Electronic Observations Solution is the digitalisation of patient observations (vital signs) also known as early warning signs (MEWS) as opposed to the use of paper MEWS Charts.
Electronic Patient Journey System (ePJS)	ePJS is the electronic system that SlaM uses to document patient notes.
Health and Social Care Information Centre (HSCIC)	The Health and Social Care Information Centre (HSCIC) is a public body which produces national data for health and social care with the aim of improving care. The HSCIC is sponsored by the Department of Health.
Health Service Journal (HSJ)	The Health Service Journal (HSJ) is a website and serial publication which covers topics relating to the National Health Service and Healthcare.
Healthcare Quality Improvement Partnership (HQIP)	The Healthcare Quality Improvement Partnership (HQIP) is an independent organisation which aims to promote quality in healthcare and increase the impact of clinical audit (see Audit entry). HQIP is led by the Academy of Medical Royal Colleges (see Academy of Medical Royal Colleges entry), The Royal College of Nursing (see Royal College of Nursing entry) and National Voices (see National Voices entry).
Hospital Episode Statistics (HES)	Hospital Episode Statistics is a data repository held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which stores information on hospital episodes i.e. admissions for all NHS trusts in England.
Local Care Record (LCR)	An secure integrated portal between SLaM, GSTT, KCH and 90+ GP practices in Southwark and Lambeth electronic health records, which provides instant real-time access to health records to care professionals during direct care.
Mental Health Services Data Set (MHSDS)	The Mental Health Services Data Set (MHSDS) is a data set held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which contains care data relating to the people who use mental health services. It is mandatory for NHS Trusts to submit data to the MHSDS.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	NCISH is a National Confidential Inquiry into Suicide and Homicide by People with Mental Illness which collected suicide data in the UK from 2003-2013 (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester). It is commissioned by the Healthcare Quality Improvement Partnership (see Healthcare Quality Improvement Partnership entry).
National Health Service England (NHSE)	National Health Service England (NHSE) is a body of the Department of Health (see Department of Health entry) which leads and commissions NHS services in England.
National Institute for Health Research (NIHR)	The National Institute for Health Research (NIHR) is the body which oversees research in the NHS.
National Reporting and Learning Service (NRLS)	The National Reporting and Learning Service (NRLS) is a system which enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.
Patient Led Assessment of Care Environment (PLACE)	Patient Led Assessment of Care Environment (PLACE) assessments are annual assessments of hospital environments which evaluate: cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance and dementia.
Prescribing Observatory for Mental Health -UK (POMH-UK Audits)	The Prescribing Observatory for Mental Health UK audits are National Clinical Audits (see National Clinical Audit entry) which assess the practice of prescribing medications within mental health services in the United Kingdom.
Safecare (HealthRoster)/E-roster	Safecare HealthRoster also known within SLaM as e-roster is the e-rostering system designed by Allocate Software (see Allocate Software entry) and used within SLaM to complete shift rostering and record sickness, absence and competencies for all staff.

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Croydon Health Services NHS

NHS Trust

Quality Account 2016-17

Contents

INTRODUCTION

Getting to "Good" if not better

Our ambition is to be rated as "Good" – if not "Outstanding" – at our next inspection by the Care Quality Commission (CQC).

When the CQC last inspected our services (October 2015) in hospital and throughout the community, they rated the Trust as "Requires Improvement," but they also reported on the "significant progress" that we had made.

In 2015, CQC rated Accident & Emergency, maternity and gynaecology, and care for children and young people as "Good." The CQC also commented that our staff were "gentle, kind and caring."

There is now a fundamental shift in the quality of our care, culture and operational performance at Croydon Health Services – and we are always striving to do better.

Nine out of ten patients would now recommend us to care for their friends or family. We will not rest until we get this to ten out of ten.

For the second year in a row, our Trust has been recognised for encouraging and supporting staff at every level to make the changes they want to see. Our way of working through Listening into Action (LiA) has seen 100 inspiring stories of transformation published across the NHS. Around a tenth of these have been led by our incredible staff. These changes are delivering real benefits to our patients and service users, including shortened waiting times for blood tests, and an open reporting culture to improve safety and shared learning

Like many parts of the NHS, demand for our services has continued to grow. This has made the past year uniquely challenging – not least to make the resources we have go as far as possible.

In 2016/17, Croydon Health Services was placed into Financial Special Measures by NHS Improvement. However, thanks to the commitment and professionalism of our staff, the Trust had exited the improvement regime after just seven months.

Our financial recovery plan has been carefully developed to reduce costs, without compromising care. Every efficiency scheme has been scrutinised by the Trust's Clinical Cabinet – our most senior clinicians – to ensure that the quality, safety and performance of our services are not affected.

The Trust however still has a long road ahead to reduce its financial deficit whilst maintaining expected performance standards, including emergency care and cancer services.

Our Quality Account is an important document. It gives us an opportunity to look back and show you all that we have achieved over the past year and the challenges we have faced. It also sets out our quality priorities going forward and steps we will take to continuously improve our care in Croydon.

Mike Bell
Chairman

PART 1
INFORMATION ABOUT THE QUALITY ACCOUNT

Statement on quality from the Chief Executive

Proud of Croydon Health Services

I am always proud of our incredible workforce at Croydon Health Services NHS Trust, but never more so when I look back at all we have achieved over the year to provide high-quality and compassionate care to people in Croydon. These achievements and our progress throughout 2016/17 are documented in our 2016/17 Quality Accounts.

I am pleased to report that quality of our care and performance in 2016/17 has met, if not exceeded, many expected standards.

We have consistently met all cancer waiting time targets last year, seeing 40% of all urgent referrals for suspected cancer within just seven days. This is half the time specified in the national standard.

Croydon Health Services has also performed better than the national average with over 96% of patients experiencing 'harm-free care'. This is a national scheme to reduce the prevalence of falls, pressure ulcers (or bed sores), blood clots and catheter-acquired infections in hospital.

Our length of stay for patients admitted into hospital after a fall is now one of the lowest in London. This is due to our early assessment by specialists in the Acute Care of the Elderly Unit at Croydon University Hospital, and also close working with our therapy team to give people continuity of care and ongoing support in the community after a hospital stay.

All of this is due to the dedication, hard work and commitment of our staff at the Trust. We have more than 3,600 fantastic staff working on the frontline and behind-the-scenes to care for people in hospital, at home and in clinics throughout Croydon. We are also supported by more than 350 wonderful volunteers.

The NHS is always at the heart of every community, but our job takes on even greater importance when faced with tragedies like the Croydon tram derailment on 9 November 2016. On that day, our staff cared for 38 people in total from the crash, along with many of their families.

This incident rocked our community, but it also solidified the vital role that we must play when caring for anyone and everyone in Croydon – whatever the circumstance.

Working in the NHS is a privilege – it is always busy and always rewarding – but it can often be difficult; and past year has been challenging, especially for our frontline staff. The Trust's results in the annual NHS staff survey fell below the national average in some areas. This included staff satisfaction with resources available.

The survey also showed that our staff their motivation as four out of five – above the national average of 3.94. This is a great achievement considering the Trust was in Financial Special Measures at the time. It is a real testament to the resilience and passion of our workforce.

Almost three quarters (74%) of staff responding say that our patient's or service user's care was the Trust's top priority – up 9% from 2014.

For the first time, 77% clinical facing staff at the Trust had the voluntary flu jab. In previous years, this has been around 50%. Our performance placed us second among London acute trusts and above the national target of 75%. As a result, we were 'highly commended' in the annual NHS Employers Awards.

This year, as part of Listening into Action (LiA), we have appointed 30 LiA Ambassadors from staff at all levels. They have been selected to tackle 30 issues across the Trust that they themselves have put forward to further enhance our care, including greater provision of pain relief for surgical patients, and more continuity of care for expectant women with our community midwifery team.
.
In our drive for an open and learning culture, we have also launched five "Freedom to Speak Up" guardians, doctors, nurses, therapists and managers, to help further embed a safety culture across the Trust. These guardians are helping to encourage an open environment where our staff feel able to raise concerns if they have them, and to know that they will be listened to and supported. We have also changed our incident reporting system to enable staff to record incidents anonymously, if they prefer..

It is important that all of the Trust's leaders are visible to our patients, service users, visitors and staff. So, every Wednesday morning our executive team services across the Trust to support frontline staff, and to listen to their ideas and suggestions.

In all of my walkabouts across the Trust, I always ask three questions:

What do we do well?
What could we do better?
What would make the biggest difference for our patients, community or staff?

I use this to gauge our improvement progress and priorities on top of the continuous quality assurance and monitoring checks that we have in place across the Trust. These three questions are also the starting points of discussions at our regular community listening and engagement events.

More than 50 people attended our ‘Big Conversation’ in March 2017. It was a chance not only to tell them about how we have acted on past suggestions from our patients and public, but also to hear their ideas about how we can further improve.

This is vital if we are to deliver the care that the people of Croydon want and deserve, and look after the health of our community for years to come.

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

John Goulston
Chief Executive

Executive summary

All Trusts are required to produce a Quality Account to describe past and future activities to improve the quality of services they provide. In this report (from page 15) we describe our main priorities for 2017/18. We are required to include specific data from 2016/17 that we have provided to National Bodies such as the Care Quality Commission and the Health and Social Care Informatics Centre. In section 3 of this report we describe our achievements against the quality priorities we set in 2016/17. We have explained our acronyms and terms in the main text; there is also a full glossary at the end of the report.

Croydon is one of London's largest and fastest growing boroughs. Caring for Croydon means we have to do much more to help keep people well, and provide expert medical care when needed.

Croydon's population is aging and increasing but is not matched by sufficient growth in health funding. This is alongside rising expectations of care and standards. Croydon faces a number of key challenges, including: the highest overall population and number of looked after children of any London borough; increasing deprivation; significant variation in life expectancy and high rates of emergency hospital attendances and admissions per thousand population.

Croydon has a population of approximately 383,000 and is growing by about one per cent per year. Over the next 5 years this will result in; a higher number of people aged over 85; a larger proportion of younger people; an increase in the proportion of Black and Minority Ethnic Groups.

Croydon Health Services is more than a local hospital. We provide integrated NHS services to care for people at home, in schools, and health clinics across the borough.

Our experienced district nursing teams and community matrons cover every corner of Croydon to look after for people of all ages.

Our Children's Hospital at Home cares for children with long-term conditions at home – without having to travel to hospital. The Trust's 24/7 Rapid Response Service also means that adult patients can be assessed in their own homes by our specialist teams within two hours of being referred by their GP.

Croydon's one Emergency Department is based at Croydon University Hospital in the north of the borough. We see more than 400 people a day through our Emergency Department and urgent care services. Our emergency care doctors and nurses have also teamed up with local GPs to run a seamless network of urgent care

services across the borough, including booked appointments with a GP available seven days a week.

Croydon University Hospital performs around 26,000 surgical operations every year and provides more than 100 specialist services, including conditions affecting the heart, cancer care and treatment for musculoskeletal disorders. CUH also offers 24/7 maternity services, including labour ward, midwifery-led birth centre and the Crocus home birthing team.

Purley War Memorial Hospital is the Trust's sister hospital covering the south of the borough. PWMH offers easy-access to outpatient care, including diagnostic services such as blood tests and x-rays, physiotherapy and ophthalmology services run by Moorfields Eye Hospital.

For more information about our services visit www.croydonhealthservices.nhs.uk

Croydon Health Services NHS Trust is an integrated care organisation providing healthcare in both the hospital and community setting. Our clinical directorate structure is designed to maximise the benefits of this for our patients, their families.

Our priority is to ensure that the population we serve receive high quality, safe and compassionate care irrespective of what time or day they require it. As an Integrated Care Organisation, providing both hospital and community services, we will be shifting our focus of care towards prevention and early intervention to provide safer, more effective and more economic healthcare.

Key achievements last year

We set ourselves eight quality priorities in 2016/17 covering the five CQC domains of (Safe, Effective Caring, Responsive and Well-Led). Staff across the Trust have used these domains in assessing and reporting their services with the aim of making this business as usual.

We achieved many of the priorities that we set ourselves last year and a detailed review can be found on page 39. There are some priorities that we have not progressed to the level that we would have liked and with this mind we are building on the progress we have made this year and carrying over into next year's priorities

Examples of good practice include

We were the first NHS Trust to be accredited by LiA and receive the LiA accreditation mark.

We obtained level 2 for information governance compliance and improved on our compliance from previous year.

We achieved 96% for Harm free Care against a national average of 94%.

The Trust has maintained its RTT performance throughout this year and has met the 93% 'incomplete' target every month for the past 12 months.

We achieved Joint Advisory Group (JAG) accreditation.

The Trust has regularly performed in the top 5 Trusts in London for the 62 day target.

We were featured in NHS 100 stories for LiA work.

Areas for improvement that are reflected in our priorities for 2017/18
We want to improve how we share the learning from incidents and complaints.

We want to improve our incident reporting with a focus of the no harm and low level reporting.

We want to reduce the number of incidents of avoidable harm with a focus on medication safety.

We want to reduce unnecessary delays when discharging patients home after a hospital stay, and reducing avoidable hospital readmissions.

We want to improve our support and care of people with mental health conditions.

We want to keep more people in our local community healthy.

Improving quality lies at the core of all we do as a Trust. Our aim is to deliver excellent integrated care for the people of Croydon, when and where they need it and we are working to improve on our CQC rating by achieving a good or outstanding.

We constantly strive to improve the services we offer by placing quality at the heart of any planned developments. Therefore, we monitor quality activity and improvements in order to determine how well we are doing and report quality outcomes and information both locally at clinical delivery level and at Board level. Trust-wide information relating to safety, effectiveness and patient experience is analysed and reported via the Board subcommittee structure.

A formal Executive Quality Report is presented monthly to the Board. This offers analysis of performance across all these areas to inform current state and future developments. External review and monitoring also occurs from a variety of stakeholders including NHS Commissioners and regulators (such as the Care Quality Commission).

Information relating to each of the sections throughout this Quality Account is a true reflection of quality performance for 2016/17. This includes where things have not

gone as planned or where we have made errors from which we have learned lessons resulting in changes to practice.

Unless otherwise stated, tables/diagrams throughout this report are Trust-wide and reflect performance across the Trust's portfolio of services.

We have mechanisms in place to help us to learn from adverse events, complaints and patient experience feedback and many examples of this are included throughout the relevant sections.

At Croydon Health Services NHS Trust we are keen to share information publicly about the quality of our services and about our continuous improvement work. You will be able to access a copy of our Quality Account by:

• Viewing it on NHS Choices

• Viewing it on Croydon Health Services NHS Trust website

• Requesting a hard copy from our communications team CH-TR.Comms@nhs.net

We hope that you find our Quality Account informative. If it prompts further questions, or you have any comments about our services, we would like to hear from you.

PART 2

Priorities for improvement and statement of assurance from the Trust Board

Priorities for Improvement 2017/18

The safety of our patients is an important priority for the Trust. Our vision is for a safety culture that is fully embedded and integral to our everyday business, where we are leaders in the field for driving improvements in the safety of our patients, and where we have achieved a reduction in the number of patients who suffer avoidable harm.

A key challenge for the Trust is continuing to maintain and grow quality within a financially-challenged and workforce-constrained era. Our key areas of focus have been informed from national regulatory targets (including CQC targets post inspection) from the Royal Colleges, NICE and CQUIN. In addition we have also used our local intelligence gained via triangulating data from serious incident (SI) investigations, complaints, and patient and staff feedback. This has helped inform a long list of objectives for our Quality Account from which key strands of intertwined work emerged.

Our priorities for 2017/18 were developed in discussion with our Clinical Directorates, Patient Safety and Mortality Committee, and our Quality and Clinical Governance Committee. We held a public survey on our priorities which was open to staff, patients, stakeholders and members of the public. Our Commissioners Croydon CCG (Croydon Clinical Commissioning Group), and Healthwatch. They reflect a review of themes from incidents and serious incidents (SI"s) and also feedback from patients and carers and staff. We also reviewed clinical audits, NICE guidance and peer reviews and took into account local and national changes including the 5 year forward view.

We have kept those priorities from 2016/17 which remain key or because we had not made as much progress as we had hoped and where we consider further improvement is required, such as creating a safety culture and listening to our patients, to continue to allow us to make sustained improvement and build on the good work that we have achieved in the previous year.

Priorities 2017/18

Our priorities are set out below and each makes reference to the five CQC domains and our specific objectives for these.

Priority	Safe	Effective	Caring	Responsive	Well Led
1.To improve our support and care of people with mental health conditions	X	X	X	X	
2.To create a culture of safety, shared learning and listening to our patients and service users	X	X	X	X	X
3.Reducing unnecessary delays when discharging patients home after a hospital stay, and reducing avoidable hospital readmissions	X	X	X	X	
4. Improving the ways patients and service users access our care		X	X	X	X
5. Keeping more people in our local community healthy - Make Every Contact Count (MECC)		X	X	X	X

Priority One: To improve our support and care of people with mental health conditions	
Why is this a priority?	People with mental ill health are three times more likely to present to A&E than the general population. More than 1 million presentations are currently recorded as being directly related to mental ill health. People with known mental ill health are five times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical health reason. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.
How will we deliver the improvement?	On arrival of the patient a multi-disciplinary team assessment will take place at the start of the patient's journey.
Measures	• Mental Health triage of the Patient • Develop Internal Professional Standards that we all share across the trust regarding patient interaction
Targets	• Mental Health triage of the Patient within 30 minutes of arrival to ascertain clinical priority. • Development of Internal professional standards • 20% reduction in A&E attendances of the frequent attenders to A&E who would benefit from mental health and psychosocial interventions.
Reporting route	Quarterly report to Quality and Clinical Governance Committee
Responsible officer	Chief Operating Officer

Priority Two: To create a culture of safety, shared learning and listening to our patients and service users	
Why is this a priority?	Promoting a culture of safety and listening to our patients and service users views increases our patient care and experience. By sharing the learning from incidents and complaints the Trust can improve services.
How will we deliver the improvement?	• Look at themes and trends of complaints received and see a reduction in the number of complaints • Develop a culture of improvement and safety – to develop a culture where employees are committed to safe, compassionate care by improving leadership • Increase the number of patient representatives and range of patient involvement activities • Improve escalation for deteriorating patients • Roll out the learning from excellence and share continue to share the learning
Measures	• Percentage reduction in the number of complaints received • Improve the number of patient safety champions • Sustained increase the number of patient representatives and range of patient involvement activities • Reduction in the number of serious incidents under sub optimal care • Sustained improvement of the learning from excellence • Sustained increase in the response rate for FFT
Targets	• Sustained improvement in complaint response • Increase in the number of patient safety champions • Increase in the learning from mistakes league • Increase in the learning from excellence submissions • Hold Bi-Monthly quality events to share the learning from complaints and incidents • Increase in the response for rates for FFT
Reporting route	Quarterly report to Quality and Clinical Governance Committee
Responsible officer	Director of Nursing, Midwifery and Allied Health Professionals/Medical Director

Priority Three: Reducing unnecessary delays when discharging patients home after a hospital stay, and reducing avoidable hospital readmissions	
Why is this a priority?	A good flow of patients through the hospital ensures that patients are in the right place at the right time and get the care they require when they need it. Poor patient flow creates difficulties throughout the hospital, most noticeably in the Emergency Department, but interferes with the provision of good care and patient experience. Patient who stay in hospital longer than the acute phase of their condition requires, continue to deteriorate. There is a considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies.

How will we deliver the improvement?	There are four work streams identified for this priority
	• Under the mission statement of 'right patient right bed' we will deliver a)
	  ○ The Safer care bundle: Reduce length of stay through implementing best practice ward rounds and reduction in patients length of stay
	  ○ Perfect patient journey LiA work stream
	• Reduction in avoidable hospital re admissions
	• Increase of patients who are discharged by 12 midday
	• Improved multi-disciplinary working between acute and community services
	• Link with the OPTIMAL research project improvement

Measures	A range of measures will be used including: • Percentage of patients who have a reduced length of stay • Percentage discharges before 12 midday • Percentage of patients who are readmitted within a 30 day period for the same condition.
Targets	• Sustained improvement in reducing length of stay • Sustained improvement in the number of discharges before12 midday • Sustained improvement in the number of patients readmitted within a 30 day period
Reporting route	Report to the Executive Management Board
Responsible officer	Chief Operating Officer

Priority Four: Improving the ways patients and service users access our care	
Why is this a priority?	Improving the way our patients and service users access our services and the information that is provided is key to ensuring good quality care and experience is maintained. Ensuring our patients and service users has access to the right information at the right time.
How will we deliver the improvement?	Improved information to service users and primary care about the services we provide including the development of a service directory
Measures	• Review of service leaflets and information provided to patients and service users • Increase in the number of leaflets available in other languages • Development of a service directory in place on the Trust internet
Targets	• 50% of service leaflets reviewed and updated • 33% increase in service information available in other languages • New service directory in place by 2018
Reporting route	Quality and Clinical Governance Committee
Responsible officer	Director of Nursing, Midwifery and Allied Health Professionals/ Medical Director

Priority Five Keeping more people in our local community healthy - Make Every Contact Count (MECC)	
Why is this a priority?	By keeping patients at home and being treated within the community results in increased outcomes for our patients. We will achieve this by working with our partners in Local Authority and Public Health By making every contact count we can use these opportunities and advice on following a healthy lifestyle e.g. • stopping smoking • healthy diet, e.g. five a day, eat well plate, recommended sugar • and salt daily levels • healthy weight, e.g. BMI and waist circumference • recommended levels of physical activity, CMO's guidelines • recommended weekly alcohol limits3 • five ways to wellbeing
How will we deliver the improvement?	• By developing a 3 year 'Making Every Contact Count' strategy • By identifying leader and champions within the organisation • By providing training to staff on what this means and how we can implement within the organisation
Measures	• Have an organisation strategy in place on how we will make every contact count and agreeing the key goals for the organisation. • Identify champions for this initiative. • Percentage of patients who are provided on advice on smoking and alcohol and healthy living indicators.
Targets	Strategy in place by end of March 2018 Increased number of training sessions held for leaders and key staff
Reporting route	Quality and Clinical Governance Committee
Responsible officer	Director of Nursing, Midwifery and Allied Health Professionals

Statement of Directors responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of the Annual Quality Account (in line with the requirements set out in Quality Accounts legislation).

In preparing the Quality Account, directors are required to take steps to assure themselves that:

• the Quality Account presents a balanced picture of the Trust's Performance over the reporting period;

• the performance information reported in the Quality Account is reliable and accurate;

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice;

• the data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

• the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Chairman **By order of the Board Chair**

Mike Bell **28 June 2017**

Statement of assurance from the Board of Directors

Review of Services

Throughout 2016-17 we have been privileged to continue to provide services to the people of Croydon whether in their own home, at one of our community facilities or at one of our hospitals.

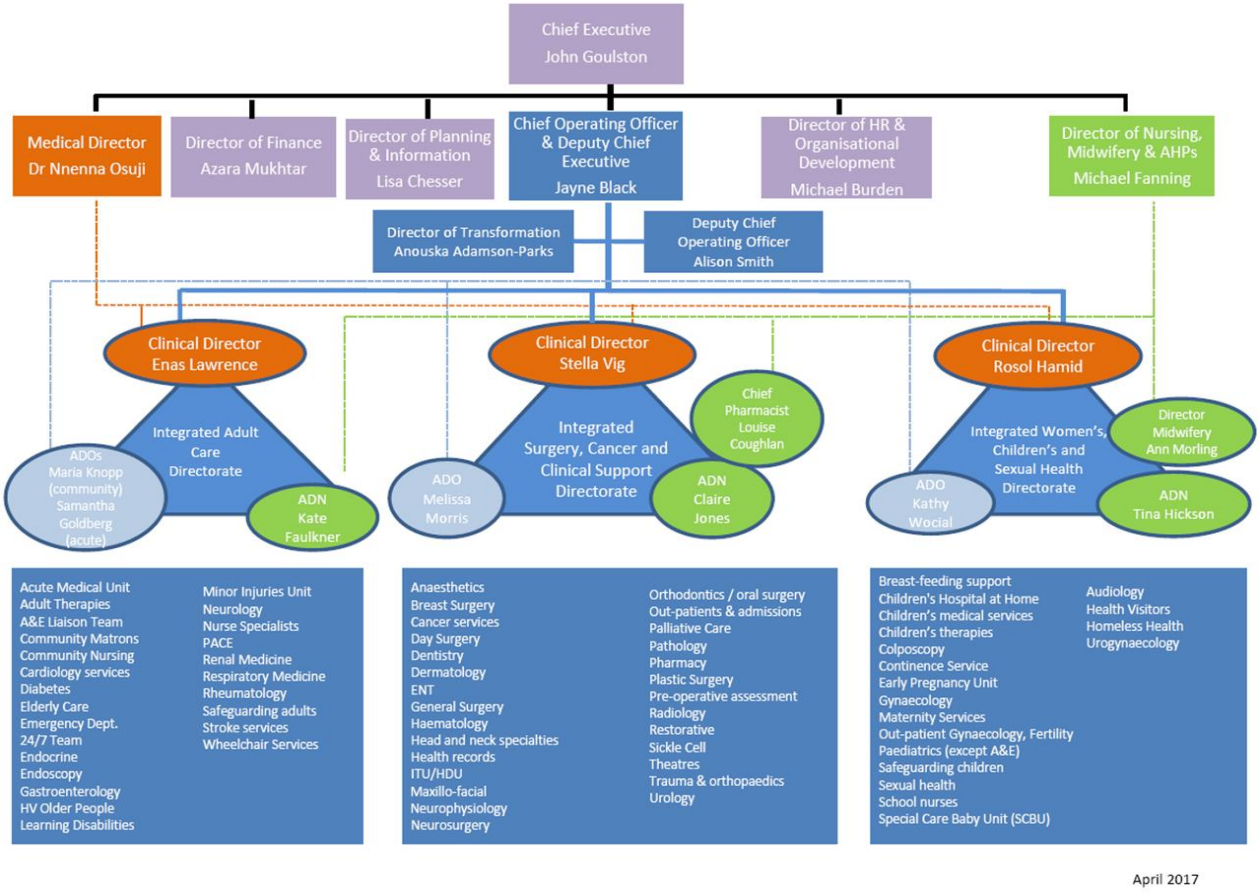
There are three Clinical Directorates within the Trust and each Directorate reviews service provision through Quarterly Quality and Performance meetings with the Chief Operating Officer and reporting to the Quality and Clinical Governance Committee, monthly Quality Boards and Clinical Governance meetings.

The Trust reviews quality indicators using a dashboard and reports so that performance can be analysed on a monthly basis. This enables services to identify priorities and actions needed to deliver improvements. The Trust organogram depicting the directorate services is on the following page.

During 2016-17 Croydon Health Services provided and/or sub-contracted 53 NHS services. The Trust has reviewed all the data available on the quality of care of 100 per cent of these services.

The income generated by the NHS services reviewed in 2016-17 represents 100% of the total income generated from the provision of NHS services by Croydon Health Services NHS Trust for 2016-17

Table of activity by quarter	Q1	Q2	Q3	Q4	Total
Total number of admissions	16.861	16,383	16,839	16,189	66,272
Total number of occupied bed days	40,878	41,634	43,514	44,026	170,052
Average number of occupied beds	452,21	452,54	472,98	489,18	465,896
Face-to-face contacts	85,487	84,045	81,845	83,152	334,529



April 2017

Service and quality accreditations

CHS was the first Trust to receive LiA accreditation. It has also achieved or is working towards external accreditations and external peer reviews a full list can be found on page 79 (external visits)

Participation in national clinical audits and National Confidential Enquiries

Participation in national clinical audits and National Confidential Enquiries enables us to benchmark the quality of the services that we provide against other NHS Trusts, and hence highlight best practice in providing high quality patient care and drive continuous improvement across our services. The Clinical Audit priorities are selected on the basis of national requirements, commissioning requirements and local evidence that has emerged from themes from incidents or complaints.

During 2016-17, the Trust participated in 41 national clinical audits and 9 national confidential enquiries. Out of the 41 national audits, 28 were in the NHS England Quality Account listed audits of which the Trust was eligible to participate in representing 100% participation.

The list of national audit reports reviewed and actions planned or undertaken are detailed in Appendix 1.

The Trust also completed 47 local clinical audits in 2016/17 as listed in Appendix 2.

The national clinical audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2016/17, are listed 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. Some areas have been marked as in progress and this means that the data is currently being submitted which includes the data gathered during the period of 2016/17.

National Audits participation

National Clinical Audit for inclusion in quality report	Data collection completed in 2016/2017	Number of cases submitted	% submitted
Acute Coronary syndrome or Acute Myocardial Infarction (MINAP)	√	In progress	In progress
Adult Asthma Audit	√	54	100%
Asthma Paediatric and adult care in Emergency Department: RCEM	√	51	100%
Bowel Cancer (NBOCAP)	√	121	100%)
Cardiac Rhythm Management (CRM)	√	In progress	In progress
Case Mix Programme (CMP)	√	In progress	In progress
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	√	380	100%
Diabetes (Paediatric) (NPDA)	√	117	100%
Elective Surgery (National PROMs Programme)	√	In progress	In progress
Endocrine and Thyroid National Audit	√	In progress	In progress
Falls and Fragility Fractures Audit programme (FFFAP)	√	10	100%
Head and Neck Cancer Audit	x	Data from St Georges	Data from St Georges
Inflammatory Bowel Disease (IBD) programme	√	110	100%
Major Trauma Audit	√	121	100%
National Audit of Dementia	√	66	100%
National Cardiac Arrest Audit (NCAA)	√	40	100%
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)	√	78	100%
National Comparative Audit of Blood Transfusion	√	14	100%

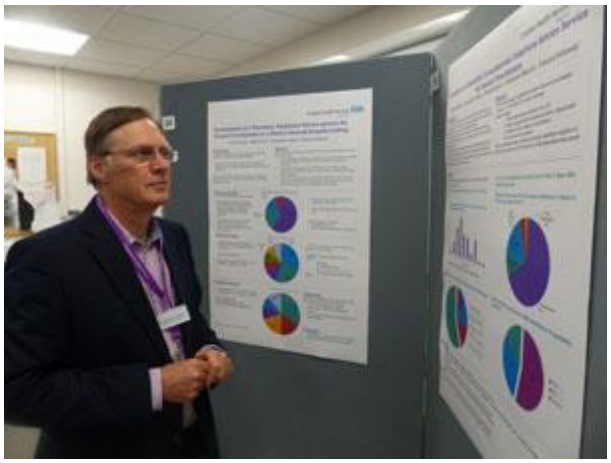
National Clinical Audit for inclusion in quality report	Data collection completed in 2016/2017	Number of cases submitted	% submitted
programme: 2015 PBM in patients undergoing elective, scheduled surgery			
National Diabetes Audit-Adults	√	32	100%
National Emergency Laparotomy Audit (NELA)	√	85	100%
National Heart Failure Audit	√	In progress	In progress
National Joint Registry (NJR)-Knee and Hip replacement	√	In progress	In progress
National Lung Cancer Audit (NLCA)	√	In progress	In progress
National Prostate Cancer	√	In progress	In progress
Neonatal Intensive and Special Care (NNAP)	√	503	100%
Oesopha-gastric Cancer (NAOGC)	√	In progress	In progress
Paediatric pneumonia	√	73	100%
Sentinel Stroke National Audit Programme (SSNAP)	√	In progress	In progress
Severe Sepsis and Septic Shock- Care in emergency departments	√	17	100%

Clinical Outcome Review Programme (Previously the National Confidential Enquiries and Centre for Maternal and Child Death Enquiries)

National Clinical Audit for inclusion in quality report		Number of cases	% submitted
NCEPOD-Child Health Clinical Outcome Review Programme, Chronic Neurodisability	√	7	100%
NCEPOD-Child Health Clinical Outcome Review Programme, Young	√	In progress	In progress

National Clinical Audit for inclusion in quality report		Number of cases	% submitted
People's Mental Health			
NCEPOD- Medical& Surgical Clinical Outcome Review Programme, Non Invasive Ventilation	√	3	100%
NCEPOD- Medical& Surgical Clinical Outcome Review Programme, Physical and Mental Health care of mental health patients in acute hospitals	√	5	100%
Child Health Clinical Outcome Review Programme	√	In progress	In progress
Learning Disability Mortality Review Programme (LeDer Programme)	√	In progress	In progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	√	In progress	In progress
NCEPOD -Acute Pancreatitis	√	5	100%
NCEPOD-Cancer in Children, Teens and Young Adults	√	In progress	In progress

Research 2016 - 2017



Research is a core part of the NHS, enabling it to improve the current and future health of the people it serves. 'Clinical research' means research that received a favourable opinion from a research ethics committee.

All patients receiving NHS services provided or sub-contracted by Croydon Health Services NHS Trust in Jan 2016 – Dec 2016 may be approached for research. Six hundred and 46 patients were recruited to participate in research approved by a research ethics committee. This figure is based on the Clinical Research Network (CRN) registered file. Compared to last year this is a 29% rise in recruitment from 2015.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff ensure they stay abreast of the latest possible treatment availabilities, and active participation in research can lead to successful patient outcomes.

In 2016-2017, 55 clinical research studies were being conducted in the Trust; 38 of which were funded by the CRN. 9 studies concluded by December 2016 of which 66% were completed as designed within the agreed time and to the agreed recruitment target. This is an improvement from last year's 63%.

March 2016 saw the completed phased roll out of HRA Approval. This is now the process for applying for approvals for all project-based research in the NHS led from England. The new system simplifies the approvals process for research, making it easier for research studies to be set up thus leaving local sites to review the feasibility of running the study with available resources.

In 2016-17 Croydon approved 22 studies of which 11 were supported by the CRN.

There was 134 clinical staff participating in research approved by research ethics committee at Croydon Health Services during 2016 – 2017. 38% of these were Research Passport Personnel supporting the research studies. These staff participated in research covering 15 specialities.

In October 2016 the HOT clinic & Research and Development team completed the third year on the WELCOME study which is an EU funded study run between seven different countries. COPD patients from Croydon will take part in this to remotely monitor their health and disease progression to aid their self-care by the use of Prototype vests have been produced and the team and consortium partners are preparing to run a trial using this later this year. his is with an eventual goal of develop it further into a commercial product.

A second EU-funded project called AEGLE completes its second year in April 2017. This is a big data analytics programme that will analyse anonymised patient data to try improve the treatment of diabetes.

The OPTIMAL project, funded by Innovate UK, has completed its second year. It is a computer system that will work with the discharge team to streamline the discharge of patients in order to reduce readmission rates within 30 days. The system is up and running in the trust and undergoing initial trials. This could have the potential to improve quality of patient care and to save the Trust money by reducing penalties incurred when patients are readmitted within 30 days.

In the last three years, 49 publications have resulted from our involvement in Research. Of these 49 publications 15 were directly from NIHR studies.

The Trust undertakes many clinical trials and new treatments to bring advances in care to people in Croydon and each year holds a day at which the best projects are shared with staff from all across the organisation.

As well as inspiring further research, the aim is that staff will now use the findings to help improve services and patient care. This year 24 research projects across three categories of Research, Audit and Clinical Service/Service Improvement were shortlisted and showcased at the Trust in May 2016. The shortlisted research included a study looking at inherited heart disease in children. Early detection of congenital heart disease can help reduce illness and death.

A team from Croydon's Cardiac Department in collaboration with Kingston Hospital used an electronic stethoscope to take heart readings from children and then developed software to make it easier to interpret the findings. They hope that in future clinicians may be able to use this to improve the quality of screening for inherited problems such as heart murmurs.

The winner of the Clinical Service/Service Improvement category was a study looking at the lung condition Chronic Obstructive Pulmonary Disease, which is often

under diagnosed particularly in the local population. The team identified obstacles to diagnosis and is now developing solutions locally to try to improve detection in the borough.

The winners of the Research category were a team that looked at rectal cancer and found that using MRI can help doctors identify patients whose tumours mean they have a worse four year survival than patients with a different tumour type. In a range of other studies, teams from the Obstetrics and Gynaecology department looked at pelvic floor problems following childbirth, including prevalence and the best way to diagnose conditions.

Use of the Commissioning for Quality and Innovation (CQUIN) framework

Commissioners hold a health budget for the Croydon population and decide how to spend it on health care services (in both the hospital and community setting) such as those provided by Croydon Health Services NHS Trust. Our local commissioners (Croydon Clinical Commissioning Group) and NHS England set us annual goals based on quality and innovation in order to bring health gains for patients. This system is called the CQUIN payment framework.

A proportion of Croydon Health Services NHS Trust income in 2015/16 was conditional on achieving CQUIN goals agreed between Croydon Health Services NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2016/17 we are on target to achieve over 80% of our CQUIN income from the NHS England and Croydon Clinical Commissioning Group (CCG) and 100% of the specialist CQUINs from NHS England. Currently estimates are a 73% achievement in 2016/17 (*as at 30/03/17 to be revised before final publication*).

The National CQUINS for 2016/17 were as follows:

- Improving the health and wellbeing of NHS Staff;
- Identification and Early Treatment of Sepsis;
- Antimicrobial resistance.

Local CQUINS agreed

- Safe Staffing
- Maternity
- Acute Kidney Injury
- Diagnostics
- Early Supported Discharge

- Medicines Management- Medicines optimisation
- Medicines Management- Antibiotic Administration
- Medicines Management- Nutritional Support
- Enhanced Recovery- Pre Operative
- Enhanced Recovery- Same Day Surgery
- Enhanced Recovery- Post Operative

The Nationwide CQUINS for 2017/18 were released in March 2017 and are as follows:

- Improvement of health and wellbeing of NHS staff
- Healthy food for NHS staff, visitors and patients
- Improving the uptake of flu vaccinations for frontline clinical staff
- Timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Timely treatment of sepsis in emergency departments and acute inpatient settings
- Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
- Reduction in antibiotic consumption per 1,000 admissions
- Improving services for people with mental health needs who present to A&E
- Advice & Guidance
- E-referrals
- Supporting proactive and safe discharge
- Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening
- Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice
- Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication
- Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening
- Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral
- Improving the assessment of wounds
- Personalised Care and Support Planning

All CQUINS will be monitored by the Quality Experience and Safety Programme to link with other Quality Initiatives.

Statements from the Care Quality Commission (CQC)

Overall rating	Requires Improvement

The CQC is the independent regulator for health and social care services in England. They make sure that we capture the care provided by hospitals meet government standards to provide people with safe, caring, effective, compassionate and high quality care.

The Trust is required to register with the CQC. Our current registration status is "registered without conditions". This means that CQC **has not** taken any enforcement action against CHS in 2016/17.

The CQC monitors these standards of care through inspections, patient feedback and other external sources of information gathered. They publish which Trusts are compliant with all the essential standards of care which and which organisations have conditions requiring improvement.

The Trust was inspected by the CQC in June 2015 and a report was published on 7th October 2015 stating the Trust was given an overall rating of **"Requires Improvement."**

A **"Good"** rating was given for the domains of Effective and Caring with the remaining domains of Safe, Responsive and Well Led given the rating of **"Requires Improvement".**

CQC has not taken enforcement action against the Trust during 2016/2017 and the Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reported period.

At a service level Urgent & Emergency Services, Maternity & Gynaecology and Services for Children & Young People were all given an overall rating of **"Good".** All other services in the hospital and community were given an overall rating of **"Requires Improvement".**

The Trust was given 4 **"must do"** actions and 31 "**should do"** actions and these were included in the Trust priorities for 2016/17. A comprehensive action plan with 188 milestones was drawn up to address these areas of improvement that has been incorporated into the Trust's Quality, Safety and Experience Programme.

The Trust is now working towards achieving a **"Good"** or **"Outstanding"** rating in our next inspection to build on our previous achievement.

Health and Safety Executive

During 2016/17 there were no incidents that were investigated by the Health and Safety Executive.

Patient Led Assessment in the Care Environment audit (PLACE)

Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments provide a framework to review how the environment supports patient privacy and dignity, quality of food provided, cleanliness and general building maintenance. The inspectors are a mix of Trust members, external inspectors and patient representatives. The group is at liberty to visit any ward or department in which patient care is provided. The assessments take place every year, and results are reported publicly.

Last year's assessment was conducted in April 2016 and report issued in May 2016. This year's PLACE assessment is due to be completed in May 2017 and report produced in June 2017

Data Quality

The Trust submitted records during 2016/17 to the Secondary Users Service (SUS) which is the single, comprehensive repository for healthcare data in England. In 16/17 the Trust achieved 98.7% against a national score of 96.5%. There are two areas where the Trust ranks below the national average and they are NHS number, and postcode. The performance against these three measures is set out below The Trust data quality score has improved significantly in 2016/17 achieving 100% for GP practice code in all areas.

	NHS number,		**postcode,**		**GP Practice Code**	
	Trust %	**National %**	**Trust %**	**National %**	**Trust %**	**National %**
Percentage for inpatient care	96.6	99.2	97.5	99.8	100	99.9
Percentage for outpatient care	97.3	99.5	97.7	99.8	100	99.8
Percentage for A&E care	96.3	96.6	98.9	99.4	100	98.0

The Trust commissioned its own independent Clinical Coding Audit in 2016/17 which found an accuracy rate of 95% which achieved an IG Toolkit rating of Level 3.

Information Governance

Level 2 Compliance achieved (69%)	**Compliant**

Information forms a key component of the current Government's Information Revolution for the NHS. This restates the NHS's intention to ensure effective decision making, inform and empower patients through the provision of accurate, accessible and coherent information.

Information Governance (IG) describes how information is handled in health and social care. The NHS Digital Information Governance Toolkit (IGT) measures compliance by NHS organisations annually against a number of requirements for different organisation (45 requirements for Acute Trusts).

Croydon Health Services NHS Trust's submission score for the 2016-17 NHS Digital Information Governance Toolkit v14 on March 31st 2017 was 69% with all requirements being level 2 compliant.

The Trust is committed to ensuring that its information is managed to the highest standards and in accordance with the Health and Social Care Act 2014, Care Standards Act 2000, The Data Protection Act 1998, The Freedom of Information Act 2000, Central Government policies and guidance from the Information Commissioner's Office.

The Trust complies with the Information Commissioner's Office checklist for reporting, managing and investigating information governance incidents. The Trust declared four information governance incidents through the NHS Digital IG Toolkit in 2016-17, two level 1 incidents (classified as disclosed in error) and two level 1 incidents (classified as lost in transit).

The ICO also issued an undertaking that committed the Trust to a particular course of actions in order to improve its compliance, completion of these actions were confirmed by the ICO April 2016 with further management of Staff IG training and legacy records destruction. The review demonstrated that CHS has taken appropriate steps and have put plans in place to address some of the requirements of the undertaking.

Reporting against core indicators (Department of Health mandatory indicators

This section includes data on nationally specified indicators for the current and previous reporting periods as part of the statutory requirements.

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This section includes data on nationally specified indicators for the current and previous reporting periods as part of the statutory requirements

Domain	Indicator	2014/15	2015/16	2016/17	Most Recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National Average	Comments
Preventing people from dying prematurely	The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust.	1.0087 Band 2 (as expected)	1.0464	0.8913 Band 2 (as expected)	0.8913	Oct '15 - Sept '16 NHS Digital	0.6897	1.1638	1.034	The Croydon Health Services NHS Trust is categorised as Band 2 for SHMI which is as expected
Enhancing quality of life for people with long-term conditions	% of admitted patient deaths with a palliative care coded at either diagnosis or specialty level for the trust.	19.8% July '13 - June'14	Data being validated	1.6%	1.6%	Oct '15 - Sept '16 NHS Digital	0%	3.7%	1.6%	This is a contextual indicator. Also this indicator falls under both domains (see above)
Helping people recover form	Patient reported outcome measure score for groin hernia surgery	The Trust did not submit data for this PROMS		Data available end of April	TBA	TBA	TBA	TBA	TBA	TBA

episodes of ill health following injury	Patient reported outcome measure score for varicose vein surgery	The Trust did not submit data for this PROMS		Data available end of April	TBA	TBA	TBA	TBA	TBA	TBA
	Patient reported outcome measure score for knee replacement surgery	The Trust did not submit data for this PROMS		Data available end of April						
Domain	Indicator	2014/15	2015/16	2016/17	Most Recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National Average	Comments
Preventing people for dying prematurely	& of patients aged 0-15 re admitted to hospital within 28 days of being discharged from hospital	5.95%		Data available end of April	TBA	TBA	TBA	TBA	TBA	TBA
Enhancing quality of life for people with long term conditions	% of patients aged 16 and over readmitted to hospital within 28 days of being discharged from hospital	15.34%	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA
Ensuring people have a positive experience of care	The Trust's responsiveness to the personal needs of its patients	60.3%	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA
	Percentage of staff employed who would recommend the Trust as a provider of care to their friends and family	47%	57%	69.83%	70.20%	March 2017	TBA	TBA	TBA	

	Friends and Family test - percentage of inpatients who would recommend the trust as a provider of care to their friend and family	91%	92.68%	93.47%	94.80%	March 2017	TBA	TBA	TBA	
	Friends and Family test - percentage of patients discharged form A &E (type 1 and 2) who would recommend the trust as a provider of care to their friend and family	90%	92.6%	93.78%	93.84%	March 2017	TBA	TBA	TBA	
Treating and caring for people in a safe environment and protecting them from avoidable harm	Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism	96%	95.28%	96.85%	97.44%	March 2017	TBA	TBA	TBA	
Treating and caring for people in a safe environment and protecting them from avoidable harm	The rate per 100,000 bed days of C difficle infection amongst patients aged 2 or over.	9.85%	13.22%	TBA	TBA	TBA	TBA	TBA	TBA	

Treating and caring for people in a safe environment and protecting them from avoidable harm	The Number of patient safety incidents reported within the Trust	2157	2319	2625	2625	01/04/2016 to 30/09/2016 (NRLS)	13485	1485	4,955	
Treating and caring for people in a safe environment and protecting them from avoidable harm	The rate of patient safety incidents reported per 1,00 bed days	26.48% per 100 bed days)	27.45 (per 1000 bed days)	29.71 (per 1000 bed days	29.71 (per 1000 bed days)	01/04/2016 to 30/09/2016 (NRLS)	71.81	21.15	41.00	
Treating and caring for people in a safe environment and protecting them from avoidable harm	Percentage of patient safety incidents reported that resulted in severe harm or death.	1.3%	0.5%	0.64%	0.64%	01/04/2016 to 30/09/2016 (NRLS)	0.018%	1.73%	0.373%	The Croydon Health Services NHS Trust

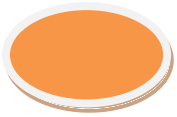
Part 3
Review of Quality Performance 2016-17

Review of Quality priorities 2016-17

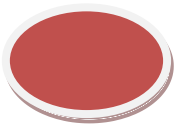
This section demonstrates the Trust's achievements throughout 2016-17 in the areas of patient safety, clinical effectiveness and patient experience. Performance against the priorities in our 2016 -17 Quality Account is included in each section.

To provide an at a glance view of performance we are using, a tick, dash, cross system.

indicates that we met our objectives for the year



made good progress but did not quite reach our objective



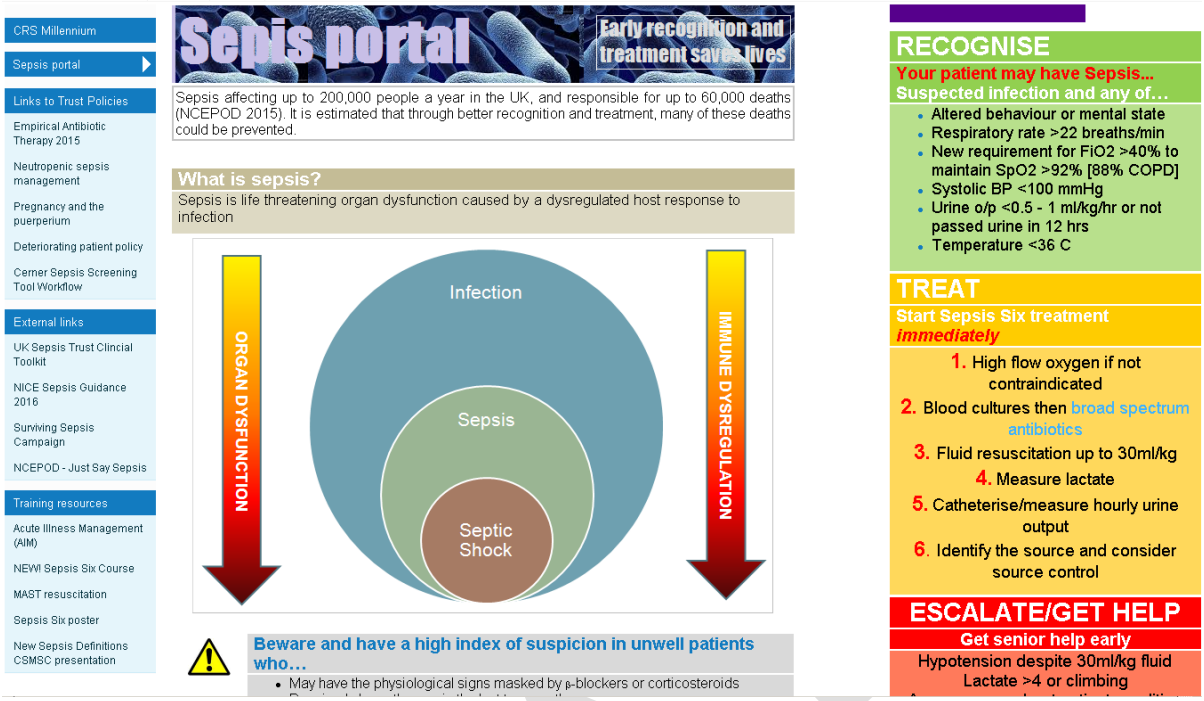
means we did not meet the objective and further work is required and will be undertaken

Priority			
1	Reduce the number of avoidable harm incidents		Made good progress

We linked our priority work area to ensure that it is weaved throughout the organisation whilst linking with our Listening into Action (LiA) work, CQUINs and local priorities. We have had a focus on areas of medication safety, mortality review, sepsis and acute kidney injury pathway.

Sepsis Task force

The Sepsis Trask force was set up to have a remit of coordination and delivery of a trust-wide unified sepsis strategy and to undertake a review all sepsis related Serious Incidents and make recommendations for action. There has been a streamline of information available on the intranet and a sepsis portal has been developed



There has been the development of the sepsis screening tool which will highlight on patient record if they are at risk of sepsis and a one click Integrated clinical records system (labs, clinical and nursing documentation, physiological observations, prescribing) (Cerner Millennium) . This alert has allowed the prompt action and instigation of the 'Sepsis six' and escalation where necessary.

We have achieved the Sepsis (ED and inpatient) and the AKI CQUIN's and it is acknowledged that performance could be improved and we will continue to work in these areas. We launched both the 'Sepsis Six# and Acute Kidney Injury cards for staff and our internal patient safety weeks and are now in regular use throughout the Trust.

Medications safety

As a Trust that uses Cerner or electronic patient records and electronic prescribing we have access to data around medication safety which has allowed real time feedback to staff. As part of the 'Knowing how you are doing' score card, ward managers and matrons are able to have real time access to allow change. A quarterly report goes to both Nursing and Midwifery Board and Medications Safety Group and Patient Safety and Mortality Committee for oversight. Matrons are currently being trained on how to use the omitted doses database so they can obtain the data themselves and can use this to implement change and reduce the omitted medications incidents.

The Trust is not currently achieving its target of reducing incidents of omitted doses by 20 per cent, however plans are in place to help achieve this as quickly as possible.

Maintaining improvement with Harm Free Care

The Trust has continued to perform to outperform the national average for delivery of harm free care with 96.4% of patients experiencing harm free compared to 94.3% nationally.

Pressure ulcers

During 2016, Trust incidence data shows a sustained reduction in pressure ulcers of all grades. There were a total of 1400 pressure ulcers reported for patients admitted to Croydon Health Services. Although this is a 12.5% increase since 2015/16 (1222), of these however, only 15% were acquired within Croydon Heath services (224) which is a 50% reduction in acquired pressure ulcers since the same period in 2016(333).

In summary Croydon Health Services NHS Trust pressure ulcer prevalence data shows the Trust is out performing the national average by 20%. This means that overall, patients within CHS experience 20% fewer pressure ulcers than all other NHS Trusts.

The incidence data suggests that fewer patients acquired pressure ulcers during their treatment within Croydon health services.

This has been achieved by:

- A Trust wide action plan that is monitored via the multi-agency pressure ulcer strategy group
- A follow up Big Conversation with Matrons and senior nurses to monitor current performance and plan for improvements.
- Early assessments and heel protectors for patients with high risks on admission into the CUH.
- Review of mattresses and trolleys for pressure ulcer prevention.

Greater number of patients assessed for risk of malnutrition.

Sustained improvement in the reduction of falls

CHS has outperformed other Trusts as reported via Safety Thermometer with a mean falls percentage of 0.66% compared to 1.59% for all organisations. The number of patients suffering a fall in Croydon Health Service's care has fallen by 5% compared to the same period last year. There were a total of 844 falls reported Feb 2015-Feb 2016 and 814 reported Feb 2016-Feb 2017. There was no change in the number of falls with severe harm (1) or moderate harm (11)

Overall Croydon performed well against other Trusts regarding:

- Number of falls per 1000 bed days
- Delirium assessments completed

- Mobility assessments undertaken
- Call bell within reach

Areas that the Falls prevention group have highlighted for improvement are;

- Recording of lying and standing blood pressure
- Continence assessments
- Multifactorial assessments for people who are at risk of falling including Vision and mobility assessments at the bedside

The Trust has recently been successful in being asked to join the National Falls Collaborative which is an NHSI initiative. As an outcome of this project we are introducing Falls champions from within our Health care assistants teams.

The champions' role will be to carry out closer observations of patient's needs particularly their usual routines within our Dementia friendly wards.

We have also developed "Bay watch" surveillance cards to make sure that any patient who is known to be at high risk of falling over is watched by someone near their bed.

Reduce catheter infections

CHS has performed well against this indicator since reporting began and this has been maintained with 0.28% of patients developing a catheter associated infection compared to 0.73% nationally.

100% root cause analysis completed on VTE

Safety Thermometer data shows that the Trust undertook VTE risk assessments on 90% of patients compared to 85.47% nationally. Improvement work is being undertaken with specific clinical areas who have not achieved the 100% target for VTE risk assessment. It should be noted that there was a data error for VTE in July 2016, CHS prevalence shows above national rates for VTE assessment.

Maintaining low hospital standardised mortality ratios

Mortality committee is now well established and provides regular reports to Patient Safety and Mortality Committee and is also reported monthly in the Trust Quality Report. All deaths are reviewed and all directorates are represented at the mortality Committee.

Monitoring how patient's food and nutritional needs are met

The Nutrition Task Force monitors nutrition and hydration standards across the organisation and ensure compliance with national guidance. The group has

developed a Trust wide nutrition and hydration action plan that is monitored by the Nutrition and Hydration Taskforce which meets monthly and included membership from the acute and community setting.

Individual ward compliance is monitored via the nursing performance scorecard and wards not achieving the standard have produced individual action plans to improve compliance. This meeting is chaired quarterly by the Director of Nursing Trust wide nutrition action plan in place and monitored via nutrition taskforce.

There have been a number of achievements to date:

- The Trust is fully compliant with Patient Safety Alert NHS/PSA/RE/2016/006- Nasogastric tube misplacement: continuing risk of death and severe harm
- Increased reporting of nutrition and hydration incidents by 20% since 2016
- Nutritional Study days organised –140 Registered nurses have attended a nutrition study session at ward level or in training department by since 2016/17. The programme covers all aspects of nutrition assessment and Malnutrition Universal Screening Tool (MUST) management in the acute setting.
- Bespoke Malnutrition Universal Screening Tool (MUST) training provided to wards.
- Nutrition-related 'Visible Wednesday' training organised including, MUST, Percutaneous Endoscopic Gastrostomy Care and Care of Nasogastric tubes. These are ward based sessions delivered by the practice development team and dieticians.
- Pathways continue to be developed for using oral nutritional supplements in management of malnutrition and through the trajectory of illness for specific patient groups- stroke and COPD initially. This will ensure compliance with NICE guidance

Challenges remain related to sustained compliance with the national Malnutrition Universal Screening Tool (MUST). We need to ensure.

- Weekly audits are completed to assess ward compliance with MUST standard.
- The Nursing metrics are used to monitor individual ward areas compliance with MUST scoring. Each ward is expected to present their results monthly within the Directorates and then quarterly to the Director of Nursing.

2	Participate in the implementation of the Maternity Ambition programme and focus on reducing the risk of intrauterine deaths and stillbirths		Met objectives for the year

The Trust has put an infrastructure in place and is fully participating in the programme. The initiative combines a small number of focused interventions based on “best available evidence and practice” and is part of a government drive to halve the rate of stillbirths from 4.7 per thousand to 2.3 per thousand by 2030.

There are four components of the bundle to address the problem by promoting best practice during both the antenatal and intrapartum periods.

The Saving Babies’ Lives Care Bundle consists of:

- Reducing smoking in pregnancy
- Enhancing detection of fetal growth restriction
- Improving awareness of the importance of fetal movement
- Improving fetal monitoring during labour

The care bundle approach is now a recognised approach to improvement across the NHS. Care bundles typically bring together a small number of focused interventions and evidence has shown that, when combined in this way, greater benefits can be achieved more quickly.

The Trust launched the ‘Saving Babies Life Care Bundle’ which is currently in the implementing stage. We brought together a Focus Group with members of the Multi-Disciplinary Team in early November 2016 to help develop strategies to affect positive change.

We are considering the elements of this initiative carefully with a view to promoting best practice, improving awareness and providing safer care. We believe that focussing on these key elements will be instrumental in bringing about a significant reduction in the number of pregnancy losses

The LiA Big Conversation, ‘Working Together to Reduce Stillbirths by 20% for Croydon Residents’ which launched the Saving Babies Lives’ Care Bundle was held on the 24th of March 2017.

This was attended by members of the multi-disciplinary team including Midwives, Health Visitors, Community Child Development Advisors, MSLC representatives and Student Midwives.

The aim was to introduce and raise awareness of the care bundle and we had fantastic participation and engagement from all that attended and some great ideas and suggestions were identified. Following the Big Conversation the feedback and ideas have been distributed amongst the team. On the 27thof April the Focus Group will meet to discuss these ideas and an action plan will be developed in response.

We are starting to implement some initiatives into our best practice guidelines:

The recommended reduced foetal movements leaflet is now included in all maternity notes from booking and discussed with women during their antenatal care.

We are educating Midwives regarding the implementation of the care bundle via the Midwives' mandatory training.

Training is being undertaken to implement the Growth Assessment Protocol (GAP) program

Smoking cessation has been reintroduced to the mandatory study week, along with mandatory e-Learning for all Midwives to support their care of women that smoke.

We have launched the K2 CTG Learning Package which all Midwives have been enrolled on, with an aim for the first 2 chapters 'Acid-Base and Fetal Physiology' and 'Intrapartum Cardiotocography' to be completed by all Midwives by the 10th of June 2017.

As a Trust we are also engaging in the Maternal and Neonatal Health Safety Collaborative which is a three-year programme to enable improvement in the quality and safety of maternity and neonatal units across England. We are in the first wave and will be attending the Maternal & Neonatal Health Safety Collaborative launch in May (a three day learning set).

3	Review paediatric pathways with a focus on the implementation of best start and a paediatric Assessment Unit		Met objectives for the year

The Seven Days Paediatric Service which is the first phase of the Paediatric Assessment Unit (PAU) has started which means children attending our Emergency Department have access to a consultant seven days a week. The Paediatric Pathway has been developed and implemented and we have also developed Intra professional standards for paediatrics.

The new observation charts, PEWS (Paediatric Early Warning Score) and action planners were introduced to Rupert Bear and Dolphin wards in the first week of September 2016. Nursing staff were trained prior to its introduction and doctors were trained as new starters began their new rotations in general paediatrics on 5th September. Feedback around the benefits of using these has been very positive.

The Trust is pleased to say that the Best Start Programme has been rolled out and that the health visiting service is now in three Best Start planning areas and is configured around Children's Centres. The health visitors are also aligned to GP Practices.

The planning groups not only include children centre staff but child in need social workers, midwives and health visitors, which has led to better communication and joined working between all stakeholders.

4	Build robust systems to document and disseminate incidents and key learning to minimise patient harm and maximise staff and well being		Made good progress

Whilst a lot of work has been undertaken in this area this year the Trust feels that the journey is not yet completed and as such has identified this as priority for 2017 /18.

The Trust has undertaken work with clinicians to improve clinical coding. This was included as part of the Patient Safety week highlighting the importance of correct coding and providing and advice on how to ensure this is correct and regular audits have been undertaken to ensure coding is accurate.

The Trust has developed a clinical dashboard to be used across the Trust. The "Knowing how we're doing" (KHWD) dashboard has increased the use of data has been added to include medication safety.

We produce "3 messages" following incidents and complaints and these are circulated weekly across the Trust and are discussed at ward meetings. The LiA shared learning work stream has been successful in embedding a change in incident reporting and the Trust has seen an increase in incident reporting of no and low harm incidents (which we see as a positive because it demonstrates a culture of openness and helps prevents future incidents through the sharing of learning. Directorates now have in place governance facilitators who work with the central governance team and agreed agendas and minute formats are in place.

We have reviewed the governance structures and have updated our clinical business units to ensure that there is a review of complaints and incidents at the business level as well as directorate level.

5	Review the provision of London Quality Standards and compliance with seven day services		Made good progress

Overall the London Quality Standards compliance stands at (85.3% *to be updated prior to publication)* which show an improvement of 5.9% from the assessment carried out in May 2016.

Improvement in Paediatric Surgery where by:

- Paediatric trained nurses appointed and in post.
- Anaesthetics who perform paediatric anaesthesia have an elective list to maintain skills and all received relevant level of training as specified by the Royal College of Anaesthetists.
- All nurses are trained in acute assessment, pain management and communication and have appropriate skill for resuscitation and safeguarding. Nursing staff undertake Paediatric Immediate Life Support (PILS) training. All training is assessed by mandatory Personal Development Plans.

Improvement in Paediatric Medicine:

- Emergency Admissions within timeframe as this is part of the surgical pathway. Paediatric Assessment Unit (PAU) in place, ward rounds taking place twice daily seven days a week. Children admitted with surgical problems are jointly managed by teams.
- All children admitted as an emergency receive twice daily ward rounds seven days a week.
- Consultant Paediatricians achieving seven day working via a weekly on-site rota.
- Nurses recruited and in post with one nurse at Band 7

6	Implement the Perfect Patient Journey programme		Met objectives for the year

There has been a lot of work undertaken with pharmacy to ensure patients are discharged smoothly including the pharmacy To Take Away (TTA) programme

- TTA Transcribing policy ratified (Apr 16)
- TTA Training programme developed and built on CRS Millennium (Jun 16)
- Directorates have provided their support to this process (Sep 16)
- Out of our 23 ward based pharmacists, 20 are eligible to undertake this role due to their level of experience
- Four Pharmacists have completed the TTA transcribing training and two are in training due to be completed by summer 2017
- Five Pharmacists are completed or going through independent prescribing
- Seven Pharmacists who are eligible but are yet to start their training
- Five pharmacists do not meet the relevant level of experience to undertake this activity.
- Reduction of the length of stay CQUIN has been met
- Neonatal length of stay CQUIN is being met with no risk of delivery being reported.
- Introduction of a number of initiatives to reduce the length of stay have been on-going including SAFER.

7	Improve how we capture and act on patient and carer feedback		Met objectives for the year

Improvement of complaint performance A full review of the complaints process was undertaken in 2016 and the trust policy and Standard Operating Procedures were updated. The changes put in place were driven by latest PHSO guidance (2014) to ensure that the complainant is kept at the centre of the complaint handling process. In addition the internal escalation procedures for complaint handling were reviewed and strengthened to provide additional management support to investigation leads. The trust overall compliance of the compliant response has remained above 80% and work is on-going to improve on this performance

Improvement patient involvements in Quality Activities Following the LiA Public Listening event in May 2016 a number of new patient engagement initiatives were introduced. This includes a new Food and Nutrition Group, the Mystery Shopper Project, the Patient and Public Policy Review Group and the new Stakeholders Equality, Diversity & Inclusion Forum. Additional dates for follow-up public engagement meetings are in place for 2017.

Patients have started to become involved in our committees and groups and some are already part of the following groups:

- ED rebuild
- Food and Nutrition
- Stakeholders Equality, Diversity & Inclusion Forum

Improving our Friends and Family Test response rate

The internal Friends and Family Test (FFT) response rates are monitored each month at every level within the trust so that response rates meet internal standards:

- Knowing how we're doing (KHWD) scorecard and information boards
- Directorate Quality Boards
- Quality and Clinical Governance Committee

Engagement with FFT has been encouraged at ward and departmental level for every service by a close working relationship with the Patient Experience Team who provides bespoke reports, ad hoc performance trackers, RaTE System training, FFT Trees (visual engagement tool) and alternative collection methods utilising

technology. The trust Board receives the monthly Quality Report which includes the response rates from FFT. The Trust overall performance for FFT has been above 93% for most areas except for maternity where in month 7 there was a drop in returns which is being investigated.

8	Implement the CQC recommendations made in September 2015		Met objectives for the year

Reduction in complaints and serious incidents
Complaints: These have ranged from 45 to 70 per month throughout the year, bringing the total to 419 YTD. There was a downward trend reported in the Month 8 Trust Quality Report.

Serious incidents:
The total number of serious incidents YTD is 74. There was an increase in the number reported in the Month 8 Trust Quality Report. There were no serious incidents reported under specialised commissioning.

Incidents resulting in moderate harm and above: There has been an overall downward trend of incidents resulting in moderate harm and above reported from month 1 (3.3%) to month 8 (2.62%).

Governance process in place
Governance structures have been reviewed and updated at Trust, Directorate and CBU level. Best Practice agendas, minutes and action trackers are now in place and are being monitored to ensure that they are being embedded. Clinical Governance meetings are being carried out and suggested format/agendas have been disseminated. It is acknowledged that there will be different formats used due to the range of specialties.

Refurbishment of theatres - full business case in place

Following the increase of the Trust capital approval limit a contractor have been appointed to draft the Outline Business Case for this project. Capital funds have been included within the 17/18 capital plan to enable this project to proceed through the Business Case process

90% of staff receives up to date training in safeguarding

All staff receive safeguarding (adults and children) level 1 training during Trust induction. Safeguarding leaflets giving updated level 1 information for adults and children are attached to staff payslips once a year.

The overall March 2017 core skills training figures are 91% against a target of 90%.

Performance against national priorities

Standards	Target	2014/15	2015/16	2016/17
Meeting the MRSA objective	0	**1**	**1**	**1**
Clostridium Difficile	16	15	20	13
RTT Waiting Times for Admitted Pathways: Percentage within 18 Weeks	90.00%	90.45%	80.10%*	65.03%*
RTT Waiting Times for Non-Admitted Pathways: Percentage within 18 Weeks	95.00%	95.89%	92.8%*	89.68%*
RTT Waiting Times for Incomplete Pathways	92.00%	95.67%	94.53%	92.81%
Diagnostic Waiting Times for Patients Waiting Over 6 Weeks for a Diagnostic Test	1.00%	6.49%	0.22%	1.83%
A&E 4 Hour Time in Department (All Types)	95.00%	93.78%	92.33%	89.01%
Cancer Waits - Referral to First Appt for Urgent Suspected Cancer (14 Days) Proportion of patients seen within 14 days of urgent GP referral	93.00%	95.85%	95.28%	96.94%
Proportion of patients with breast symptoms seen within 14 days of GP referral	93.00%	97.84%	95.08%	98.13%
Cancer Waits - Diagnosis to First Treatment (31 Days)	96.00%	97.95%	98.61%	98.74%
Cancer Waits - Proportion of patients receiving subsequent treatment within 31 days (Drug)	98.00%	100.00%	100.00%	100.00%
Cancer Waits - Referral to First Appt for Urgent Suspected Cancer (31 Days) Proportion of patients receiving subsequent treatment within 31 days (Surgery)	94.00%	100.00%	100.00%	100.00%
Cancer Waits - Referral to Treatment for Urgent Suspected Cancer (62 Days)	85.00%	87.77%	85.61%	89.26%

***Not mandatory report for2015/16 or 2016/17**

Infection control

C. difficile target

Croydon Health Services has made significant improvement in reducing healthcare associated infections (HCAI) this year.

Total HCAI C. difficile cases for period 1st April 2016 to 31st March 2017 is 13 against an annual trajectory of 16. There were several driving forces employed in achieving this target.
These include,

- Antimicrobial prescribing which stipulates that when prescribing Tazocin, Carbapenems eg Meropenem or Co-amoxiclav, staff should ensure shortest course possible is prescribed to reduce the risk of C. difficile.
- Introduction of diarrhoea poster which stipulates when to send stool specimen for C. difficile testing.
- RCA meetings on new C. difficile cases within 24hrs of the lab result
- Enhanced Surveillance on wards with a period of increased incidence of C. diffcile infection.

Antibiotic stewardship activities which include antibiotic prescribing audits and antibiotic ward rounds are also in place.

MRSA target

Total number of Healthcare-acquired MRSA bacteraemia cases (April 2016 – March 2017) is 1.

The bacteraemia that occurred in August 2016 has been allocated to CUH by the London Post-infection Review team. As the case was due to post-cardiac surgery wound infection, this should have been allocated to the tertiary centre where the surgery occurred. The Trust appealed but was unsuccessful.

To continue assurance of local effective prevention and control of MRSA and reduce MRSA transmission, the Trust MRSA guidelines advise the following:

- Routine MRSA screening for all adult emergency admissions as well as pre operative MRSA screening for all elective and emergency surgical patients.
- All patients found to be MRSA positive should be started on anti-MRSA topical treatment.
- If patients are found to be MRSA positive, the presence of MRSA should be stated in the discharge summary.
- Those patients who are MRSA negative at admission but are considered at high risk for MRSA acquisition i.e: all patients on ITU/HDU, SCBU, vascular wards, elderly care wards and those with indwelling devices or wounds (e.g. chronic ulcers, pressure sores, and surgical wounds) should be screened weekly for MRSA

Influenza and Norovirus

- The Trust treated a total of 171 influenza cases during the winter season beginning early December 2016 upto end of March 2017. The commonest circulating seasonal strain locally was Influenza A (non H1N1). The number of inpatient admissions due to this infection did create increased demand for single rooms on the general wards and the critical care unit.

- The staff uptake for the influenza vaccine was the second highest amongst the hospitals in London. There were no hospital acquired influenza infections among staff.

- There were no outbreaks of Norovirus at CUH to date this year

GRE (Glycopeptide Resistant Enterococci)

Routine pre-admission and weekly screening of ITU/HDU patients has been in place for some years. Routine screening of this group of patients has enabled ITU/HDU to provide timely single room nursing or implement enhanced infection control precautions on the main ward.

Laboratory screening results identified a transient increase in patients colonised with GRE in late November 2016. There has been no continuing increase in GRE numbers and typing results did not confirm an outbreak.

Infection Control Team have worked closely with ITU/HDU staff to identify risk factors for the increased numbers. Nursing practices, environmental cleaning standards and antibiotic prescribing have been reviewed. Changes are also being implemented to improve storage facilities and bed spaces to facilitate easy cleaning of the environment.

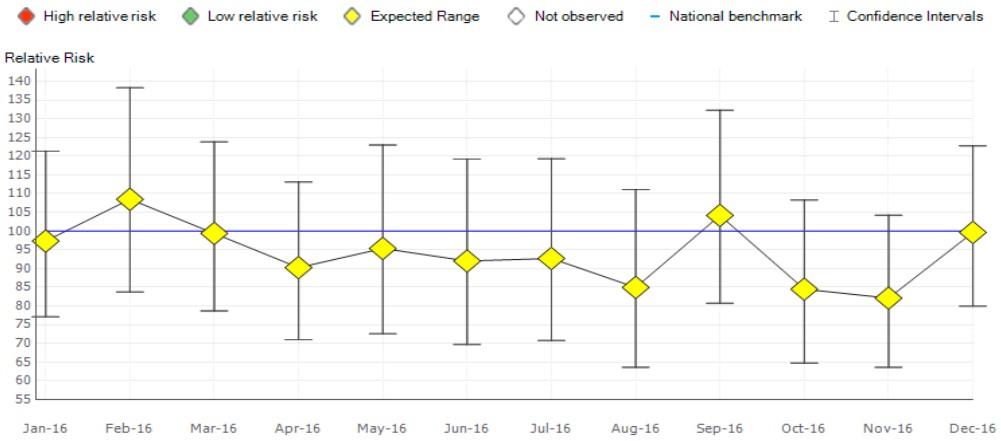
Mortality

The Trust has a robust process of retrospective case review of all in-hospital deaths and the results of the reviews are securely recorded within the Datix Incident Module.

According to the most recent Dr Foster report,

- Croydon is one of 4 Trusts whose Hospital Standardised Mortality Ratio (HSMR) is as expected within the London Peer group
- For the past 7 quarters, the trust has been within the expected range for HSMR (Fig1)
- For the last financial year FY15/16, HSMR at the trust has been as expected at 98.49
- HSMR for weekend and weekday is within the expected range
- The two Mortality metrics within the patient safety Indicators – Deaths in low risk diagnosis group and deaths after surgery are as expected

- The three diagnosis group with the highest number of observed deaths at the Trust are within Pneumonia, Septicaemia and Aspiration Pneumonitis, food/vomitus.
  The Board and our patients should be assured of the mortality issue at CHS
  The following represents the most recently available data for the Trust' s HSMR monthly trend



CQC Mortality Outlier Alert

The Trust received notification of a mortality alert from CQC for deaths from cardiac dysrhythmias. A comprehensive retrospective note review from the Cerner electronic system was undertaken and an action plan is in place to address the issues identified.

Progress update following Mortality reviews

- Mortality intranet page has been set up to make Mortality process resources easily accessible to staff.
- Random Audit of 10% of the Level 1 Mortality review cases for Quality Assurance is undertaken monthly.
- Introduction of electronic referral to HM Coroners.
- Re- Launch of the Escalation of deteriorating adults group.

Patient Safety Incidents

The Trust has been clear in its expectation that staff report near miss and unexpected adverse events using the Trust's web-based (Datix) incident reporting system.

Use of this reporting system enables the Trust to use its data well, regularly interrogating the information recorded, carrying out investigations and trend analysis and interpreting outcomes in relation to patient experience and safety.

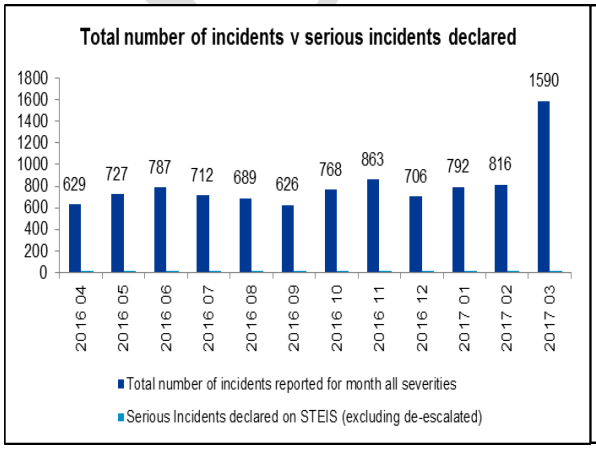
The Trust's Datix system is electronically linked to the National Reporting and Learning System (NRLS) and patient safety incidents are uploaded to this central reporting and analysis centre. Local investigation of all adverse events is supported within the Trust to ensure that appropriate challenge to existing practice is encouraged and good practice identified is rewarded. Periods of reflective practice in supervision and learning from investigations through regular learning events (known as clinical governance) are two ways in which learning is shared throughout the organisation. This year the Trust was identified as a pilot site for the roll out Datix version 15.2

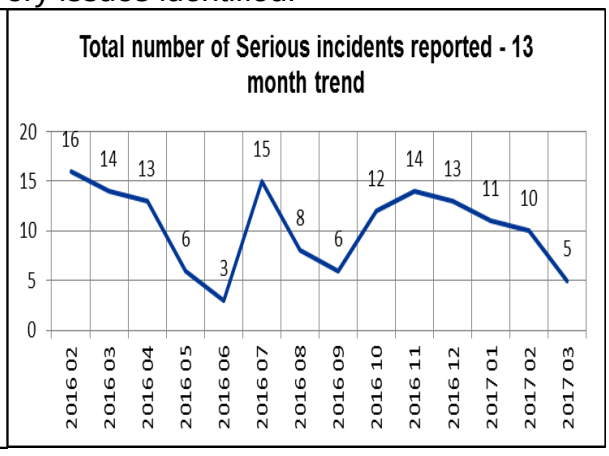
The Datix incident report form captures information to drive the quality and usefulness of safety information captured such as:

- 'Being Open' meetings with patients and their representatives (Duty of Candour)
- Flagging safeguarding concerns, including rationale for why a safeguarding is raised
- Recording root cause and lessons learnt

During the 2016/2017, 9705 adverse events and near misses (7059 clinical incidents and 2646 non clinical) have been reported by Trust staff using the Trust's reporting system; of which 114 were reported and investigated as Serious Incidents.

Of the Serious Incidents reported 16 were de-escalated, as following investigation the Trust identified that the incident no longer met the Serious Incident criteria or where there were no care or service delivery issues identified.





During 2016/17 the Trust reported one Never Event. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. The Never Event in 2016-17 related to a patient having a procedure they were not consented for and the use of the WHO checklist would have prevented this incident.

Following the Never Event, the Medical Director reported key messages to all staff and discussed at Grand round. Immediate actions included wristband identification policy,' full stop' for WHO checklist for all day case procedures.

Investigation panels are convened to bring together multidisciplinary senior colleagues to complete the investigation including a colleague who has been trained in RCA techniques.

The Trust has robust investigation process and all serious Incident final reports are also subject to an internal quality assurance programme, with sign off by either the Medical Director or the Director of Nursing, Midwifery and Allied Health Professionals prior to being sent on to the Clinical Commissioning Group for external scrutiny of the report and appropriateness of the actions before final closure of the Serious Incident.

In September 2016 we held for the second year our patient safety week. Throughout the week we highlighted a number of areas from Sepsis, coding, AKI, duty of candour, harm free care initiates and medications safety. We also launched into week our patient safety champions and safety pledges.

Duty of Candour

All healthcare professionals have a responsibility of being open with service users, their next of kin, carers and advocates, when something goes wrong with their treatment or care causing moderate or severe harm.

This is known as Duty of Candour and means conversations between the health professional and the patient or next of kin comprising:

- A full and true account of what has happened and answering any questions
- An apology and offer of appropriate support
- Advice on investigation being conducted
- Sharing the findings and learning

Croydon Healthcare Services has embraced the Duty of Candour principles with the appointment of a Clinical Lead and a Family Liaison and Investigation Facilitator to support clinical staff in enabling an effective Duty of Candour process within the Trust. They work with the hospital chaplaincy service in ensuring support is available to patients, next of kin and carers.

Awareness of the duty of candour process is being raised at the Trust Induction and also through provision of talks at ward staff handover meetings.

The investigation findings are shared with the patients / next of kin through "family meetings" where these have been accepted. Although this is a difficult time for both families and staff, the meetings have identified further learning from the events and provided another perspective leading to improved safety and quality of service to users as well as families and carers.

The Trust Executive Incident Review Group has a monitoring role to ensure the duty of candour is complied with. This includes a weekly review of incidents that may have caused moderate or severe harm. The Directorate Quality Board meetings also support in monitoring the duty of candour process.

We have reviewed the patient leaflet on duty of candour, and incorporated a section on "mortality review" within the bereavement document. This is when an incident may have been detected following the patient's death. The Datix system has been updated with a revised duty of candour section.

Friends and Family Test

The test records the percentage of respondents who would recommend a service to their friends and family. There are no nationally set standards for this score however the internal standard at Croydon Health Services is currently at 90%

Recommendation scores are monitored monthly for each service and the standard was met consistently across services.

The overall majority of FFT respondents highly recommend care across all services at Croydon Health Services.

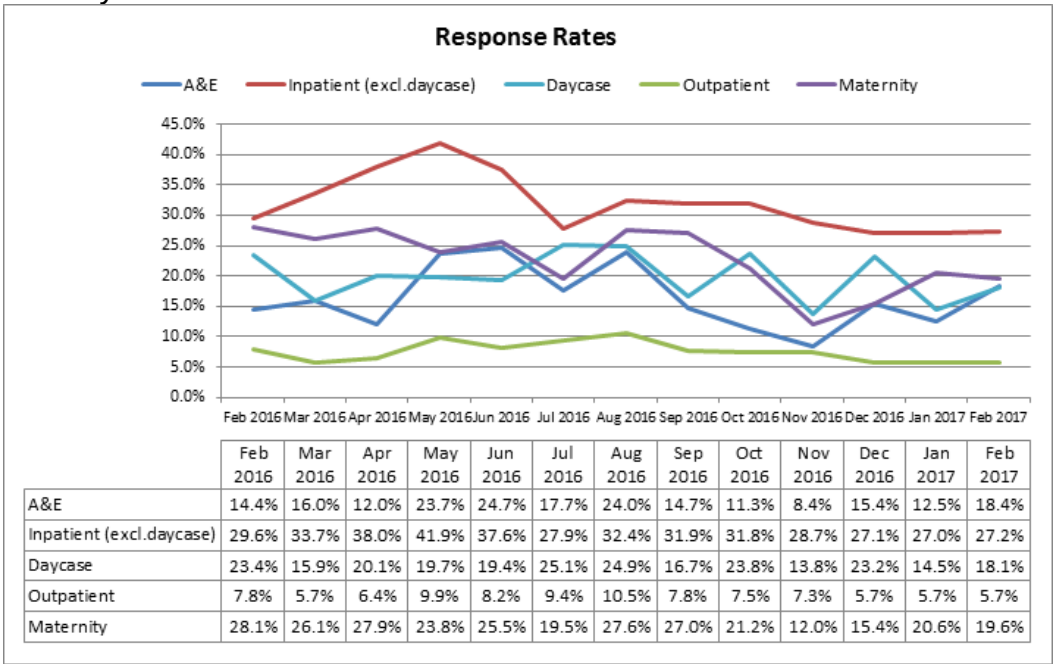
Internal standards for the Friends and Family Test Response Rates

Service	Standard
A&E (combined Adult and Paeds)	20%
Inpatients	30%
Maternity (aggregate)	20%
OPD	none

Day Cases	20%

The response rate results for this reporting period show variability across services during 2016-17. The results are monitored each month at both Board and Ward level, and in response, management actions are initiated to strengthen the results. Results dropped in Q4 and the Patient Experience Manager is supporting wards and departments to better utilise the electronic devices available to them.

Monthly data for each CBU is reviewed at directorate level



	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017
A&E	14.4%	16.0%	12.0%	23.7%	24.7%	17.7%	24.0%	14.7%	11.3%	8.4%	15.4%	12.5%	18.4%
Inpatient (excl.daycase)	29.6%	33.7%	38.0%	41.9%	37.6%	27.9%	32.4%	31.9%	31.8%	28.7%	27.1%	27.0%	27.2%
Daycase	23.4%	15.9%	20.1%	19.7%	19.4%	25.1%	24.9%	16.7%	23.8%	13.8%	23.2%	14.5%	18.1%
Outpatient	7.8%	5.7%	6.4%	9.9%	8.2%	9.4%	10.5%	7.8%	7.5%	7.3%	5.7%	5.7%	5.7%
Maternity	28.1%	26.1%	27.9%	23.8%	25.5%	19.5%	27.6%	27.0%	21.2%	12.0%	15.4%	20.6%	19.6%

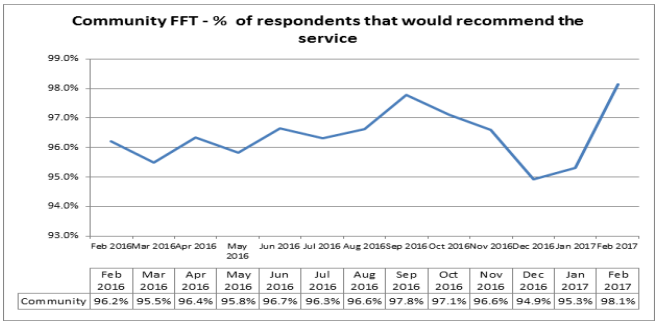
FFT results across the trust are monitored locally by Knowing How We're Doing (KHWD) methodology and results and actions are displayed publicly

Community Services FFT results February 2016

Response rates cannot be calculated for community patients because depending on the service and the care plan for the patient, a patient can be seen by a community service for two weeks (A&E Liaison) or for the rest of their lives (Heart Failure team).

Community patients are not expected to complete an FFT form every time they visit the service therefore the response rates cannot be determined using the number of patients seen by the community each month. As a result the Trust data available relates to recommendation scores only.

The recommendation rates are consistently good across services.



	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017
Community	96.2%	95.5%	96.4%	95.8%	96.7%	96.3%	96.6%	97.8%	97.1%	96.6%	94.9%	95.3%	98.1%

Improvement Actions

The Patient Experience Team continues to support wards and departments to improve response rates and recommendation scores and has initiated and directly supported a number of improvement actions during the year.

These include:

- Weekly performance trackers
- 1:1 ward manager meetings with Patient Experience Manager
- Roll out of FFT trees to promote public engagement
- Introduction of new electronic tablets
- FFT data now standard item on Directorate Quality Board agenda
- Monthly Knowing How We Doing (KHWD) meetings

Staff Friends and Family Test (FFT)

The Staff Friends and Family Test (FFT) continue on an upward trend for staff advocacy of CHS to friends and family as a place to receive care or treatment and as a place to work. The results of the last survey conducted in Quarter 2 (Jul - Sept 2016) demonstrates the highest and most positive scores since the survey began in April 2014. Some 72.8% of respondents indicated they would recommend the Trust to family and friends as a place to receive care or treatment and 71% indicated they would recommend the Trust as a place to work.

PALS and Complaints

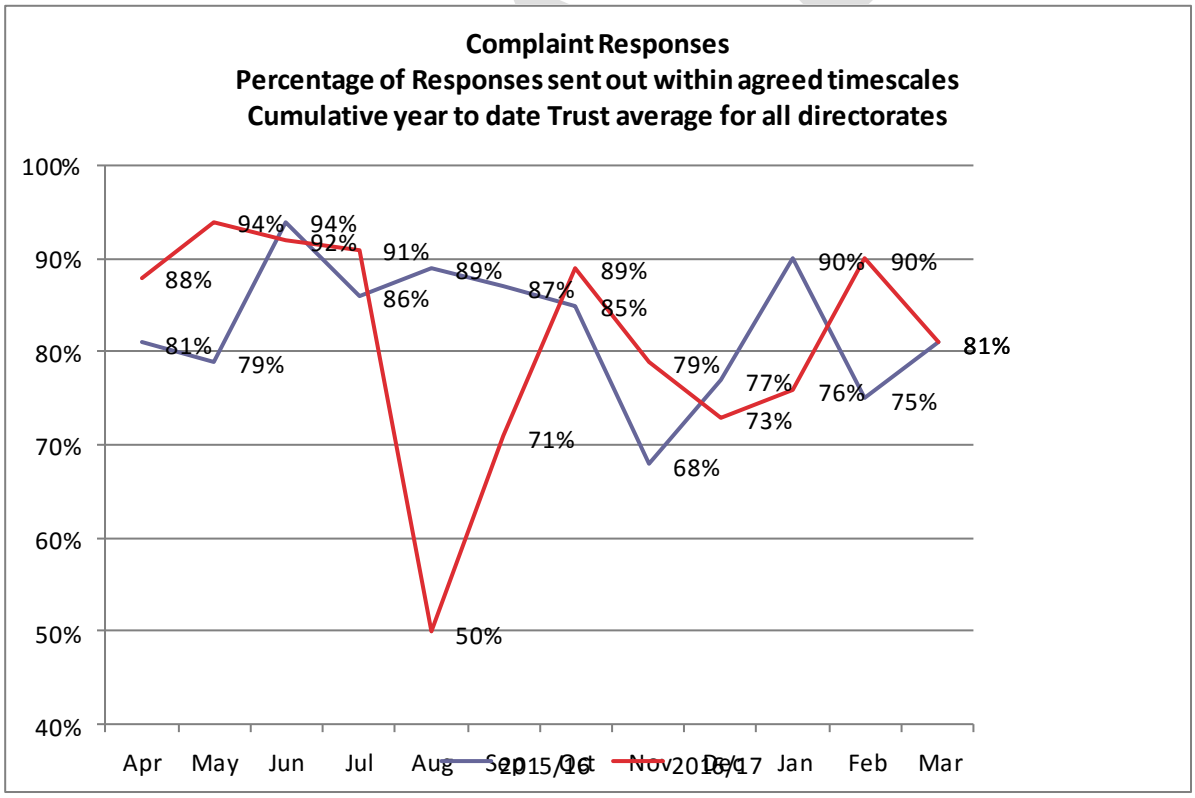
PALS

During 2016/17 the PALS team received 2419 cases. This is an increase of 77% compared to 1865 received during 2015/16. Since July 2016 actions have been put in place to improve the patient/relative/carer experience which has seen an increase over the months. In agreement with the complainant, complaints/concerns are resolved much earlier and informally without the need for the formal complaints process. The PALS team have a new professional look, and are now visible on wards resolving concerns, improving patient satisfaction and making staff aware of their PALS contacts The profile of the PALS team has been raised within the organisation and a uniform has been introduced to allow PALS staff to be easily identifiable.

Complaints

During 2016/17 the complaints team received an increase in **617** formal complaints compared to **499** received during 2015/16. The Trust standard is that we are committed to responding to 80% of formal complaints within an agreed timescale with the complainant, and the Trust achieved 80% compliance for 2016/17.

Month 5 dipped to an all-time low of 50% of responses sent out within agreed timescales. There was a full review of the internal escalation process which was applied by the complaints department to facilitate enhanced and proactive management of directorate responses within agreed timescales. The process was updated to empower band 5 complaints co-ordinators to start the escalation process directly with directorate senior managers. As a result, the escalation process has been updated to 'fast track' delays via senior directorate managers at an earlier point in the process. The proactive escalation of delays is agreed at the complaints team weekly operational meeting and weekly performance data is provided to execs and directorate leads. Performance was monitored and improved on a week by week basis and full recovery was achieved by month 7. In terms of complaint response, the Trust seeks to acknowledge complaints within 3 working days of receipt and at present we achieved an average of 97% for the 2016/17 Period.



Safe Staffing

All hospitals in England are still required to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

In October the Trust invited expert nurses from NHS Improvement to look at the way our nursing staff assess their patient acuity and the number of nursing staff we need to nurse patients safely.

CHS continues to display daily nurse staffing levels on each ward on a daily basis for each shift. A report on safe staffing is reported to the Trust Board on a six-monthly basis and included information on nurse staffing on all in patient wards as well as how our staffing compares to our peers across London. On a local level the Trust continues to report the actual staffing levels against our planned staffing levels on a monthly basis and these results are published nationally via UNIFY data published on the NHS Choices website.

The Trust continues to monitor ward nurse staffing levels each day and this is then triangulated against the acuity of the patients on that day. This enables us to escalate areas where additional resources may be needed and respond quickly.

The average fill rate for registered nurses across the in-patient wards and is an assimilation of day and night shifts. CHS remains comparable with our peers. The reduction in August 2016 is likely to be due to shortage of nurses during national school holidays. That in Jan 2017 is likely to be due to the opening of escalation wards in response to higher admission rates across the winter months.

Recruitment

Through the procurement and implementation of a new e-recruitment system, the Trust has reduced its average time to hire* from 26 weeks to just under 11 weeks. An increased focus on Nursing and Midwifery recruitment has led to the implementation of regular recruitment open days. In the 2016/17 financial year these open days led to the appointment of an additional 60 Nurses and Midwives to the Trust. To further support recruitment of these staff groups promotional flyers were produced for the following areas:

- Emergency Department
- Paediatric Emergency Department
- ITU
- Theatres
- Medicine
- Surgery
- Elderly Care
- Community
- Health Visiting
- School Nursing
- Maternity
- SCBU

These flyers are used at Trust Recruitment open days, University open days and also displayed around the Trust. Electronic versions have been created so they are added to each appropriate Nursing/Midwifery job advert and are also available on the Croydon Health Services website.

**excluding Medical and Dental Staff*

E-roster

Croydon Health Services was one of 20 Trusts that took part in a National Quality Improvement Collaborative. The programme supported Trusts to deliver workforce efficiency gains by using improvement methodology enabling them to make changes that lead directly to improvements in care delivery. The Collaborative model was developed by the Institute for Health Improvement (IHI) and the programme was run by Allocate Software.

Following successful participation in the programme the Trust was awarded the Certificate for 'Innovation in Approaching Change' in acknowledgement of the Weekly Nursing Resource meetings and monthly/annual Roster quality awards scheme.

To further build on this success the Trust will shortly be implementing the 'Safecare' module of e-roster which allows for visibility of patient acuity to more accurately match staffing resource with patient needs.

Volunteers

The Trust now has almost 400 active volunteers. Last year saw the launch of the 'Lunch Club', an innovative programme enabling patients recovering from long-term conditions to eat lunch in the Oasis Restaurant as part of their rehabilitation.

Staff Survey

Overall there has been a significant improvement in staff engagement in contrast to our 2014* results, which also matches the trend of our peer group with respect to continuous improvement.

**It should be noted the analysis undertaken within this report is based on the 2014 staff survey results and not 2015. The reason for this is because our 2015 staff survey results have been excluded from the national data set. The exclusion is due to the fact that in 2015 the Trust applied local exclusions, specifically the exclusion of junior doctors and staff with less than 1 years' service. These local exclusions were applied incorrectly and therefore raised concerns from the regulator about potential bias. In light of these concerns the Trust agreed with the recommendation that the 2015 staff survey data set would be excluded.*

Positively, since 2014 scores in the following key patient care categories have improved greatly

- Care of patients / service users is my organisation's top priority (+9%)
- My organisation acts on concerns raised by patients / service users (+5%)
- I would recommend my organisation as a place to work (+6%)
- If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (+9%)

For 2016 we also benchmarked higher than our peer group in a number of categories – our top five being

- Quality of non-mandatory training, learning or development (CHS 4.13 v Peers 4.07)
- Quality of appraisals (CHS 3.27 v Peers 3.11)
- Staff Motivation at Work (CHS 4.00 v Peers 3.94)
- Percentage of staff / colleagues reporting most experience of violence (CHS 71% v Peers 67%)
- Percentage of staff experiencing physical violence from patients, relatives, or the public in the last 12 months. (CHS 12% v Peers 13%).

Arguably our staff motivation score is a remarkable feat given the survey was undertaken during our placement in financial special measures.

Equality and Inclusion

Through the development of our Equality, Diversity and Inclusion Strategy we have managed to build an infrastructure to achieve our mission “to make CHS a place where diversity and inclusion is promoted and celebrated”.

In December 2016 the Trust Board signed off and published on the internet the following documents;

- Equality, Diversity and Inclusion Strategy 2016-2019 (including a Delivery Plan)
- Equality Objectives for 2016-2018
- Equal Opportunities Policy
- Work Force Race Equality Standard (WRES) 2016 data
- Equality Delivery System (EDS2)

To ensure the smooth delivery and governance of the Equality, Diversity and Inclusion Strategy and other key requirements, we have set up the following groups;

- Equality, Diversity and Inclusion Committee
- Staff Working Groups
- Stakeholders Equality, Diversity and Inclusion (EDI) Forum

The Equality, Diversity and Inclusion Committee is made up of senior managers across the Trust. Their role is to oversee the delivery of the Strategy, and the integration of the WRES and EDS2 into the Business Planning process, together with identifying the actions that need to be taken in HR and across the Directorate. In addition we have made improvements to ensure that our staff have an opportunity to engage through the Staff Working Groups with the aim of improving the equality agenda throughout the organisation.

The Stakeholders EDI Forum is an external group of voluntary and community sector organisations that was formulated in September 2016. The Forum currently has 16 members representing Age, Disability, Race and Sexual Orientation. EDS2 is a national programme to assist the Trust in meeting our legal equality duties, which entails providing evidence to ensure that patients and service users are engaged in the process of designing and delivering services that are appropriate to their needs. Implementation of EDS2 in 2016 included the assessment of services within the Directorates of Integrated Adults Care, Integrated Surgery Cancer & Clinical Support, Integrated Women, Children and Sexual Health. The Trust has been working towards improving patient experience by develop working arrangements and assessments with the Stakeholders EDI Forum.

The Trust's Annual Report 2016 will be published by April 2017, once the EDS2 grades and actions have been agreed the outcomes. Additional services will be assessed under EDS2 throughout 2017 -2018 and we will continue to use the Stakeholders EDI Forum to help us to measure how well we are doing to meet the diverse needs of patients and carers who use our services.

Freedom to speak up Guardian

At Croydon Health Services NHS Trust, we value staff opinion and feedback and are willing to listen and respond to concerns raised. This commitment is supported by the Trust policy and delivery of staff sessions on the Freedom to Speak Up process, ensuring the issues raised are listened to, properly investigated and that feedback is received on actions taken.

CHS is committed to empowering and supporting staff to raise concerns regarding any issues they come across in the workplace. Five nominated Freedom to Speak Up (FTSU) Guardians from diverse staff groups are available to provide objective confidential advise and support to staff raising concerns about any issues. The Trust has provided multiple avenues for raising concerns to ensure there are appropriate routes for escalating concerns if necessary.

Furthermore, Freedom to Speak up sessions are provided to ensure staff feel empowered and supported to challenge, debate and raise concerns as part of normal work practice. Freedom to Speak Up sessions are also delivered to managers and supervisors who have a responsibility for creating an open and positive environment within their teams to ensure concerns raised are well received, fully investigated and responded to. CHS is committed to creating an environment

where all staff feel safe in raising concerns and feel confident that their concerns will be addressed.

The Trust continues to work with the Joint Staff Consultative Committee (JSCC) to encourage a more open safety culture built on the ethos of listening and taking actions to address concerns raised by staff**.**

Emergency Department

Like most acute trusts across the country, CHS have found it challenging to see and treat 95 per cent of patients who attend our Emergency Department within four hours in 2016/17.

Our performance however has placed Croydon Health Services within the top five of all London acute trusts for five months of the year (Apr to Aug 2016), and within the top ten for eight months (including Nov-Dec 2016, and Jan 2017).

We ended the year achieving 89.03% per cent – just under 6% per cent off the national target, and just over 2% per cent from our emergency care trajectory.

Our staff continue to work extremely hard in order to see all of our patients quickly and thoroughly, and priority will be given to our patients with the most pressing health needs.

Following the emergency care “reset,” NHS England and NHS Improvement wrote to all trusts (9 March 2017) setting out the actions needed for the turnaround of A&E performance. There remains a significant amount of work to do to recover and improve performance back to an acceptable level and all local systems are required to comply with the minimum national expectations for delivery of the four hour emergency care standard, that is, 90% by or in September 2017 and 95% by March 2018.

Across England, local health systems have been categorised into groups based on recent emergency care performance metrics and levels of risk within the health economy. Croydon is in group 3 (with group 1 being the most challenged, and group 4 the least).

The lessons learned from this year will be analysed, and the views and suggestions of our emergency care clinical teams listened to in order to develop a realistic Croydon Emergency Care Delivery Plan for 2017/18 for sign-off and close monitoring at the Trust Board

Cancer Waits

The Trust has maintained its Referral to Treatment (RTT) waiting times performance throughout this year and has met the 93 % 'incomplete' target every month for the past 12 months. The Trust has worked hard to ensure the 52 week waiters are reduced and for the last 5 months of the financial years 2016/17 there have no 52 week waiters.

The Trust has met the majority of its target and has regularly performed in the top five Trusts in London for the 62 day target. We have achieved the 14 day standards for each month for 2016/17

New developments for Macmillan cancer team:

- Implementing the NHS England Pilot project for Vague Abdominal Symptom pathway
- Two bids to NHS England Transformation fund have been successful. The first is to test a new diagnostic test for LGI cancer; the second project is to pilot a lead cancer nurse for primary care.
- AOS rapid access early diagnosis pathway is now running, with a GP telephone advisory service.
- The prostate cancer pathway is now led by an Advanced Nurse Practitioner.
- Increased nursing establishment for lung and breast cancer pathways.
- Clinical governance schedule established for Macmillan cancer team.
- Audit of complex IV access devices undertaken and new training schedule developed. IV access policy has been updated.
- Revision and dissemination of IV conscious sedation near to completion.
- Quality rounds by Head of Nursing and Interventional Radiology ANP undertaken to assess 8 & 9, with targetted education and training to areas of risk.
- Core panel of representatives from Macmillan cancer team to lead or support SIs and Datix reports relating to cancer.
- "I want great care" to be introduced for cancer patients as part of Royal Marsden Partner & Vanguard.

Listening into Action (LiA)

2016
LiA Accredited

In March 2016, Croydon Health Services received Listening into Action (LiA) re-accreditation for the second year in recognition of continued commitment to engaging and empowering staff to deliver change and service improvements. In the course of the year, the Trust held two patient and stakeholders LiA Conversations with patients, carers, service users and other members of the local community. Other initiatives have included;

Community feedback on actions taken on previous conversations to seek their views about areas of priority for the new financial year. Some of the improvement actions delivered through listening to patients and service users.

Introduction of a Patient and Public Policy Review Group that assists in providing patient and service user input on policies that impact the needs of patients and their relatives e.g. the Visitors and Carers Policy, Patient Property Policy and Hourly Rounds Procedure.

Introduction of a Food Quality Review Panel, supported by the Catering Manager, which is involved in food testing and also assessing the processes and quality of meals served to inpatients.

The Trust Wave 5 LiA plan included 13 Big Ticket Teams which have led to significant progress on our improvement journey around the quality and safety of patient care and patient experience. All the teams presented improvement outcomes at the exciting, exhilarating and engaging Wave 5 'Pass it on' event held in November 2016 and some of the positive outcomes delivered through the LiA Wave 5 Big Ticket teams include;

No Catheter, no catheter associated urinary tract infection: Reduction in the number of catheterised patients by 40% on 3 wards through the LiA team.

Increase in no and low harm incidents Through the Shared Learning Team incident reporting has seen a positive increase of 25% from 2014/2015 to 2015/2016. This is an essential governance quality indicator for the Trust.

Pharmacy TTA (To Take Away): The Introduction of the Pharmacy TTA process which involves training pharmacists on drugs prescription to support junior doctors and efficient discharge of patients.

Procurement of 12 bladder scanners: These have been funded by the Clinical Commissioning Group for the establishment of the catheter pathway in the community to ensure patients are able to be managed in the community without recourse to the emergency department due to lack of an existing pathway.

Mental Capacity Act Matters led by Endoscopy team: The team has reviewed and remapped the patient journey for USC/Urgent/Routine and Inpatients Pathways to ensure consent and capacity issues are identified early and appropriate measures put in place to support patients.

Introduction of visible daily ward walk rounds: These occur between 8am-10am and ensure Matrons are in touch with patients and provide daily support and supervision to frontline staff on the wards.

High quality care for patients with cognitive impairment: The Enhanced Care team designed and implemented an education programme that enhances the skills of nurses in providing high quality care for patients with cognitive impairment.

Named clinics for pregnant women: The introduction of named clinics are designed to ensure continuity of care for pregnant women through midwives having responsibility for the same clinic every week and a buddy to provide cover when required.

Free staff health checks: Free staff health checks were provided to approximately 400 staff in 2016 and, where required, onward referrals were made to relevant services.

Furthermore, the '**Let's Do it'** team led initiative continues to deliver quality and safety improvements that directly benefit patients, service users and staff.

Examples of these include;
Introduction of a patient 'Lunch Club' which enables patients to socialise and enjoy their lunch in the Oasis Restaurant, feedback from patients has all been positive and patients appreciate the environment and meals.

Implementation of new hand injury service which allows patients to receive quicker assessment and specialist hand injury treatment at the Trust, improving patient care and experience.

Rapid response team joint working with the London Ambulance Service (LAS) to visit patients who frequently call out ambulances and attend A&E in Croydon. The first patient to be reviewed had called the LAS over 40 times in a couple of months but the call out was reduced to once in three weeks without hospital admission after using this service.

New delivery system to the store through bulk orders. The Purley Community Nurses reduced cost of delivery by up to £60 per item by implementing a new delivery system to the store through bulk orders. This has also increased time to care as less time is spent by qualified nurses re-ordering equipment.

There is evidence to demonstrate the positive impact of LiA on quality, safety and experience of patients, service users and staff. The Trust strives to continue on this improvement journey and in February 2017 launched 30 new LiA Ambassadors from across the organisation to lead on tackling 30 issues and implement vital changes that will positively impact services and support further quality improvement at CHS.

'Frog Isolation Room' on the Rupert Bear paediatric ward at Croydon University

Beautiful, colourful images of pond life including frogs, ladybirds and butterflies now adorn the walls of the 'Frog Isolation Room' on the Rupert Bear paediatric ward at Croydon University Hospital, thanks to an £8,000 refurbishment project by Momentum children's charity.

Momentum, which supports children with cancer and life-limiting conditions in South West London and Surrey, was able to carry out these refurbishments thanks to supporters Croydon Relief In Need, Zurich Community Foundation and Axis Foundation, who between them donated £8,000 needed for the makeover.

The new decor, featuring the charity's mascot Mo the Owl has transformed the Isolation Room from a previously plain and clinical-looking space into a more child-friendly and welcoming place.

Paediatric oncology patients can sometimes stay in the Isolation Cubicle for days on end, not only at diagnosis, but at any point during their cancer journey. Having a bright and cheerful room eases their stay in hospital and ultimately reduces their anxiety and assists their recovery.

Children's services

Mayor of Croydon has officially opened Croydon's first Child Development Centre to provide multi-disciplinary services for children with special educational needs and disabilities (SEND). Child Development Centres are the established best practice model for SEND and are based on the idea that all children deserve access to a range of high quality services.

The new centre in Malling Close, Addiscombe brings together all SEND services, including those that previously were based at the Crystal Centre in Broad Green, and will deliver real benefits for children, families and staff. This is a celebration of excellent partnership working between families, the NHS in Croydon and Croydon Council.

More than 100 people, including staff and local families, came along to the official opening of the centre in January 2017. This is a fantastic new resource which is much needed by the local community and it will improve the delivery of services for many children and their families

The new centre, which has been created with support from Croydon Council will provide:

- Children's Hearing Service (Audiology)
- Children's Physiotherapy

• Children's Occupational Therapy
• Community Paediatrics
• Children ENT clinics
• Children's Speech and Language Therapy
• Children's Community Nursing services

For children and families, the benefits include an improved experience in a more child-friendly environment and better parking facilities. They should also find that they need to attend fewer appointments because multi-agency working means decisions can be made more quickly.

For staff, the benefits include the opportunity to work effectively with greater integration of services, improved multi-agency assessments and more rapid decision-making. The centre also offers a modern working environment, better parking and opportunities for flexible.

International Nurses' Day

The first black president of the Royal College of Nursing visited Croydon Health Services NHS Trust in May 2016 as part of the organisation's International Nurses' Day celebrations. Cecilia Anim met with nurses from all across the trust on Wednesday 11 May to share her experiences from and her journey, from a midwife in Ghana to being elected RCN president in 2014.

She presented awards to the Trust's Nurse of the Year, Midwife of the Year and Healthcare Assistant of the Year. All were praised for going above and beyond expectations, being inspirational to colleagues and providing excellent care at all times.

During Ms Anim's visit she also officially unveiled a new sculpture in the main entrance of Croydon University Hospital to commemorate nursing. The sculpture takes the uniform worn during the Crimean War by as the symbol of nursing and has words such as "care", "compassion" and "respect" carved into the wood.

Chaplaincy

We undertook an audit of the Chaplaincy Department based on the NHS Chaplaincy Guidelines 2015 'Promoting Excellence in Pastoral, Spiritual & Religious Care'.

The methodology for the audit was based on guidelines issued by the UKBHC UK Board of Healthcare Chaplaincy). We drew criteria from the Guidelines by which to assess the Chaplaincy Department at Croydon University Hospital. From the criteria we developed a self-assessment question to which we could respond with the evidence for the answer.

The audit took a number of months to complete as it was exhaustive in scope covering every aspect of Chaplaincy activity. We were gratified to find that the Chaplaincy department in Croydon University Hospital is performing very well. The whole process also gave rise to new ideas and areas where we need to make improvements or further develop what we do. Accordingly criteria not met have been used as the basis for an action plan for 2017.

Under the leadership of the Trust's new Diversity & Inclusion Manager there have been a number of changes. We have changed the structure of the sub-groups. To be known as staff networking groups these will in future only include staff members.

Those from outside the organisation will be invited to be part of a larger consultative group which will span all the protected characteristics. Accordingly the Religion sub-group, which has always included members from among the staff and those from outside the organisation, met for the final time this year. The meeting gave an opportunity both to look back over the achievements of more than a decade, to discuss the plans for the future and to thank the members for their hard work and wisdom.

The chaplaincy conduct a number of weekly visits which are patient-led and conversations take place with the agreement of the patient. All such encounters fall within the strict guidelines of confidentiality expected of chaplains, as of all NHS staff.

'Pastoral' includes everyday conversation, the sharing of human concerns, joys and sorrows.

'Spiritual' refers to all encounters where conversation has moved beyond the everyday to a discussion of more abstract spiritual concerns – the patient's hopes and dreams for the future, the principles of life that are important to them, their search for meaning in pain.

'**Religious**' refers to all conversations and encounters where the patient has spoken about their faith, has explored where God might be in their present situation or has requested prayer/sacramental ministry or asked for a member of their own faith community/their own minister to be called to see them.

'Short' means any encounter up to 5 minutes in duration.

'Medium' means any encounter between 5 – 15 minutes.
'Long' means any encounter over 15 minutes.

Chaplaincy Visits 2016								
Pastoral'			Spiritual'			Religious		
Short	**Medium**	**Long**	**Short**	**Medium**	**Long**	**Short**	**Medium**	**Long**
4002	657	179	1204	347	44	1062	518	204

In April 2016 we had the opening of the 'Garden Suite' where bereaved couples can spend time with their baby in comfort and privacy

The Garden of Healing and Wholeness, created using a generous bequest from former Chaplaincy team member, was formally opened with a service of blessing followed by a cream tea on 24th June.

The garden is planted with flowers, shrubs and herbs associated with healing and a booklet has been created explaining how each plant was used by early physicians. It is very much a work in progress— Spring 2017 will see the snowdrops and Lent Lillies flower for the first time.

Croydon Tram Crash
It was a privilege as Chaplains to be working alongside our clinical colleagues as the whole Trust pulled together to respond to the tragedy and to offer care and support to the injured and the bereaved. On the day our main role was in supporting relatives awaiting news, those who had been injured and those who found themselves bereaved. Later on we were involved in offering support to colleagues and facilitating staff debrief sessions.

The Chapel continues to open its door to welcome people of all faiths and none to experience the peace, and space for reflection, it can provide, comments left in our visitors book underline the value placed upon it.

Iron deficiency anaemia (IDA)

The Trust has launched a new clinic to tackle iron deficiency anaemia, a condition thought to affect around 20,000 people in Croydon.

Iron deficiency anaemia (IDA) occurs when people have fewer red blood cells because of a lack of iron in the body. As these cells help store and carry oxygen in the blood, people's organs and tissues don't get as much oxygen as they usually would.

This causes a range of symptoms including tiredness, shortness of breath and palpitations. If left untreated it can make people more susceptible to illness and can increase the risk of heart and lung complications.

It is particularly important to establish the cause because it is not always due to people's diet and can be triggered by a range of other factors, including chronic, heavy periods or gastrointestinal bleeding. GPs will usually start patients on oral iron supplements and follow them up in the GP practice. However, for some, this does not prove successful so they need to be seen by a specialist to investigate what is causing the condition.

A new iron deficiency anaemia clinic has been set up by Croydon Health Services to help these patients and ensure they are seen quickly. At the clinic, which is led by Consultant Nurse people who have been confirmed to have iron deficiency anaemia will be assessed and where appropriate, offered an intravenous iron infusion. The treatment is given over a 15 – 30 minute period in the haematology day care unit and patients are monitored for a short period afterwards to ensure they are fit and well to go home.

A follow up appointment is made to check on their progress, to see if a further dose is required and to develop a long-term management plan, in conjunction with specialist referrals made by their GP.

The clinic is based in the main outpatient department at Croydon University Hospital and people can be referred to it by their GP or other community services. The team plans to expand its work further by identifying if any patients scheduled for elective surgery have IDA so that the condition can be managed before they undergo a procedure. This should help to improve their recovery and reduce the likelihood to require a blood transfusion and minimise the length of stay in hospital.

As part of the team's commitment to improving the care and treatment of IDA, Croydon Health Services NHS Trust were represented at the launch of an Anaemia Manifesto in the House of Commons. The manifesto sets out a 5-point action plan to define best practice principles for optimal iron deficiency anaemia management, tailor services locally, develop a strong evidence base of IDA data, create educational materials for healthcare professionals and those at risk of IDA.

Health Visiting Team for Older People Service

A pioneering health visiting service which delivers vital support and care to frail, elderly people in Croydon celebrated its 20th anniversary.
The Health Visiting Team for Older People Service, began as a pilot project in 1996 with just one member of staff.
Now, 20 years on the team supports around 1000 older people all across the borough and is made up of 15 people including health visitors, community nurses, healthcare assistants and clerical staff.

Although health visiting services are found all across the country, having one dedicated to older people is so unusual that other organisations from all across England, Wales and Scotland have visited the Croydon service to learn about its work.
The service demonstrates the huge benefits of joint working across health and social care and is just one of the ways in which Croydon organisations are working together to improve care for older people.

An alliance of health and social care providers - including Croydon Health Services NHS Trust, Croydon CCG, South London and Maudsley NHS FT, Croydon Age UK, Croydon GP Collaborative and Croydon Council Adult Social Care - is currently redesigning services to join up health and social care for all over 65s in the borough. Its aim is to cut through organisational boundaries so people can stay in control of their care and be healthy and active for as long as possible.

Croydon Stars

The Annual Croydon Stars Awards which took place in April last year were a chance for the Trust to thank members of staff and unsung heroes who are inspiring to their colleagues and offer patients outstanding care in its hospitals, clinics and in people's homes.

The awards covered aspects such as outstanding leadership, achievement, teamwork, and volunteering. There were also two recognising the best team and individual who as part of Listening into Action 2 have ensured staff can make any changes needed to improve care.

Award winners include an 86-year-old volunteer who has spent 13 years helping patients, an inspiring physiotherapist who delivers exceptional care and two nurses who have worked for more than 40 years at Croydon University Hospital.

Statement from Croydon Clinical Commissioning Group

To be provided by Croydon CCG before the 01/06/2017

Statement from healthwatch Croydon

To be provided by Healthwatch Croydon before the 01/06/2017

Statement from Croydon Council's Health, Social Care and Housing Scrutiny Sub Committee

To be provided by
Croydon Council before the 01/06/2017

Statement from External Auditors

To be provided by
External Audit before the 01/06/2017

External Visits Summary Report for April 2016 – March 2017

In April 2016 to March 2017, 25 visits, assessments, audits and reviews specific to the Trust were reported. Of these, 12 are closed, 12 still remain open and 1 is awaiting final report. See the table below for more information.

Visit Name	Executive Lead/ Clinical Director	Directorate	No. of Recommendations /Actions	Number of Open Actions	Outcome/ Comments	RAG
Croydon Environmental Health Officer - Follow-up visit for Catering April 2016	Allan Morley	Estates & Facilities	0	0	Given a rating of 4. Trust is now compliant.	**Green**
JAG 5-yearly Assessment 12 May 2016	Enas Lawrence	Integrated Adult Care	0	0	Accreditation awarded.	**Green**
Joint Targeted Area Inspection CQC-Ofsted-HMCI 16-20 May 2016	Rosol Hamid	Integrated Women, Children and Sexual Health	17	2	Less than 3 actions relating to ED outstanding.	**Amber**
PLACE Patient-Led Assessments 27 -29 April 2016	Allan Morley	Estates & Facilities	204	69	CLOSED. Superseded by the November 2016 visit	**Closed**
London Fire Brigade Familiarisation Visit 2 June 2016	Allan Morley	Estates & Facilities	0	0	Reported to Audit & Safeguarding	**Green**
UKAS Re-visit for Haematology Laboratory 21 June 2016	Stella Vig	Integrated Surgery, Cancer and Clinical Support	0	0	No concerns identified. Lab retains its CPA accreditation.	**Green**
SGS Surveillance Audit - Unannounced Visit 21 June 2016	Allan Morley	Estates & Facilities	5	4	1 Major and 4 Minor non-conformities.	**Closed**

Visit Name	Executive Lead/ Clinical Director	Directorate	No. of Recommendations /Actions	Number of Open Actions	Outcome/ Comments	RAG
					Action for Major non-conformity completed. Superseded by 25-26 January 2017 Audit.	
LSA SoM Audit scheduled for 29 June 2016	Rosol Hamid	Integrated Women, Children and Sexual Health	1	0	Action completed	**Green**
NHS Quality Surveillance - Paediatric Oncology 22 June 2016	Rosol Hamid	Integrated Women, Children and Sexual Health	4	0	Actions completed	**Green**
NHS Quality Surveillance - Cancer of Unknown Primary (CUP) MDT Peer Review July 2016	Stella Vig	Integrated Surgery, Cancer and Clinical Support	1	0	Action Completed. No report or action plan received.	**Green**
HESL Risk Based Review - Dental 14 July 2016	Michael Burden	PGMC	6	5	Actions on-going on 5 recommendations	**Amber**
HESL - Speciality Focused Visit - GPVTS (Paediatrics) 14 July 2016	Michael Burden	PGMC	1	1	Action plan 2016 awaiting further update from HEE	**Awaiting report**
London Fire Brigade Audit of Maternity Department; Lee Harvey 4 August 2016	Allan Morley	Estates & Facilities	0	0	No adverse comments or actions required	**Green**
Acute Paediatric Services Peer Review – RCPCH 10-11 October	Rosol Hamid	Integrated Women, Children and Sexual	1	1	There is nothing specific to warrant an	**Amber**

Visit Name	Executive Lead/ Clinical Director	Directorate	No. of Recommendations /Actions	Number of Open Actions	Outcome/ Comments	RAG
2016		Health			action plan. Action is in progress. The planned Paediatric Village Business Case is going ahead and would address the issues raised.	
LFB - PGMC Post Fire Audit 20 October 2016	Allan Morley	Estates & Facilities	0	0	LFB satisfied with response and investigation	**Green**
LFB Audit - London Wing and Lancaster Suite 27 October 2016	Allan Morley	Estates & Facilities	1	1	Lack of fire wardens in ward areas noted, but no notice issued. Progress will be monitored by LFB fire safety officers	**Amber**
LFB - Operational update 10 November 2016	Allan Morley	Estates & Facilities	3	1	Awaiting installation of Premises Information Box	**Amber**
Community Paediatric Services (Children's Medical Services) Peer Review - RCPCH November 2016	Rosol Hamid	Integrated Women, Children and Sexual Health	14	12	Improvement action plan is being developed. Actions	**Amber**

Visit Name	Executive Lead/ Clinical Director	Directorate	No. of Recommendations /Actions	Number of Open Actions	Outcome/ Comments	RAG
					on-going	
PLACE Patient-Led Assessments Validation - Mini PLACE 30 November 2016	Allan Morley	Estates & Facilities	207	94	Actions on-going and on track to be completed	**Amber**
Stroke Unit Visit 2016	Enas Lawrence	Integrated Adult Care	-	-	Draft report received but awaiting final approval from CCG	**Awaiting report**
Safer Parking Scheme Assessment - Main site, London Road and Purley Hospital December 2016	Allan Morley	Estates & Facilities	0	0	Gained accreditation for both sites. Accreditation letters & certificates received	**Green**
SGS Surveillance Audit 25 - 26 January 2017	Allan Morley	Estates & Facilities	15	7	8 Majors and 7 Minors. Actions on-going and on track to be completed	**Amber**
Aseptic Services Unit Audit of Pharmacy - Quality Assurance Pharmacy Services 31 January 2017	Stella Vig	Integrated Surgery, Cancer and Clinical Support	28	23	3 Major, 12 Moderate and 13 Minor deficiencies	**Amber**
Environmental Health Office Food Safety Inspection 7 March 2017	Allan Morley	Estates & Facilities	6	4	Actions on-going and on track to be completed	**Amber**
PHE - Endoscopy annual Health and Safety Environmental Audit/Risk	Enas Lawrence	Integrated Adult Care	-	-	No information on visit received as yet.	**Awaiting report**

Visit Name	Executive Lead/ Clinical Director	Directorate	No. of Recommendations /Actions	Number of Open Actions	Outcome/ Comments	RAG
Assessment 8 March 2017						

KEY

Details of specific actions undertaken from the national clinical Audit

National Audit	Actions to improve quality
Myocardial Ischaemia National Audit Project: 2014 – 2015	The outcome of the audit demonstrates improved comparative performance on management of Myocardial Ischaemic conditions. The Trust maintained a 100% performance for the proportion of nSTEMI patients admitted to cardiac unit or ward. The performance increased from 88.5% to 91% for patients who had an angiography before discharge. The proportion of patients who received all secondary prevention medication for which they were eligible improved from 80.1% to 88.2%. The median length of Stay (LOS) reduced from 5 to 4. The proportion of nSTEMI patients seen by cardiologist or a member of the team decreased from 100% to 96.6%. The Trust is working with the clinicians to improve on the areas where performances were below 100%.
National Pregnancy in Diabetes Audit Report 2015	The obstetric team following the outcome of the audit is working on setting up a preconception clinic which will include the services of endocrinologist to offer women the right information at the right time and information on the importance of, and options for safe effective contraception.
National Gastric Cancer Audit 2016	The Trust is continuing with the practice of referring all patients with HGD to St Thomas hospital. All patients with a new diagnosis of OG cancer are offered staging CT to, and MDT discussion on best modality of treatment for patients with OG cancer.
National Clinical Audit of Biological Therapies. UK Inflammatory Bowel Disease (IBD) Audit	The Trust is continuing with the recommended practice of giving Infliximab biosimilar if appropriate and screening patients progressing to biologic therapy for TB, Hep B &C and HIV. Patients are reviewed face to face within 3 months of starting biologics to ascertain improvement in disease activity index. They are also reviewed throughout the year via email and telephone helpline and at month 10 to decide on continuation or discontinuation of biologic therapy. Patients found to be steroid dependant are counselled on the long term effect and if clinically indicated are considered for biologic therapy.
National Diabetes Foot Care Audit	CHS care performance was higher for most indicators compared to the national performance average. For instance, 50% of patients met their NICE recommended target compared to NDF average of 43.3%. Also in 4.5% of the ulcer episodes, patients were reported to have persistent ulceration at 24 weeks, compared to 23.2% nationally. Again, 16% of the ulcer episodes were seen within 2 days of the initial presentation to another health professional compared to 13.4% nationally and no ulcer episode were not seen for 2 days or more month, compared to 8.6% nationally.

National Audit	Actions to improve quality
	CHS diabetic team is working with clinical staff to improve on the performance to make sure good performances are sustained, and practices are improved particularly with documentation of 24 week outcome.
National Diabetes Audit 2014-2016	The outcome of the audit presents opportunities for improvement which the Trust has initiated actions to improve. In the case of patients with Type 1 diabetes, the required eight care processes consisting HBA1C, Blood pressure, Cholesterol, Serum creatinine, Urine albumin, Foot Surveillance, BMI, and Smoking were completed for 15.4% for patients compared to 37.3% for England. In the case of patients with Type 2 Diabetes, the eight care processes were completed for 42.1% compared to 53.9% for England. Despite the low performance for completion of all care processes for patients in 2015-16, the performances were an improvement over that of 2014-15 which was 14.3%. The diabetes service has rolled out education programmes for doctors and nurses particularly those working in the diabetes service to ensure that all care processes are completed for all Type1 and 2 diabetic patients. There is audit planned to ascertain compliance to the expected practices.
National Diabetes Inpatient Audit 2016	Results from national audit indicates that patients were very satisfied with their diabetes care overall with a score of 91% compared to England average of 83.7%. The Trust has put in place programmes including LiA conversation through the pharmacy service to address diabetes medication prescription and administration errors for nurses and doctors as these areas of care require improvement. The nursing directorate is emphasising on proper handover on patients to make sure staff are aware of patients' past medical history and presenting diagnosis. The Trust is increasing effort to ensure that diabetes patients are reviewed during inpatient care with emphasis on timely referrals of diabetes patients to diabetes nurses and consultants.
NPDA National Paediatric Diabetes Audit 2015-16 Report	CHS performance for completeness of the seven care processes which include HBA1c, Blood pressure, thyroid, Body mass index, albuminuria, Eye screening, and Foot examination was similar or better than most of the indicators nationally although the overall completeness was 22.4% compared to 35.5% across England and Wales for young people aged 12 years and older with Type 1 diabetes. CHS diabetic team is working with clinical staff to improve on the performance to make sure performances are improved particularly for foot examination and albuminuria.
National Audit of Cardiac	The number of ICD's implanted at CUH for primary and secondary prevention is 90% and 10% respectively (national average 50% and 50% respectively). The number of CRT-D's

National Audit	Actions to improve quality
Rhythm Management Devices	implanted at CUH for primary prevention is 93% and the national average is 77% The Trust is aiming at setting up specialist syncope pathways to enable earlier and improved identification of patients who may benefit from pacemakers and this has been discussed with the CCG. The Trust has intends to recruit a second consultant cardiologist with expertise in arrhythmias and cardiac devices. This will be a shared post with King's College Hospital (60%CUH / 40%KCH). This additional specialist arrhythmia consultant will enable improved education, improved pathways and therefore earlier and greater 'capture' of patients requiring pacemakers through improved expertise.
Maternal Mortality Surveillance Report 2016	CHS is working to address nationally identified areas of care that needs improvement. The areas include pre-pregnancy advice services, early pregnancy care, caring for women with hypertensive disorders, critical illness, and multidisciplinary approach to cardiovascular conditions.
National Bowel Cancer Audit	CHS is continuing with supporting bowel cancer screening programme to help diagnosis patients with early bowel cancer is demonstrated.

Local Clinical Audit

Specific actions being implemented from clinical audits

Local Audit	Actions to improve quality
WHO Checklist Practices audit	The Trust in its commitment to achieve a zero incident of a never event is continuing with both real-time direct observational and documentation audits, sharing results from the audits with relevant staff and services, and increasing education on the need to adhere to the process of sign in, timeout and sign out checks for all surgical procedures in the theatres. There is currently a group comprising of senior clinician, nurses and managers working with theatre staff to ensure complete compliance to WHO checklist in all departments where there are surgical procedures.
Peri-operative management of surgical patients with diabetes	Pre-operative assessment bundle for diabetic patients currently include section for assessment of chronic glucose control. There is awareness for prompt check for a recent HbA1c or repeat test for patients with diabetes among clinical staff.
Capacity QIP	Endoscopy Service as a consequence of the audit has conducted a concurrent LiA conversation regarding capacity and consent in

Local Audit	Actions to improve quality
	Endoscopy department to increase staff awareness on mental capacity in relation to endoscopy procedures.
Learning disability In Patient Audit	Outcome of recent audit highlighted areas for improvement in services to patients with learning disability. The Learning Disability Service is continuing to promote use of the Health Care Passport (HCP) as key to meeting the needs of patients with a learning disability. The Service through forums including, Learning Disability Partnership Board Carers Group and accessible family and friends' have developed feedback pack to get feedback from patients. The Service is also working to promote the concept of 'calling ahead ' for people with a learning disability and their carers/family members to pre-warn Emergency Department staff of any reasonable adjustments which may need to be made for patients on arrival. MCA compliance for adult patients with learning disabilities is also being monitored closely.
MUST Audit	Audit outcome presented the need for improvement to achieve MUST practice complete compliance to help identify and support patients who require nutritional input in the hospital. There is Nutrition Task Force led weekly ward rounds on poor performing wards and this is increasing awareness and supporting staff on the wards to assess nutritional status of patients.
Management of spontaneous pneumothorax in adults	Recent audit completed demonstrated compliant with interventional procedures. To sustain and improve practices, adult pneumothorax chest drain Proforma has been developed and rolled out in the A&E department by the Respiratory Service. Awareness to improve documentation of consent chest drain procedures, chest drain size, and of written advice given on discharge has been created.
Improving discharges in the intermediate care setting	CHS through introduction of electronic standardized template has significantly improves the quality of discharge summaries by prompting inclusion of relevant information which is then emailed to the GPs. The electronic discharge summaries were a collaborative effort from the medial team, nursing staff, occupational therapists, physiotherapists and social services