University College London Hospitals

NHS Foundation Trust

uclh

# Quality account 2012/13

University College Hospital

National Hospital for Neurology and Neurosurgery

Eastman Dental Hospital

Royal National Throat, Nose and Ear Hospital

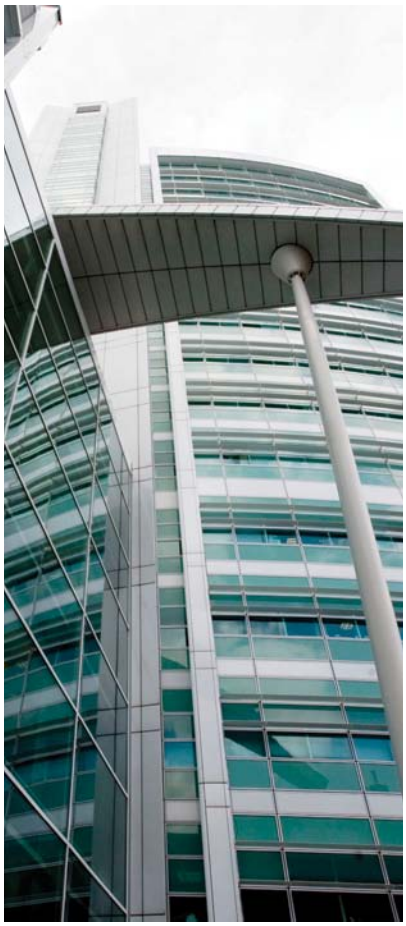
Heart Hospital

Royal London Hospital for Integrated Medicine

# Contents

# 1 Statement on quality from the Chief Executive

## Our vision is to make University College Hospitals NHS Foundation Trust the best place for patients to be treated and for staff to work.



This means delivering excellent clinical outcomes in a caring, compassionate and safe environment. Translating this into individual patient experience depends on the skill and dedication of all our staff and on the commitment at Board level to provide an environment in which our quality ambitions can be delivered. This Quality Account (also known as the Quality Report) reflects how we are going about this and the progress we are making.

Achievements during 2012/13 include strong performance in the national inpatient survey and in the staff survey showing that we are making positive progress. Eight out of ten staff would recommend UCLH as a place to work or receive treatment and patients rated their care as more than eight out of ten. We continue to make progress on key national safety measures such as falls with harm and prevention of venous thrombosis and we continue to have one of the lowest mortality rates nationally.

Despite the many successes there are things we still need to improve and we are determined to strengthen our efforts in areas such as infection control, performance in the national cancer survey and out patient waiting times.

In the last year we launched our new values – safety, kindness, teamworking and improving – which should be at the heart of every interaction with our patients and our colleagues. Around 1500 staff and patients were involved in the process of defining our values so we can expect ownership and delivery across UCLH.

The findings of the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust have also served to remind the NHS as a whole that patients should be at the centre of care delivery. With this very much at the forefront of our thinking we are continuing to make high quality, safe care our top priority.

I am pleased to be able to present this Quality Account to you and I believe it to be a fair and balanced report on the quality of care within the Trust. I also confirm that, to the best of my knowledge, the information contained within the report is accurate.

**Sir Robert Naylor**
Chief Executive

# 2 Introduction

## Current view of University College London Hospital NHS Foundation Trust's position on quality

Common to all our services is our quality philosophy which is that patient safety and harm-free care, excellent clinical outcomes and high quality patient experience should be central to all we do. Each year this guides our quality priorities and our Trust objectives which in turn provide the framework within which we operate throughout the year. Our Quality Account provides an annual opportunity for us to take stock of achievements and progress to date and to look forward to what our aspirations should be for the year ahead.

We recognise that the culture of an organisation has a significant impact on quality and safety and certain features such as leadership, clinical engagement and common values are of utmost importance. Therefore in addition to the priorities described above we have worked in recent years to establish a multi professional leadership academy as well as a Ward Sister Leadership programme. We have also embedded our tradition of clinical leadership and engagement within our organisational structure, which means practising clinicians are involved in the running of University College London Hospital NHS Foundation Trust (UCLH) at all levels from wards to the Board. Through our Making a Difference Together programme launched in 2011 we are focusing on the values and behaviours we believe need to be the cornerstone of our service to patients and we are working with groups of front line staff to identify what we need to improve to make their work easier and more effective.

We have also worked to ensure an effective quality and safety infrastructure capable of scrutinising, challenging and assuring standards of care and safety across the Trust. To this end our Quality and Safety Committee, which is a committee of the Board, has revised its format and focus during 2012.

In the following pages we have listed some of the highlights of last year as well as identifying where we did not make the progress we had hoped for, and we have summarised our quality improvement journey over the last few years.

Finally, it is relevant to our Quality Account to acknowledge that 2012/13 has been a milestone for the NHS with the publication of the Francis Report and high profile mortality issues in a number of other trusts. These serve to remind all healthcare organisations that safety and quality must be the core values of the NHS. At UCLH we continue to believe that quality is our constant mission. The Francis Report contains some important messages and numerous recommendations about the ingredients and processes necessary to delivering a safe, high quality service. We have been working on many of these at UCLH for a number of years but we are nonetheless assessing the recommendations, seeking assurance that we meet the standards and evaluating ourselves against the findings of the report. To date we have undertaken an assessment of our current status against all the recommendations to identify what assurance we have that we meet the standards and where we believe there are lessons for us. We have discussed the report and our response with the Board of Directors and are organising events with staff, governors and the public to help inform decisions about future developments and priorities.

## Quality highlights of 2012/13

### Trust values

During the year we developed and launched our values to guide how we work as an organisation and to support our quality improvement.

### Staff survey

In the national staff survey we were in the top 20% of all acute trusts for staff engagement.

### Inpatient survey

We maintained our performance in the national inpatient survey and were again one of the best performing London teaching hospitals.

### Dr Foster Good Hospital Guide

We achieved the second lowest mortality rate nationally and performed very well in the guide making it into the handful of hospitals given top rating for the balance of performance, efficiency and quality.

### Falls

We saw a 60% reduction in falls related fractures compared with last year.

### NHSLA

We were successful in retaining our CNST level 3 status against the Maternity risk management standards.

### The cancer centre

Last year we opened our new Cancer Centre bringing outpatient consultation and treatment facilities together in a purpose built centre.

### RNTNEH

We achieved a smooth transition for the Royal National Throat Nose and Ear hospital into our family of hospitals.

## Where we need to improve

### Infection

We were set very challenging Clostridium difficile and MRSA targets last year. Disappointingly, we exceeded our threshold for MRSA infections having 6 cases in the year against a target of 5 cases and 54 Clostridium difficile cases against our threshold of 44. 10 Clostridium difficile cases have been agreed with commissioners as probably not hospital acquired and 1 MRSA case was agreed as not preventable and untreatable. Nonetheless we accept the importance of eliminating hospital associated infections and so we will assess how we can do better in the coming year.

### Cancer survey

We were very disappointed that cancer patients again did not report a good experience of care in UCLH and the cancer system in London in our 2012 Cancer Patient Experience Survey.The move into the new Cancer Centre took place after the survey was conducted and is clearly an opportunity to improve the experience of patients but we realise we need to capitalise on this with plans to improve communications, emotional support and information.

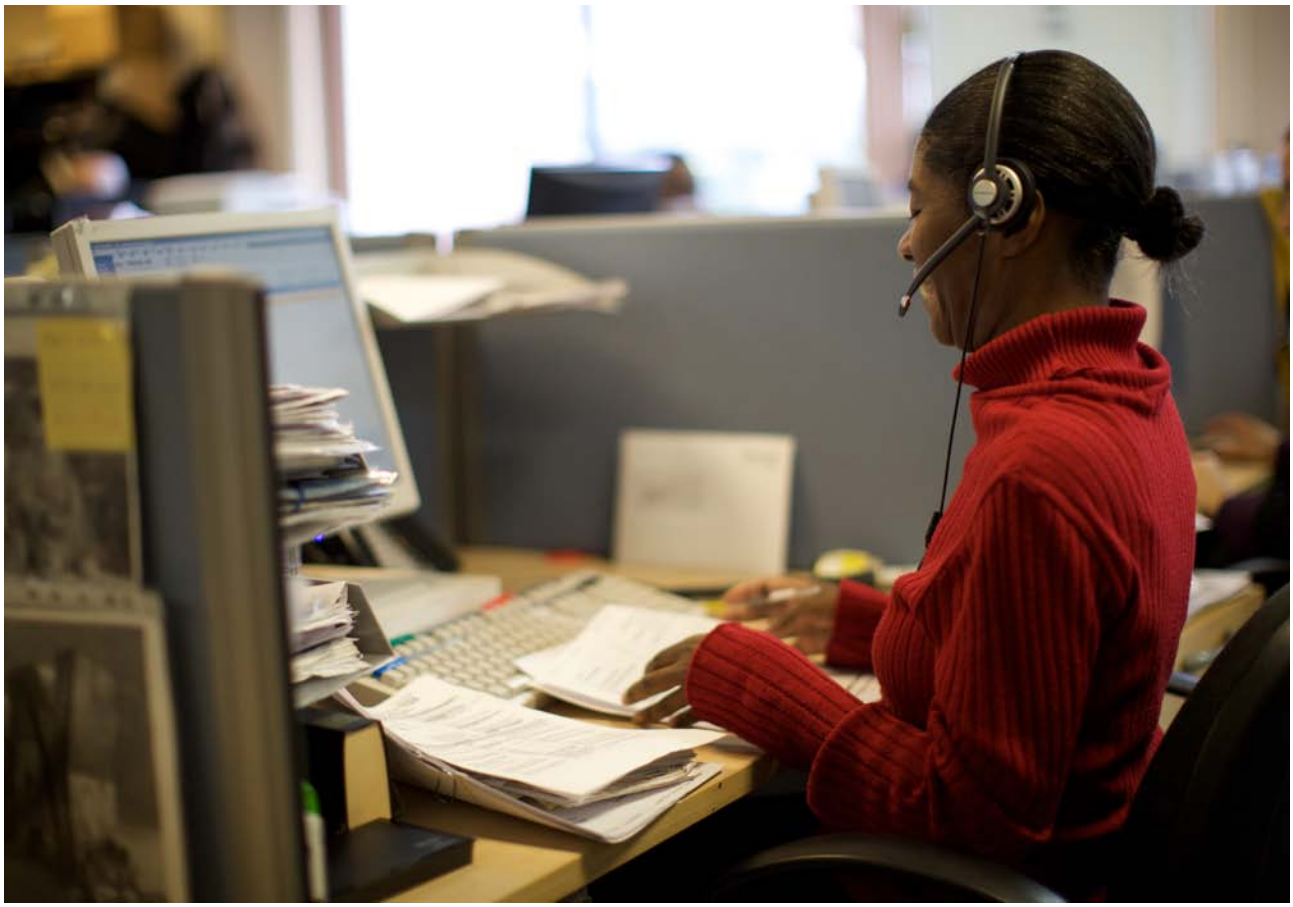
Our cancer teams are committed to improving their patients' experience and continue to develop their plans based on our patients' feedback.


## Waiting times

Waiting times in A&E and cancer clinics have been particularly challenging for us and, in keeping with many other trusts, we have struggled at times to meet our national performance targets. We experienced a particularly difficult eight week period in the autumn due to the continually rising demand on our A&E. We have worked hard to make more beds available and to improve the patient flow in UCH and this is work which will continue through the coming months in preparation for the winter period which is usually our busiest period.

## Adminstrative processes

We know from patient feedback that some of our administrative processes can be slow and frustrating for patients in such areas as planning admissions and making appointments. Despite improvement programmes we still have things that we know we need to improve and this will be an area of focus in the coming year.



## Our quality improvement story

The table below charts our Quality Account priorities over the last few years and demonstrates the continuity of some priorities along side newly emerging priorities.

| 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Patient Experience | | | |
| Improve patient involvement | Improve patient experience in five CQUIN* areas | Improve patient experience in five CQUIN areas | Improve patient experience in five CQUIN areas |
| | | Improve trust & confidence in nurses | Review planned admission process |
| | | Improve storage for personal belongings | Improve quality of food |
| | | Ensure availability of hand gel | Improve nursing communication with patients |
| | Improve outpatient experience | Improve overall care rating in out patients | Improve overall care rating in outpatients |
| | Improve cancer patient experience | Improve cancer patient experience | Improve cancer patient experience |
| | | | Improve our end of life care |
| | | | Improve the management of pain relief |
| Patient Safety | | | |
| Reduce harm from falls | Reduce harm from surgical site infection & central line infections | Reduce number of falls resulting in harm | Reduce harm from falls, VTE, HAPU & infection |
| | Assess patient Venous Thromboembolism (VTE) risk | Eliminate grade 4 Hospital Acquired Pressure Ulcers (HAPU) | Reduce medication omissions |
| | | Increase VTE risk assess | Use Ward Safety Checklist on daily ward rounds |
| Clinical Outcomes | | | |
| Review & improve the recognition of acutely ill patients | Review our unplanned readmissions | Review our unplanned readmissions | Continue to improve mortality ratio |
| | Improve our hospital mortality ratio | Improve our hospital mortality ratio | Develop clinical outcome measures specific to each specialty |

**CQUIN – Commissioning for Quality and Innovation – is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work.*

In addition to contributing to the Trust wide programmes, local teams routinely identify their own quality improvement topics in areas that they want to enhance the safety, experience or clinical outcomes of their specific patient community. In this way the ethos of continuous improvement is embedded within UCLH and is personal and proactive.

# 3 Priorities for improvement and statement of assurance from the Board

## Our quality priorities for 2013/14

Patient safety, excellent clinical outcomes and positive patient experience have remained constant as our overarching quality objectives. Each year we assess our performance against previous quality priorities and take account of national reports and emerging themes. This year we have again evaluated our focus for the coming year and have identified a number of priorities for 2013. Each priority comes under one of the three quality objectives.

### Patient Experience

Improving the experience of our inpatients, cancer patients and outpatients. This includes:

- giving timely and relevant information
- a special focus on end of life care
- a special focus on providing effective pain management for inpatients

### Patient Safety

Reducing avoidable harm specifically in relation to falls, pressure ulcers, infections and thrombosis. In addition we are including:

- reducing the risk of poor communication by improving the use of our Ward Safety Checklist in daily ward rounds
- reducing medication omissions.

### Clinical Outcomes

Developing specific clinical outcome measures at specialty level which are capable of comparison with peers as well as continuing to improve our performance on hospital mortality ratios.

In determining our priorities for 2013/14 we have consulted with our Quality and Safety Committee and clinical Boards. Through our Clinical Quality Review Group we have consulted with our commissioners and GP representatives and we have also taken into account the views of our governor and patient representatives. The Quality & Safety Committee on behalf of the Board approved the priorities which will be reported on to the Committee regularly through the year.

# Priority 1: Patient Experience

## 1. Increasing overall patient satisfaction as measured by national surveys

### Why we have chosen this priority

We know that listening and responding to patient feedback is a crucial part of quality improvement. However well we may think we are doing, it is our patient feedback that counts most. The annual national surveys provide detailed feedback to us as well as enabling us to benchmark ourselves nationally and against London peers. We have analysed the 2012 inpatient survey to identify our priorities for the coming year. Our previous improvement plans for cancer and out patients also carry over as these are long term plans. We know that waiting for appointments and treatments is distressing for patients and so these continue to be a priority. For cancer patients we have also chosen information and emotional support as our measures of success.

### What are we trying to improve?

- We aim to improve our inpatient survey performance against the new Family and Friends Test which is now a national CQUIN measure
- We will also target areas based on our last survey performance where we believe we need to improve
- We intend to continue our improvement programme for cancer and out patient experience

## 1.1 Inpatient Survey – what success will look like:

| CQUIN focus | 2012 result | 2013 target |
|---|---|---|
| How likely are you to recommend our ward to friends and family if they needed similar care or treatment? | N/A | Achieve at least a 15% response rate for the Friends and Family Test in Quarter 1, increasing throughout the year |

| Issues arising from 2012 survey | 2012 result | 2013 target |
|---|---|---|
| Planned admission: date changed by hospital | 9.2/10 | 9.4/10 |
| Trust and confidence in nurses | 8.5/10 | 8.9/10 |
| Nurses: answers you could understand | 8.4/10 | 8.8/10 |
| Hospital food was fair or poor | 5.2/10 | 5.5/10 |

NB: CQC converts individual survey responses to scores out of 10, with 10 representing best possible.

## 1.2 Out patient Survey

The national out patient survey is not scheduled to be conducted this year but we will continue with our improvement plan and will track progress using our real time patient surveys. We are particularly targeting overall satisfaction and our Board had concerns about the time that patients wait to be seen for their clinic appointment so this is also a top priority. Real time survey results are showing that we have made progress with waiting times in some clinics and we intend to work hard on this in the coming year.

| Question | 2011 result | Target |
|---|---|---|
| Overall how would you rate the care you received | 82/100 | 83/100 |
| How long after the stated appointment time did the appointment start?* | 59/100 | 70/100 |

*Patient waited no longer than 30mins for appointment to start
NB: Scores are % out of 100

## 1.3 Cancer Survey

Since receiving our national results in August 2012, improving the cancer patient experience has become an even more important priority for us. Our results showed that despite our improvement plans the reported experience of our cancer patients had not improved. From our results we have established four main themes which are Explanation and Involvement in decisions, Respecting the Patient, Emotional Support and Written Information. Each theme has a detailed programme of actions. Progress will be tracked using real time patient surveys.

| Question | 2012 result | Target |
|---|---|---|
| Overall how would you rate the care you received | 85/100 | 90/100 |
| How long after the stated appointment time did the appointment start?* | 56/100 | 79/100 |
| Were you able to discuss any worries and fears with hospital staff during your hospital visit? | 56/100 | 69/100 |
| Hospital staff definitely gave patient enough emotional support | 61/100 | 76/100 |

*Patient waited no longer than 30mins for appointment to start
NB: Scores are % out of 100

### How will we monitor progress?

Our real time patient survey system is now fully available in all areas of UCLH as well as being on the UCLH website so that patients can "self survey" and can also leave free text comments which are a very rich source of descriptive information.

The system enables a wide range of staff from ward to Board to review reports for a given area at any time. This information will be used by a variety of improvement programmes such as the Outpatient Efficiency Group, Cancer Patient Experience Group and Inpatient Survey Steering Group to track progress and monitor improvements. Most importantly it will be used at ward and department level so that staff can monitor patient experience in real time.

## 2. Improve the consistency and effectiveness of pain management for inpatients

### Why have we chosen this priority?

Our clinical staff and patient representatives view this as an important issue for improving patient experience and as part of our "Making a Difference Together" programme, it was identified as a high priority. Our performance on this question in the national survey is slightly better than the national average but we are of the view that this is not good enough.

### What are we trying to improve?

- We aim to improve the skill and knowledge of front line clinical staff in undertaking regular pain assessment and implementing appropriate pain relieving strategies
- We will extend the availability of our pain specialists to provide expertise to clinical staff and directly to patients

### What will success look like?

- >80% compliance with conducting pain assessments
- Patient feedback "Was everything done to help to control your pain" is improved by 5% (from 72% to 77%)

> "Modern, clean facilities, excellent staff that treat you as a person. Great patient facilities at Cotton Rooms."

> "Very high quality of nursing care, fantastic room and I was well looked after but doctors barely saw me before and after surgery and never told me how the operation had gone."

> "Would recommend for nursing, good positive atmosphere, attentive care, and excellent medical care from the anaesthetist surgeon. Super. It's been 23years since having GA so was a little nervous. Very reassured from moment I arrived. Thank you every one."

> "This hospital has a high reputation but there is scope for improvement e.g. In team liaison, medical management, nursing communications, adjustments for diverse patients, and efficiency in discharge arrangements."

> "Everything was explained to me as my treatment was progressing. Everyone was caring and helpful. Excellent hospital and staff."

## 3. Improve our end of life care

### Why did we choose this priority?

Health and social care staff often find it difficult to initiate discussions with people about the fact that they are approaching the end of their life. This can be a most difficult time for patients and families and we know from feedback that we don't always get things right. Discussions about choices, preferences and preferred place of care are of the utmost importance at this time. For this reason we chose this as a patient/family experience priority and it has the support of clinical staff, governors and our community colleagues.

### What are we trying to improve?

- Skills and confidence of healthcare workers in initiating conversations about end of life issues
- Assessment of the needs & preferences of patients and/or family members
- Advance care planning

### What will success look like?

- Communication skills training provided to identified clinical staff
- > 80% compliance in discussing with patient/ family & recording preferred place & priorities

### How will we monitor progress?

Progress will be monitored via our End of Life Steering Group and will involve tracking the provision and uptake of training and regular auditing of whether end of life conversations are taking place at the right time with the right patients.

# Priority 2: Patient safety

## 1. Using the Safety Thermometer to reduce harm from falls, VTE, pressure ulcers and infection

### Why we chose this priority

The concept of reducing avoidable harm arises from a growing body of evidence within healthcare about certain complications which can, and should, be avoidable. It is nationally recognised that the achievement of "harm-free" care requires continual work and we know we still have a considerable way to go.

### What will success look like?

- Reduction of 17% in falls with harm compared to last year
- Overall reduction of 30% in all pressure ulcers
- Achieve our threshold for MRSA and Clostridium difficile infections
- Identify all cases of hospital acquired VTE for inpatients and conduct root cause analysis

### How will we monitor this?

Progress will be monitored by the Nursing and Midwifery Board for falls and pressure ulcers; by the Trust Infection and Control Committee for infections and by the VTE Steering Group for VTEs. The Quality and Safety Committee will monitor progress overall.

## 2. Improve the use of Ward Safety Checklist in daily ward round

### Why have we chosen this priority

In modern healthcare, treatment is delivered in multi-professional teams which makes effective communications vital so that key information is shared and passed on. Miscommunication is a major contributory factor in many incidents and adverse occurrences. The Ward Safety Checklist was developed within UCLH as a framework for use by teams of doctors, nurses and other health professionals to make sure that all pertinent information is covered and discussed during the daily ward round.

### What will success look like?

- Ward rounds conducted daily with a minimum of a nurse and senior medical decision maker in attendance
- Structured conversation takes place covering the key elements on the WSC
- Patient is involved in the conversation

### How will this be monitored?

Executive Safety Walkrounds take place regularly in clinical areas and the question about frequency of ward rounds and use of WSC will be included in conversations with staff. Separately, observational audits will be conducted.

## 3. Medication omissions

### Why have we chosen this priority?

Medication errors are one of the top three categories of reported incidents nationally and within that omission of medication is the most common type of incident. Medication is an important part of treatment and should be given regularly as prescribed. In discussion with our governors we have agreed that this should be a particular area of focus in the coming year as we aim to ensure that all medication is given as ordered and that omissions only occur for valid recorded reasons.

### What will success look like?

- Preventable dose omissions reduced by 50% from 2.5% of all prescribed doses to 1.25%

### How will this be monitored?

We will monitor this by our monthly medication audits which are a safety indicator on our Quality & Safety scorecard. Medication audits are reported to our Medication Safety Committee and reviewed by the UCLH Quality & Safety Committee.

# Priority 3: Clinical Outcomes

## 1. Develop specialty specific clinical outcomes measures

### Why we have chosen this priority?

We want to give more information to patients, public and commissioners about clinical outcomes at specialty level as it is often more meaningful to them than hospital level information. We have chosen to begin by developing three specific clinical outcome measures per specialty with a view to ultimately making this information available on our website and benchmarking with neighbouring trusts within the health sector.

### What will success look like?

- All specialties will have three identified specialty specific indicators
- Data will be available against each indicator
- Benchmarking data from at least 1 comparable Trust will be collected

### How will we monitor this?

We will monitor this via the UCLH performance scorecards and clinical board reviews and report to the Quality and Safety Committee.

## 2. Improve our performance on hospital mortality

### Why have we chosen this priority?

Hospital mortality ratios compare the actual number of patients who die following treatment at a trust with the number who would be expected to die based on the national average death rates and the particular characteristics of the patients treated. A low mortality ratio is seen as a barometer of quality & safety and at UCLH we have consistently had one of the lowest mortality ratios nationally. In the coming year we will continue to work to further improve the mortality ratio which includes detailed reviews of deaths that occur; an evaluation of weekend mortality and thematic analysis of all unexpected deaths. From these sources we will identify where potential improvement can be made. We will also continue our focus on recognition of acutely unwell patients. Identifying deterioration early improves the chances of survival and is therefore an important component of improving mortality.

### What will success look like?

- Twice yearly deaths review will identify specific conditions with a higher mortality and undertake detailed reviews using the Global Trigger Tool deaths review toolkit
- Compliance with vital signs recording will be > 90%
- Cardiac arrests will be reduced by 10%

### How will we monitor this?

We will monitor this via the UCLH performance scorecard and review monthly at the UCLH Quality & Safety Committee.

# Statements of assurance from the Board

All providers of NHS services are required to produce an annual Quality Account and certain elements within it are mandatory. This section contains the mandatory information along with an explanation of our quality governance arrangements.

The quality governance arrangements within UCLH ensure that key quality indicators and reports are regularly reviewed by clinical teams and by committees up to and including the Board of Directors. There are a number of committees and executive groups with specific responsibilities for aspects of the quality agenda, which report to the UCLH Quality and Safety Committee. An Executive Performance Group reviews interrelated performance across financial, operational and quality agendas. The Board of Directors receives a monthly corporate performance report (available on the UCLH website as part of the published Board papers) that includes a range of quality indicators across the three domains of patient safety, experience and clinical effectiveness. In addition the Board receives quarterly reports in areas such as serious incidents, child safeguarding and complaints and annual reports in areas such as clinical audit. The Board is further assured by reviews undertaken by internal audit which this year has included review of clinical audit, complaints and Care Quality Commission registration arrangements.

## A review of our services

During 2012/13 UCLH NHS Foundation Trust continued to provide NHS services within 60 specialties delivered through Divisions which are grouped into three clinical boards. Through the following processes the Board reviews all the data available on the quality of all the NHS services provided as part of our internal and external management and assurance processes. The income generated by the NHS services represents 98.3% of the total income generated from the provision of NHS services by UCLH NHS Foundation Trust for 2012/13.

## Participation in clinical audits

Clinical audit is an evaluation of the quality of care provided against agreed standards and is a key component of quality improvement. Its aim is to provide assurance and to identify improvement opportunities. UCLH NHS Foundation Trust has a yearly programme of clinical audits which includes three types of audit:

1. National clinical audit, where UCLH aims to participate, where applicable. The full list of these and UCLH participation is shown in the table below.
2. Corporate clinical audit, where we set a list of clinical audits that all specialties should carry out based on UCLH priorities.
3. Local clinical audit that is determined by clinical teams and specialties and which reflect their local priorities and interests.

Audit findings are reviewed by clinical teams in their Clinical Governance meetings, as a basis for peer review and for targeting or tracking

improvements. A Quality Improvement and Clinical Audit Committee oversees the corporate clinical audit programme and activity, and reports to the Quality and Safety Committee.

## National Clinical Audit

During 2012/13, 42 National Clinical Audits (NCA) and 6 National Confidential Enquiries (NCE) applied to NHS services that UCLH provides. During that period, UCLH participated in 40 (95 %) NCAs and 6 (100%) NCEs of those for which it was eligible. The reason for not participating is identified against the specific audit. Decisions not to participate are authorised by the Clinical Board Medical Director.

UCLH eligibility and participation in national clinical audits and national confidential enquiries during 2012/13 are detailed below, alongside the number of cases submitted.

| Audit | UCLH eligible | UCLH participation | Cases submitted |
|---|---|---|---|
| Lung Cancer (NLCA) | ✓ | ✓ | 113 |
| National bowel cancer audit programme (NBOCAP) | ✓ | ✓ | 100 (Up to Jan 2013) Continual data collection |
| Oesophago-gastric cancer audit (NOGCA) | ✓ | ✓ | 195 |
| National Inflammatory Bowel Disease Audit (inc Ulcerative Colitis & Crohn's Disease) | ✓ | ✓ | Data collection in progress |
| PROMs Hernia | ✓ | ✓ | HERNIA: 97 (Up to Jan 2013) Continual data collection |
| National carotid interventions audit (UKCIA) | ✓ | ✓ | 43 (Up to Jan 2013) Continual data collection |
| PROMs varicose veins | ✓ | ✓ | VEIN: 112 (Up to Jan 2013) Continual data collection |
| National Vascular Database | ✓ | ✓ | 36 (Up to Jan 2013) Continual data collection |
| National head & neck cancer comparative audit (DAHNO) | ✓ | ✓ | 86 |
| National joint registry (NJR) | ✓ | ✓ | 346 (up to 13/12/12) Continual data collection |
| National hip fracture database (NHFD) | ✓ | ✓ | 112 (Up to Jan 2013) Continual data collection |

| Audit | UCLH eligible | UCLH participation | Cases submitted |
|---|---|---|---|
| PROMs knee and hip replacements | ✓ | ✓ | KNEE: 153<br>HIP: 149<br>(Up to Jan 2013)<br>Continual data collection |
| National Potential Donors Audit | ✓ | ✓ | NHNN: 62<br>UCH: 133<br>Trust Total: 195<br>(NB: cases submitted are patients audited not cases of organ donors) |
| Adult cardiac surgery audit (CABG & valvular surgery) | ✓ | ✓ | 664<br>(Up to Jan 2013)<br>Continual data collection |
| Congenital heart disease | ✓ | ✓ | 102<br>(Up to Jan 2013)<br>Continual data collection |
| National Audit of Angioplasty Procedures (NICOR) | ✓ | ✓ | 591<br>(Up to Jan 2013)<br>Continual data collection |
| Heart failure audit | ✓ | ✓ | 166<br>(Up to Jan 2013)<br>Continual data collection |
| Cardiac rhythm management | ✓ | ✓ | 1182<br>(Up to Jan 2013)<br>Continual data collection |
| Myocardial ischaemia national audit project (MINAP) | ✓ | ✓ | 442<br>(Up to Jan 2013)<br>Continual data collection |
| Pulmonary Hypertension | Service not provided at UCLH | N/A | N/A |
| National Pain Audit | ✓ | ✓ | 17<br>(via University College London (UCL) Paediatric Pain Research Centre) |
| Parkinson's Disease | ✓ | ✓ | 20 |
| Sentinel Stroke National Audit Project (SSNAP) | ✓ | ✓ | Data collection in progress |
| National neonatal audit programme (NNAP) | ✓ | ✓ | 761<br>(Up to Jan 2013)<br>Continual data collection |

| Audit | UCLH eligible | UCLH participation | Cases submitted |
|---|---|---|---|
| National Paediatric Diabetes audit (NPDA) | ✓ | ✓ | 346 |
| Childhood Epilepsy | ✓ | ✓ | Data collection begins March 13 |
| Paediatric Intensive Care (PICANet) | Service not provided at UCLH | N/A | N/A |
| Paediatric Pneumonia | ✓ | ✓ | Data collection in progress |
| Paediatric Asthma | ✓ | ✓ | Data collection in progress |
| Cardiac Arrest | ✓ | ✗ | UCLH chose to contribute to the University College London Partners (UCLP) Cardiac Arrest data sharing project instead of the national audit. This was approved by the Medical Director. |
| Adult Critical Care (Case Mix Programme) | ✓ | ✓ | 1639 (Up to Dec 2012) Continual data collection |
| Severe Trauma (TARN) | ✓ | ✓ | 60 UCH, 51 NHNN, TOTAL cases 111 (Up to Jan 2013) Continual data collection |
| Fever in Children | ✓ | ✓ | 50 |
| Fractured Neck of Femur | ✓ | ✓ | 40 |
| Renal Colic | ✓ | ✓ | 20 |
| National Diabetes Audit (NDA) (Adult) includes National Diabetes Inpatient Audit (NADIA) | ✓ | ✓ | 114 for NADIA |
| National Audit of Dementia | ✓ | ✓ | 40 |
| Emergency Use of Oxygen | ✓ | ✗ | UCLH contributed to this audit in 2011 and in 2012 the audit resource has been directed to other respiratory national audits. |
| Adult Community Acquired Pneumonia | ✓ | ✓ | Data collection in progress |
| Non-invasive Ventilation | ✓ | ✓ | Data collection in progress |

| Audit | UCLH eligible | UCLH participation | Cases submitted |
|---|---|---|---|
| COPD | ✓ | ✓ | Data collection in progress |
| Adult Asthma | ✓ | ✓ | 24 |
| Bronchiectasis | ✓ | ✓ | Data collection in progress |
| Renal replacement | Service not provided at UCLH | N/A | N/A |
| National Comparative Audit of Blood Transfusion | ✓ | ✓ | 167 |
| Intra-thoracic transplant | Service not provided at UCLH | ✓ | N/A |
| Renal transplant | Service not provided at UCLH | ✓ | N/A |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD)<br><br>(Also known as Medical and Surgical Clinical Outcome Review Programme, or Patient Outcome and Death) | ✓ | ✓ | 3 Alcohol related liver disease<br><br>N/A Subarachnoid Haemorrhage (data collection in progress) |
| National Review of Asthma Deaths | ✓ | ✓ | 0 (no asthma deaths were eligible for submission) |
| Maternal, infant and newborn programme (MBRRACE-UK)*<br><br>(Also known as Maternal, Newborn and Infant Clinical Outcome Review Programme)<br><br>*This programme was previously also listed as Perinatal Mortality | ✓ | ✓ | 47 Neonates<br><br>1 Maternal |
| Child health programme (CHR-UK)<br><br>(Also known as the Child Health Clinical Outcome Review Programme) | ✓ | ✓ | Data collection in progress |

The reports of 54 national clinical audits and 295 local audits were reviewed by UCLH in 2012/13. A considerable number of changes and improvements have been implemented as a result and below are some examples of actions UCLH intends to take to improve the quality of healthcare provided.

## Examples of improvement resulting from national clinical audits:

**1) Paediatric Epilepsy 12 point audit:** Developed a pathway for children presenting to University College Hospital with paroxysmal episodes. Lack of an epilepsy nurse was identified as a gap in the service – Camden: a post for a Paediatric epilepsy nurse is being advertised and one for Islington has been approved.

**2) Trauma Audit & Research Network – Audit of Computerised Tomography (CT) times:** An audit including all key processes relating to time to CT showed slight improvement. Work is in progress relating to out of hours CT reporting times and the provision of a CT scanner in the reconfiguration of the Emergency Department is expected to improve CT times significantly.

**3) Critical care:** National Audit Project – 4th audit round (Royal College of Anaesthetists 2012). We benchmarked our activity, devised an education programme and introduced an Emergency airway trolley. We used the national report as a catalyst to deliver on a capital investment for essential monitoring equipment. A re-audit showed improved care of the emergency airway patient. We published the data in the British Journal of Hospital Medicine in 2012. A repeat audit in February 2013, showed sustained quality improvement.

**4) Women's Health: Centre for Maternal and Child Enquiries (CMACE) Maternal Death Review** – Currently Women's Health is in the process of revising its guidelines on sepsis following publication of Trust wide guidelines. This will also include an information leaflet for women. The Maternal Death Guideline is currently under review in line with recommendations.

**5) RNTNEH Cochlear Implants:** As a result of national bilateral cochlear implant audit findings, we now encourage parents to take up the offer of bilateral cochlear implantation as it leads to better outcomes, and encourage earlier sequential implantation for children with one implant as the results are poorer with delayed sequential implantation.

## Corporate Clinical Audit

In 2012/13 there were at least 10 clinical audit areas which were directly related to the Trust quality priorities as shown in green in the table below. It is acknowledged that patient surveys are not audits per se, but they are included here as they are an important component of the quality improvement programme and are the best available indicator of patient experience.

| Objective | Quality Priorities | Supporting Corporate Audit Activity |
|---|---|---|
| Deliver Excellent Clinical Outcomes | • Improve performance on hospital mortality | • Vital signs<br>• Deteriorating patient<br>• Cardiac arrest & PERT calls audit<br>• World Health Organisation (WHO) Safe Surgery Checklist |
| | • Reduce avoidable emergency admissions<br>• Achieve 100% participation in clinical audits | • Readmissions within 30 days |
| Improve Patient Safety | • Reduce hospital acquired infections | • Hand Hygiene<br>• Surgical wound infection surveillance<br>• MRSA Bacteraemia<br>• Adherence to surgical prophylaxis guidance<br>• Antibiotic prescribing<br>• Saving Lives care bundle<br>• Urinary tract infections<br>• Clostridium difficile infections |
| | • Reduce hospital acquired pressure ulcers and patient falls | • NHS Safety Thermometer (pressure ulcers, falls & urinary tract infection in patients with a catheter) |
| | • Reduce the number of blood clots and medication errors | • VTE Risk assessments<br>• VTE Administrations of prophylaxis<br>• Medication Safety |
| Deliver High Quality Patient Experience | • Improve the appointment and transport booking services we offer to patients | • Patient Surveys:<br>  ▸ Inpatients<br>  ▸ Outpatients<br>  ▸ Cancer<br>  ▸ Maternity |
| | • Implement the 'Making a Difference Together' campaign | • Real time patient feedback |
| | • Specifically improve patient experience in cancer services | • Pre and post operative patient reported outcomes<br>• Pain assessment and management<br>• Decision-making & communication in uncertainty |

| Objective | Quality Priorities | Supporting Corporate Audit Activity |
|---|---|---|
| Integrate Care with Partners to Improve Patient Care | • Work with GPs to improve patient pathways in long-term conditions<br>• Improve timeliness and quality of all communications with GPs and community carers<br>• Evaluate urgent care centre and implement if agreed with GPs | • GP communications:<br>▸ Letters from A&E to GP<br>▸ Letters from Outpatients to GP<br>▸ Letters from Inpatients to GP |

## Local Clinical Audit

Local clinical audits are developed by teams and specialties in response to issues identified at a local level. They may be related to, for example, a specific procedure, or to provision of a service. Some examples are given below.

### Examples of improvement resulting from local clinical audit

**1) Respiratory:** The lung cancer audit highlighted that not enough new patients were seeing a lung cancer nurse at diagnosis. This provided important data to support a business case for a new lung cancer clinical nurse specialist (CNS) who has recently been appointed.

**2) Care of the elderly:** We have made improvements in identifying delirium, we now have patient passports in place ("forget-me-not" cards) detailing the person's preferences and night time routine.

**3) Eastman Dental Hospital (EDH):** EDH modified the World Health Organisation (WHO) safe surgery check list for use in the outpatient setting for surgical and extraction procedures to avoid the risk of wrong tooth extraction. Since the amended checklist has been implemented, there have been no incidents and it has been beneficial to the trainees and the staff as well as the patient.

**4) Diabetes** – Assessing treatment satisfaction, knowledge and adherence for patients attending the Pituitary Nurse-led Clinic at University College Hospital found a good level of patient satisfaction and provided the driver for continuing emphasis on patient education and assessment of adherence to treatment.

**5) H&N** – Introduction of the triple scan (Computerised Tomography (CT), Magnetic Resonance Imaging (MRI) and Ultrasound Scans (US)) in one day to the rapid access diagnostic clinic compared with data from the year before without the triple scanning. This was a local audit due to be presented at a national meeting this year and has shown a statistically significant reduction in the time to complete radiology, time to make diagnosis and time to commence treatment; a significant service improvement.

### Improving Dementia Care

**We have made improvements in caring for patients who have delirium.**

### Extending use of Safety Checklists

**Departments undertaking procedures are adapting the WHO safe surgery checklist to avoid the risk of errors.**

**6) NHNN** – Standards of EEG recording and reporting: The findings have led to an improvement in the quality of our recordings and reports (i.e. amendment of our photic stimulation procedure, detailed annotation of previous EEG findings, medication intake, time of recent seizures and reasons for not performing hyperventilation or photic stimulation).

**7) Paediatrics** – Primary tumours in young adult survivors of childhood Posterior fossa tumours and prior therapeutic protocol. Monitoring late effects on childhood brain tumours showed an increase in the occurrences of second primary tumours and hypothesised the possibility of intensive adjuvant chemotherapy playing a role. The audit recorded the prevalence of second primary tumours in survivors of childhood brain tumours to determine the contribution of intensive chemotherapy and Growth hormone. An increased prevalence of second primary tumours was noted that were aggressive and occurred earlier in the group receiving chemotherapy. The result of this audit is being published to encourage continued monitoring and raise awareness among colleagues and patients and to direct further study as the numbers were small.

**8) GI** – Effect of surgery on weight loss, co-morbidity resolution and nutritional deficiencies for a sample of very overweight patients. Outcome: leading to change in post-operative nutritional replacement for patients' post-sleeve gastrectomy.

## Our participation in clinical research

Clinical research looks to improve the clinical treatments available to patients and to discover new ways of managing conditions. UCLH is at the forefront of research and actively works to bring effective solutions promptly to the bedside.

UCLH is recognised as one of 11 leading centres for experimental medicine in England. In partnership with University College London, UCLH has secured National Institute of Health Research Biomedical Research Centre status for another five years (2012-17). The Biomedical Research Centre has a focus on our four broad areas of world class strength for innovative, early phase research in Cancer, Neuroscience, Cardiometabolic diseases and Infection, Immunity and Inflammation.

A key focus for the National Institute for Health Research is the development and delivery of quality, relevant, patient focused research within the NHS. UCLH continues to embrace this aim, remaining at the forefront of research activity, creating and supporting research infrastructures, providing expert and prompt support in research and regulatory approvals, and promoting key academic and commercial collaborations.

UCLH continues to develop the active involvement of patients and the public in research design and process through training and other resources, to ensure those studies which take place at UCLH are relevant and inclusive of patients. UCLH will also be focusing its efforts on improving patient and public access to information about research to improve patient choice and experience.

In the period 2012/13, a total of 253 new research studies were approved to begin recruitment at UCLH. These range from Clinical Trials of Medicinal Products and Device studies, through to service and patient satisfaction studies. At any one time, the number of studies involving UCLH patients and open to recruitment or follow-up, has consistently been around 1,200. Of these, around 30 per cent of studies are adopted onto the National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio of research.

Figures released in September 2012 highlight the contribution made by UCLH to the NIHR Portfolio, ranking in the top 10 trusts in the UK for the number of studies adopted, and in the top five for recruitment to Portfolio studies.

UCLH continues to support a large portfolio of clinical trials and studies. The Trust is one of the largest recruiters of patients to NIHR portfolio adopted studies, contributing to over 8000 recruits in 2012/13. Recruitment to studies at UCLH for both adopted and non-adopted studies is estimated in excess of 20,000 recruits for 2012/13.

## CQUIN payment framework

Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work. The final payment made to UCLH in respect of CQUIN goals in 2011/12 was £7.3M of a total possible £8.0M. Through discussions with our commissioners we agreed a number of improvement goals for 2012/13 that reflect areas of improvement interest nationally, within London and locally.

The amount of income in 2012/13 agreed between UCLH and NHS North Central London based on quality improvement and innovation goals was

£14,468,575, which represented 2.5% of the trust contract income. We achieved £14,129,080 (97.7%) (This is subject to final formal agreement by commissioners).

Generally each CQUIN is made up of up to four elements with their own targets and thresholds to achieve across the four quarters of the year. As indicated the majority of these were met during the year, those where the trust did not fully achieve the requirements included; narrowly missing the 95% target level for VTE assessment for two quarters. Of the seven specified procedures each quarter (28 in total) for the enhanced recovery programme with targeted length of stay reductions four were not achieved. We also failed to achieve sufficient communication to GPs in respect of one element of the smoking cessation for two quarters.

As the CQUINs cover a range of requirements which are variable across each quarter of the year, further or specific detail are available on request.

A high level summary of the CQUIN measures for 2012/13 is shown in the following table:

| Performance Indicator | Financial value | Performance Indicator | Financial value |
|---|---|---|---|
| VTE assessment | £434,057 | Enhanced recovery – improvements in care pathway and compliance with | £2,604,344 |
| VTE – appropriate prescribing of prohylaxis | £289,372 | COPD | £2,893,715 |
| Improving patient experience | £723,429 | Alcohol Misuse | £2,025,601 |
| Dementia | £723,429 | Integrated care (Frailty) | £2,604,344 |
| National Safety Thermometer | £723,429 | Smoking Cessation | £578,743 |
| | | Cancer staging | £868,115 |

Further details of the agreed goals for 2012/13 and for the following 12-month period are available on request from:

Greg Stevens, Head of Performance and Planning
Email: greg.stevens@uclh.nhs.uk
Tel: 020 3448 3920
Address: Performance Department, 2nd Floor Central, 250 Euston Road, NW1 2PG

## Care Quality Commission (CQC) registration and compliance

The Care Quality Commission (CQC) is the organisation that regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with CQC in order to provide services and are required to maintain specified "essential standards" in order to retain their registration.

As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each trust which is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information CQC may undertake an unplanned, responsive inspection.

UCLH is fully registered with the CQC across all locations without conditions.

No enforcement action has been taken against UCLH during 2012/13.

In 2012/13 the CQC undertook three inspections within the Trust:

- July 2012: Unannounced, planned inspection at University College Hospital and Elizabeth Garret Anderson Wing.

This inspection included

- Care of the Elderly
- Cancer Services
- Maternity Services
- 4 wards
- A&E and Acute Admission Unit
- Complaints and governance corporate teams

9 standards were inspected and we were found to be meeting all standards.

- July 2012: Unannounced inspection at Sir William Gower Centre. This was a responsive inspection arising from concerns raised with the CQC.

8 standards were inspected and the Unit was found to be meeting all standards.

- November 2012: Unannounced, planned inspection at NHNN. The inspection included

  - Medical and Surgical Intensive Care and High Dependency
  - 2 wards
  - Outpatients

8 standards were inspected and the hospital was found to be meeting the standards.

Following all CQC inspections we find their reports and observations helpful for the commentary they contain. Suggestions that CQC made include strengthening Mental Capacity Act (MCA) training and reviewing bank nurse shift cover for vacancies. Improvements the Trust has made are increasing the MCA training support and progressing an extensive nurse recruitment programme.

In addition to inspections, we have received seven queries from the CQC arising from comments made to them. On each occasion an investigation and detailed report on actions have been submitted. All responses have been accepted.

## Data quality

Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high-quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement. At UCLH we monitor the accuracy of data in a number of ways including a monthly data quality review group. UCLH has improvement groups including coding improvement and medical records improvement, and we monitor our performance through data quality metrics across a broad range of information.


STAFF NURSE
Lillian Nkurunziza

## NHS number and General Medical Practice Code Validity

UCLH provides submissions to the Secondary Uses System (SUS). This is a single source of comprehensive data which enables a range of reporting and analysis in the UK and is run by the NHS Information Centre. UCLH submitted records during 2012/13 to the SUS service for inclusion in the Hospital Episode Statistics.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 97.1 per cent for admitted patient care
  - 77.5 per cent for outpatient care
  - 76.2 per cent for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
  - 96.2 per cent for admitted care -
  - 97.1 per cent for outpatient care -
  - 79.2 per cent for accident and emergency care

## Information Governance Toolkit attainment levels

The Information Governance Toolkit (IGT) provides an overall measure of the quality of data systems, standards and processes. The score a trust achieves is therefore indicative of how well they have followed guidance and good practice.

The IGT score for 2012/13 (Version 10) was 70%, with an overall rating of satisfactory (compared with 69% per cent against Version 9 in 2011/12).

## Clinical coding error rate

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

UCLH NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission (AC) and the error rates reported in the latest published audit undertaken in 2012 for diagnoses and treatment coding were:

- Primary Diagnoses Incorrect: 4.5%
- Secondary Diagnoses Incorrect: 10%
- Primary Procedures Incorrect: 4%
- Secondary Procedures Incorrect: 9%

Overall coding accuracy was 93% and UCLH was therefore successful in retaining its IGT level 3 status for 2012/13. These results should not be extrapolated further than the actual sample audited. The following specialties were audited:

- Cardiology in admitted patient care
- Neurology in admitted patient care
- Transfers between UCLH hospitals for admitted patient care
- TARGETED admitted patient care audit for NORTH east london cluster:
  - JA12B Malignant breast disorders with intermediate CC
  - HD23B Intermediate knee procedures for non trauma with CC
  - LA04D Kidney or urinary tract infections with length of stay 2 days or more with major CC
  - DZ11B Lobar, atypical or viral pneumonia with CC
  - EB07H Arrhythmia or conduction disorders with CC
  - QZ17B Non-surgical peripheral vascular disease with intermediate CC
- Cardiology in outpatients
- Midwifery in outpatients
- Hepatology in outpatients
- Accident and Emergency

The combined outcomes of IGT and AC audit performance determine the clinical coding department's overall accuracy level and IGT level standing, with a level 3 position ranking the highest and calling for 93%* coding accuracy rates, as well as evidence of robust training, audit and clinical engagement frameworks. UCLH's high rating within the IGT coding audit reinforces its good performance in providing high quality coding in line with national coding rules, standards and conventions, that in turn provides for indicative service planning, billing and epidemiological processes.

- Overall average based on national requirements of 95% coding accuracy for primary diagnosis and procedure and 90% coding accuracy for secondary diagnosis and procedure

# 4 Progress against priorities

## Progress report on priorities for 2012/13

Detailed action plans and measures were developed for each of the priorities last year. Performance has been monitored through the year by clinical teams, divisions and UCLH committees. Of the targets we set ourselves we achieved or partially achieved 65% and did not achieve 35% and these priorities roll over for a further year. The following table summarises our progress:

| Our priority | What success looks like | What we achieved |
|---|---|---|
| Improve patient experience | | |
| Inpatient experience | • Ensure we maintain performance in CQUIN priorities<br>• Improve patients being able to find someone to discuss worries with | **We partially achieved this** in that we met our CQUIN priorities but we did not improve on patients being able to find someone to discuss worries with. This priority rolls over. |
| Outpatient experience | • Improve waiting times in OP<br>• Improve contact with patients about appointments<br>• Improve explanations in clinics about what is happening & why | **We did achieve this**<br>**Work has commenced on this**<br>**Work in progress** |
| Cancer patient experience | • Improve explanation & information<br>• Improve involvement in decisions<br>• Improve support from clinical nurse specialist | **We did not achieve these and further work is in progress** |
| Reduce avoidable harm | | |
| Reducing the harm from falls | • Reduce the number of patients who suffer fractures as a result of falls | **We did achieve this** and reduced fractures by 60% |
| Reducing HAPU | • Ensure all wards are using the SSKIN bundle to reduce the risk of a HAPU | **We did not achieve this** and audit shows inconsistent compliance on wards |
| Reducing harm from VTE | • Ensure at least 95% of adult inpatients have VTE risk assessments & appropriate treatment | Our audits show VTE Prophylaxis 94.4% (Feb YTD) and eVTE Risk Assessments 94.6% (Feb YTD) |
| Infection control | • Reduce the incidence of hospital acquired C.difficile to no more than 44 | **We did not achieve this** although we have made significant progress in reducing the number of cases. We exceeded our target by 10 cases |

| Our priority | What success looks like | What we achieved |
|---|---|---|
| Improve clinical outcomes | | |
| Improve mortality | • Improve vital signs recording to >85%<br>• Reduce the number of cardiac arrests | **We did achieve this** many wards now achieve over 90% & the UCLH average is 91.3%<br>**We did achieve this** Cardiac arrests reduced from 203 in 11-12 to 120 so far this year |
| Reduce avoidable emergency readmissions | • Reduce rate of avoidable emergency readmissions | **We did achieve this** |

## Progress against each of the 2012/13 Priorities

### Priority 1: Improve patient experience

Throughout the year we seek feedback from our patients so that we can better understand their experience and can focus on things that they tell us aren't working well. Last year we increased our efforts to gain feedback by introducing a new real time system for patients to give us feedback each time they visit one of our hospitals using iPad surveys, web link as well as paper based surveys. Currently in the region of 1,000 patients per month leave feedback for us which means that all wards and department can see at a glance what patients are telling them about the experiences they have had in real time.

During the year we have had a national inpatient survey as part of the Care Quality Commission (CQC) programme and received the report from the national cancer patient experience survey.

#### 2012 Inpatient survey

Our national inpatient survey showed that we continue to achieve a strong performance against London peers as well as maintaining a good performance nationally. Our focus for the year was on embedding existing improvements and on improving performance in the CQUIN priorities, especially on "finding someone to discuss worries and fears". We achieved the CQUIN target set by our commissioners overall and will continue our improvement plans in the coming year. This patient experience CQUIN has now been replaced by the Family and Friends Test question.

| CQUIN focus | 2011 | 2012 |
|---|---|---|
| Involvement in care decisions | 7.6/10 | 7.5/10 |
| Privacy when discussing treatment | 8.3/10 | 8.3/10 |
| Discharge medication side-effects | 5.0/10 | 5.9/10 |
| Knowing who to contact after discharge | 8.2/10 | 8.3/10 |
| Finding someone to discuss worries and fears | 6.2/10 | 5.9/10 |

*Higher scores are better
NB: CQC converts individual survey responses to scores out of 10, with 10 representing best possible.

## Outpatient survey

The national outpatient survey is carried out on a two year cycle and was not scheduled for last year. Nonetheless we use our real time patient survey to continue to collect feedback and we identified a number of improvements we would be working on:

- Rolling out our Productive Outpatients programme to improve the efficiency and smooth running of clinics
- Reduce waiting time in clinics
- Improve contact with patients about appointments

During the year UCLH has continued to roll out its Productive Outpatient Programme (which is a programme to improve the smooth running and efficiency of clinics). 30 teams have now taken part impacting around 300 clinics. Improvement in both patient and staff experience have been seen as a result and the programme will continue during the coming year.

Those clinics involved in the Productive Programme have seen significant improvements in patients waiting times as well as the length of time waiting for an appointment.

UCLH is also currently trialling different methods to identify the best way to communicate with patients about their appointments and during this year will be piloting a text messaging service.

Below are some comments from our real time outpatient survey which demonstrate the improvement in waiting times.

> "Excellent, seen very quickly."

> "There have been massive improvements in the Basil Samuels Clinic since I first came here. It is an excellent hospital, both inpatient and outpatient. Time keeping has improved enormously. Thank you all very much."

> "I was seen within a few minutes of arriving."

## Cancer survey

The national Cancer Patient Experience Survey was conducted in autumn 2011 and reported in August 2012. Although the survey showed modest improvement in some areas, it did not show the improvement that we were aiming for. Since then we have therefore made this a major priority for 2013/14.

The 2011-12 National Cancer Patient Experience Survey results were published in August 2012. Our progress against the targets we set is detailed in the table below.

| Survey Question | 2010 | 2011/2 Result | 2011/2 Target |
|---|---|---|---|
| Patient felt they were told sensitively that they had cancer | 77/100 | 77/100 | 83/100 |
| Patient completely understood explanation of what was wrong | 64/100 | 65/100 | 73/100 |
| Patient definitely involved in decisions about which treatment | 66/100 | 68/100 | 69/100 |
| Last time seen, time spent with CNS about right | 90/100 | Not asked | 94/100 |
| Patient had trust and confidence in all doctors treating them | 80/100 | 82/100 | 82/100 |
| Patient had trust and confidence in all ward nurses | 55/100 | 60/100 | 63/100 |

NB: Scores are % out of 100

- Since the last survey we have moved outpatient clinics and treatments into the new University College Hospital Macmillan Cancer Centre. From the results of the survey we have undertaken a thorough assessment of what patients were telling us and have identified 4 key themes listed on page 10 on which we need to work. Each theme covers a number of similar issues along the cancer pathway.

We have also collaborated with other London trusts to learn from what they have successfully implemented and have a dedicated cancer programme team helping to deliver the improvements. We have also designed a real time survey so that we can track progress and adjust plans as appropriate.

## Complaints

Formal complaints provide an important mechanism by which UCLH can assess the quality of services provided. No matter what information we derive from surveys, a written complaint indicates that in some sense the high-quality care we aim for has not been delivered to an individual. For this reason we continuously assess how individual complaints are managed within UCLH. Complaints and their responses are seen by members of the Board including the Medical Director, Chief Executive & Chairman. We also regularly assess and analyse our complaints for the valuable intelligence they contain about our processes and our culture. Whilst we have a good record in terms of complaints referred to the Ombudsman and to date none has been investigated or upheld we nonetheless intend to review our processes to make them better for our patients. During 2012/13 following liaison with the Ombudsman financial remedy was agreed with one complainant. No complaints were formally investigated or upheld. by the Ombudsman.

During 2012/13 the Trust received 677 formal complaints. Whilst representing a 30% rise compared to 2011/12 (when 520 were received) the number is comparable to the 671 received in both 2010/11 and in 2009/10. The increase is being closely monitored. During the year six complaints were received which were subsequently investigated as incidents.

## Responding to complaints

### Case study Heart Hospital

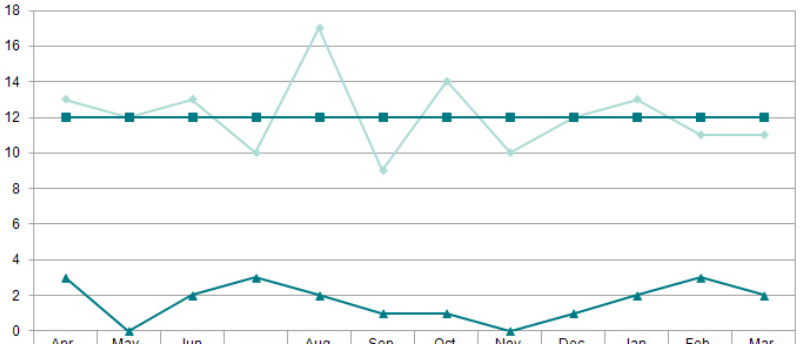
Following a generally poor patient experience on one of our short stay wards, improvements have been made through the increased availability of food and drinks outside normal meal times and the introduction of flexible rising times for patients who have procedures undertaken late the previous day. Pilot work is also underway to improve working practices around admission and discharge to ensure patients are not asked to leave their beds too early or kept waiting unnecessarily.

## Priority 2: Improve Patient Safety (Reduce avoidable harm)

### Reducing harm from falls

Inpatient falls remain one of the highest reported incidents across the NHS. At their worst falls can result in very serious harm to patients, which may mean they are unable to be discharged home, or in the most serious cases can lead to death. UCLH has therefore continued to focus on reducing the amount and level of harm from falls and our target was to reduce the number of falls with harm. This year the focus has been on embedding the falls prevention care bundle that was introduced in 2011/12. Overall the trend of falls resulting in harm continues downwards. Most importantly we have seen that the number of falls resulting in fractures, for example of the hip, has reduced by 60% compared to 2011/12.

**Falls resulting in harm and falls resulting in moderate and above harm 2012-13**




| | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls resulting in harm | 13 | 12 | 13 | 10 | 17 | 9 | 14 | 10 | 12 | 13 | 11 | 11 |
| Target | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| Falls with moderate and above harm | 3 | 0 | 2 | 3 | 2 | 1 | 1 | 0 | 1 | 2 | 3 | 2 |

### Reducing harm from venous thromboembolism (blood clots)

Blood clots or venous thromboembolism (VTE) cause thousands of deaths nationally each year and many are thought to be preventable. For this reason preventing blood clots is a national priority as reflected in the CQUIN requirement for 2012/13 and the coming year. Assessing a patient's risk of developing blood clots is the first part of prevention and initiating preventative treatment (thromboprophylaxis) in patients who are at-risk is the second. Our target for 2012/13 was to achieve 95% compliance in both risk assessment and VTE prophylaxis.

The completion of risk assessments is tracked and monitored for each patient admitted to the Trust using the eVTE (electronic) risk assessment tool, which forms part of the computerised patient record. As can be seen from the graph below, in every month close to, or in excess of, 95 per cent of eligible patients in the Trust have been risk assessed for VTE on admission to hospital.

In addition, monthly audits of administration of thromboprophylaxis have been completed to ensure that "at risk" patients requiring this treatment receive it correctly. The graph below shows the results of these monthly audits which demonstrate that close to, or in excess of, 95% of

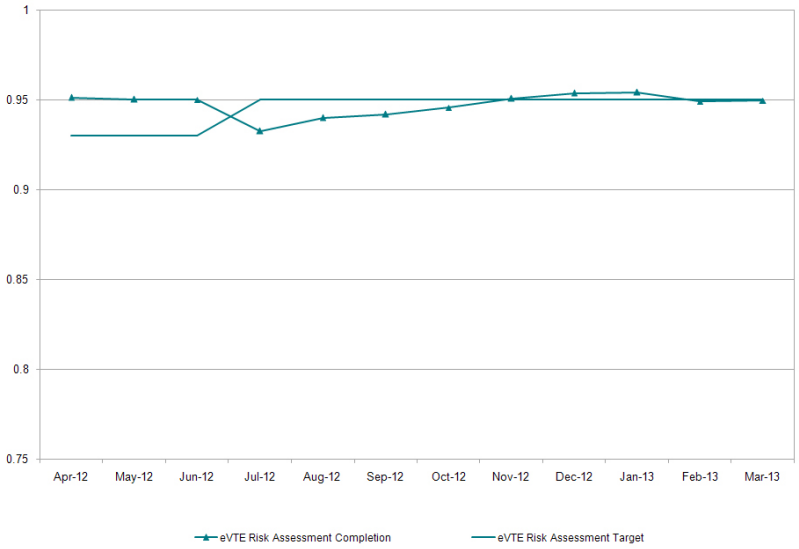
patients in the audits receive thromboprophylaxis appropriately.

The Trust remains committed to all patients being risk assessed and receiving appropriate thromboprophylaxis and to this end the results of the above audits are included in the divisional quality scorecards which are discussed within each clinical board and at the Quality & Safety Committee. Local performance is closely monitored by clinical teams within the divisions.

In addition there has been focus during 2012/13 on improving the reporting, investigating and learning when patients develop a blood clot. This can be difficult to track as the cases may be diagnosed in a variety of clinical settings and symptoms may not appear until after the patient has been discharged from hospital.

We have improved processes for capturing and reporting all cases of VTE diagnosed in the Trust. These cases are reported to the specialist haematology team where they are assessed against the criteria for a hospital acquired thrombosis (HAT). A system has been agreed for completing root cause analysis of cases of HAT to identify those that could be considered to have been avoidable and ensure that the lessons are learned from any such incidents. Further development and application of this work and implementation of the lessons learned will be a particular focus for 2013/14.

## eVTE Risk Assessment Completion Trustwide 2012-13

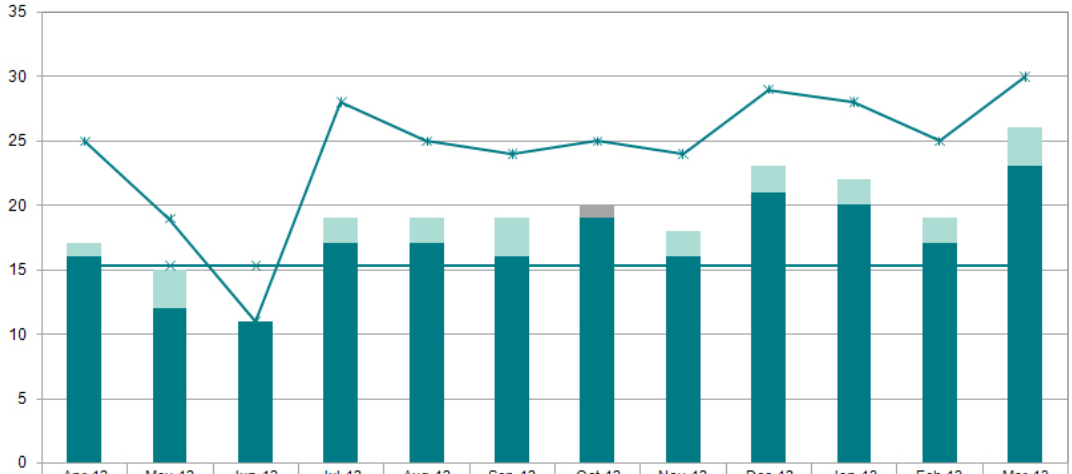



## VTE Prophylaxis Compliance 2012-13

## Reducing harm from hospital-acquired pressure ulcers (HAPU)

Hospital acquired pressure ulcers (HAPU) remains a priority for UCLH. The focus in 2012 has been the continued implementation of the SSKIN pressure ulcer prevention care bundle. However we have struggled to deliver this priority and have seen a slight increase in numbers of pressure ulcers in recent months and the incidence of category 3 HAPU remains a concern. We have seen a virtual elimination of category 4 pressure ulcers, with only 1 during the year. All category 2 and above HAPU are fully investigated and category 3 & 4 are treated formally as a serious incident. We have seen a lack of consistency in the application of the SSKIN bundle and addressing this is a current priority. In response to this we have invested in nurse consultant and practitioner posts to educate staff in the prevention/management of pressure ulcers and to enforce best practice in pressure ulcer care.

### All Pressure Ulcers Acquired In UCLH in 2012/13



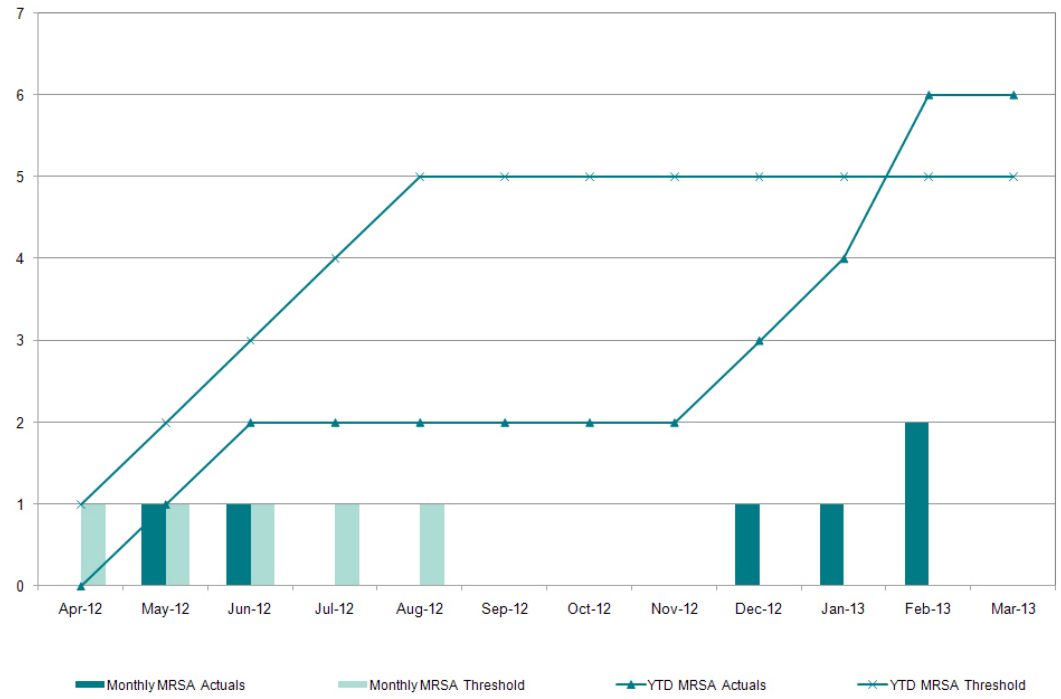

| | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Category 4 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Category 3 | 1 | 3 | 0 | 2 | 2 | 3 | 0 | 2 | 2 | 2 | 2 | 3 |
| Category 2 | 16 | 12 | 11 | 17 | 17 | 16 | 19 | 16 | 21 | 20 | 17 | 23 |
| Target for Category 2 and above | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 | 15.33334 |
| All Pressure Ulcers | 25 | 19 | 11 | 28 | 25 | 24 | 25 | 24 | 29 | 28 | 25 | 30 |

## Reducing harm from healthcare-associated infection (HCAI)

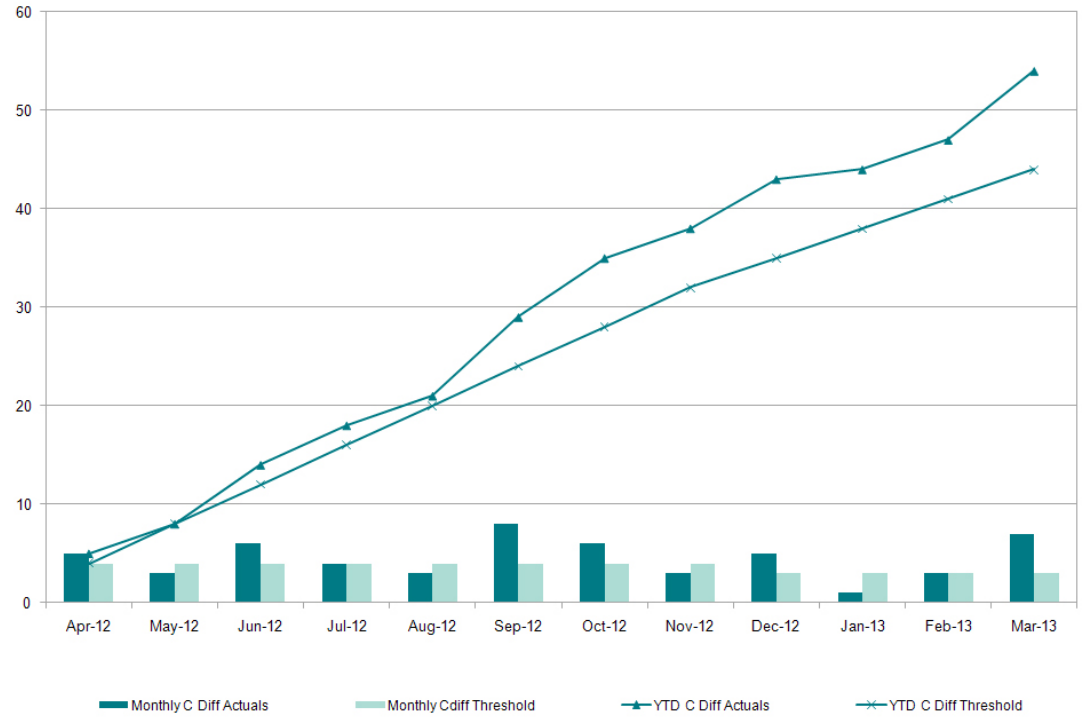
Our aim for 2012/13 was to have no more than 5 MRSA infections and to reduce clostridium difficile infections to 44. Disappointingly, we exceeded our MRSA threshold of 5 by just 1 case, which commissioners agreed was not preventable and untreatable. We also exceeded the clostridium difficile threshold with 54 cases, 10 of which commissioners agreed were not hospital acquired.

We have commissioned two external reviews of different aspects of infection control to give us a fresh perspective and these have been helpful in confirming our infection control strategy and making some recommendations on how we could further implement best practice. In response to this we have been able to further refine our improvement plan.

## Trust Acquired MRSA Bactaraemia Infections 2012-13




## Trust Acquired Clostridium Difficile Infections 2012-13



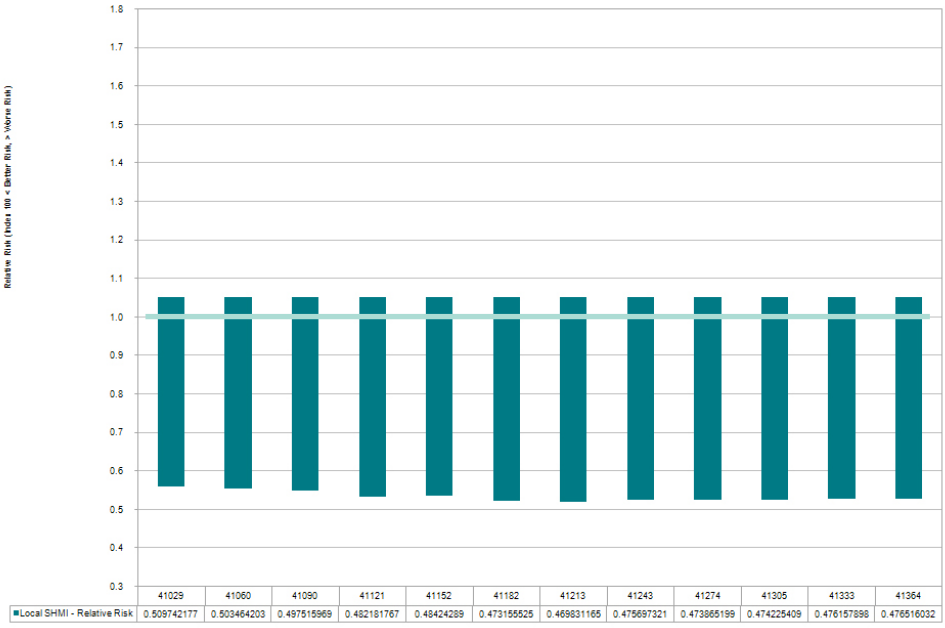
## Priority 3: Clinical outcomes

### Reducing mortality rates

Hospital standardised mortality rate (HSMR) compares a trust's actual number of deaths with the expected number. If a trust has an HSMR of 100 this means the number of deaths is exactly as would be expected. Lower than 100 means fewer deaths than could be expected.

A low mortality rate is seen as a barometer of quality and safety and has continued to be a quality priority at UCLH over the years. In 2012 the HSMR for the Trust was 65.6. HSMR has now been replaced with a new indicator, the Summary Hospital level Mortality Indicator (SHMI). The SHMI includes the total number of patients who died in hospital plus those who died within 30 days of discharge and is risk adjusted to take account of age, gender, method of admission and diagnostic grouping. Our SHMI performance for 2011/12 was 0.72 and reduced in 2012/13 to 0.68 (Oct-11 to Sep-12) which places the Trust as one of the best performing trusts nationally.

**Mortality in hospital – SHMI – 1 yr rolling data 1 month in arrears**



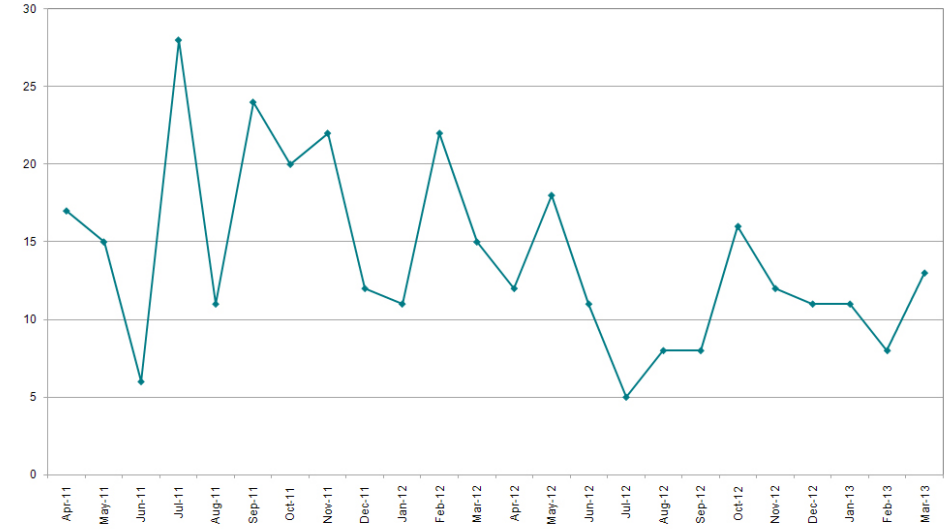

* Hospitals who have a SHMI of 1.0 have mortality rates exactly as expected when compared to all NHS providers in England. UCLH's SHMI value is very much less than 1.0, which means that patients at UCLH are less likely to die than similar patients admitted to other providers. To calculate this figure you can divide all observed deaths by the number of expected deaths for those patients.

### Cardiac arrest & vital signs recording

Early recognition of acutely unwell patients improves their chance of survival and is therefore an important component of this priority. We continually audit cardiac arrest calls and our target was to reduce the number of calls. The graph below demonstrates that we have seen an

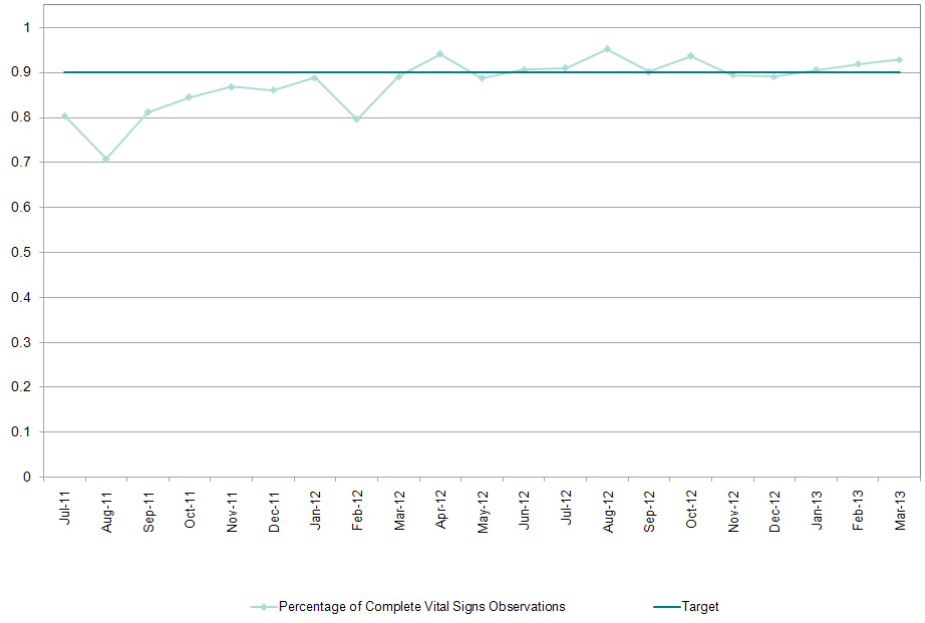
improvement in the number of cardiac arrests which is suggestive of improvement in the management of acutely unwell patients through earlier intervention.

### Number of Cardiac Arrests



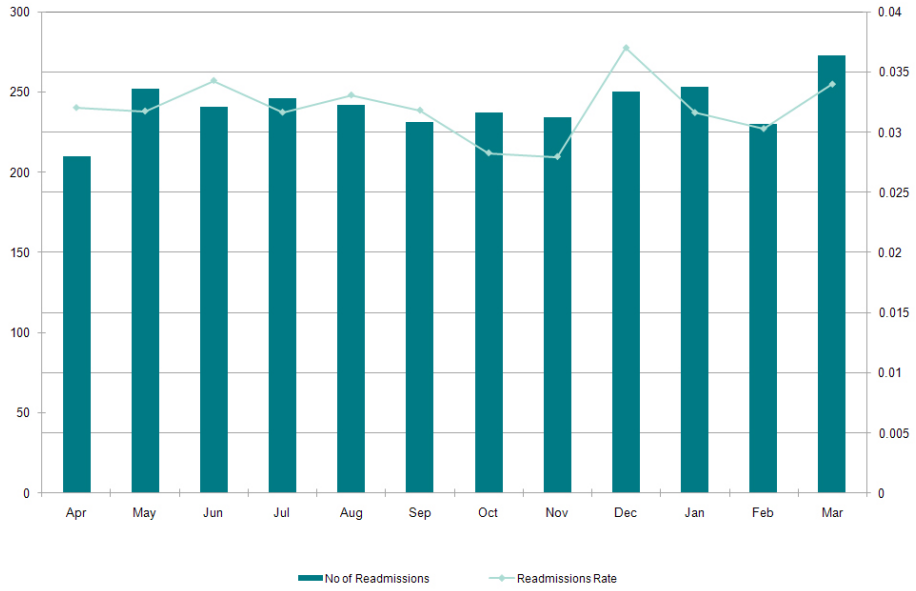

An effective early warning system that enables staff to seek expert help to prevent further deterioration is heavily reliant on accurate and timely recording of patients' vital signs (pulse, blood pressure, breathing rate, temperature, oxygen level and conscious level) For this reason we audit compliance with our vital signs standard on a monthly basis and during the year we have seen a sustained improvement with many wards achieving over 90% compliance and our overall average being 91.3% against a 90% target.

### Percentage of Completed Vital Signs Observations



## Priority 4: Reducing readmissions

### Emergency Readmissions within 30 days 2012-13




A key focus of the last year was to reduce the overall level of readmissions to the trust. To support this a number of projects were initiated, which included setting up of "hot" clinics to see patients quickly, removing the need for them to come to the emergency department or to be readmitted for assessment, dedicated nurse specialist time, direct access telephone numbers and improved discharge information.

UCLH and NCL commissioners undertook a joint clinical audit of readmissions to evaluate the proportion of readmissions that were clinically avoidable and also to identify the key reasons driving readmissions. The audit identified that 17% of readmissions to UCLH were potentially avoidable, in accordance with this finding, 17% was set as the target readmission reduction for the Trust.

Unfortunately, we have not seen a reduction in the overall rate in year. This illustrates the complexity and challenge in this area. It will remain a focus in 2013/14 and will require ongoing collaborative working between UCLH and primary care, which has started but needs further development. A key focus is to embed a discharge care bundle which is being led through the integrated care agenda.

- The Trust follows the Payment by Results Guidance 2012/13 agreed with commissioners which refers to avoidable readmission within 30 days.

# 5 Review of quality performance

## Table of progress against national priorities and locally chosen priorities

The following table provides information against a number of national priorities and also incorporates a selection of measures from the UCLH Quality and Safety scorecard which forms part of our continuous Trust review and reporting. Where possible we have included historical performance and where available we have included national benchmarks.

| We have chosen to measure our performance against the following metrics: | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2012/13 Benchmark | What this means |
|---|---|---|---|---|---|---|
| Safety measures reported | | | | | | |
| 1 Patients with MRSA infection/10,000 bed days † | 0.82 | 0.48 | 0.18 | 0.21 | 0.13 | Lower scores are better |
| 2 Patients with *Clostridium difficile* infection/10,000 bed days † | 3.29 | 2.29 | 2.00 | 1.93 | 2.19 | Lower scores are better |
| 3 Percentage of all inpatients screened for MRSA – census matched < | | | 83.4% | 84.6% | 90.0% | Higher percentage is better |
| 4 Medication incidents + | 672 | 969 | 1069 | 1109 | N/A | Higher scores may indicate a more open reporting culture |
| 5 Inpatient falls with harm ~ < | N/A | N/A | 159 | 145 | 144 | Lower scores are better |
| 6 CVC line care | | 74.9% | 95% | 93.5% | No local target | This is the compliance with CVC care protocol, higher scores are better |
| 7 Safe surgery intervention (time out using who safety checklist) | N/A | 71% | 84% | 91% ++ | | |
| 8 Vital signs audit (Harm from deterioration ) | N/A | 76% | 82.9% | 91.4% | No local target | |
| 9 Surgical site infections + | | 4.3% | 5% | 7.5% | No local target | Lower scores are better. |
| 10 Summary Hospital-level Mortality Indicator (SHMI) -Rolling one year period, six months in arrears | | | 72 | 68 | 100 | NHS Choices website. Rolling one year period, six months in arrears |
| 11 Stroke mortality rates (Based on diagnoses I61x, I64x, P101, P524) ** | 15.00% | 8.75% | 8.10% | 9.00% | | |
| 12 Deaths in hospital + | 784 | 802 | 824 | 679 | | Lower numbers are better. |
| 13 Cancelled operations + < | 1.2% | 0.9% | 1.0% | 0.94% | 0.8% | Lower scores are better. |

| We have chosen to measure our performance against the following metrics: | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2012/13 Benchmark | What this means |
|---|---|---|---|---|---|---|
| 14 29 day Emergency Readmission rate + (readmissions to UCLH) | 3.8% | 3.5% | 3.40% | 3.10% (Feb 12 to Jan 13) | 6.6% (Feb 12 to Jan 13) | Lower numbers are better. |
| 15 Complication following surgery < | 118 | 75 | 133 | 127 | 143 | Lower numbers are better. |
| Patient experience measures reported | | | | | | |
| 16 Overall satisfaction rating + | 83.0% | 83.0% | 8.3**** | 8.3 | | Higher numbers are better |
| 17 Involvement in decisions + | 76.0% | 75% | 7.6**** | 7.5 | | Higher numbers are better |
| 18 Worries and fears + | 63.0% | 60% | 6.2**** | 5.9 | | Higher numbers are better |
| Staff experience measures reported | | | | | | |
| 19 Staff job satisfaction+ | 3.43*** | 3.46 | 3.61 | 3.62 | 3.58 | Higher numbers are better |
| 20 Appraisal & re-validation rates+ | 70% | 74% | 82% | 86% | 84% | Higher numbers are better |
| 21 Care of patients is my Trust's top priority | 72% | N/A | 79% | 79 % | 63% | Higher numbers are better |
| 22 Staff would recommend the Trust as a place to work+ | 64% (3,82) | 3.88 | 3.98 | 3.99 | 3.57 | Higher numbers are better |
| 23 If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust+ | 0.8 | 80% | 85% | 83% | 60% | Higher numbers are better |

† Trust Attributable infection cases only; beddays excludes daycases. 2012-13 figure obtained by using total number of C-diff cases on HPA website, 12-13 bed days calculated using uplifted 10-11 bed days

* Incident reporting across all categories of incidents has seen a significant increase in 2010/11 due to the introduction of on line reporting making it quicker/easier to report.
** Since the publication of the 10-11 Quality account, the definition of the stroke mortality indicator has been revised following advice from relevant
clinicians. The numbers of deaths for this indicator are relatively few and so we have also provided confidence limits for this indicator. This shows that
we can be 95% confident that the Trust's actual performance lies within these upper and lower limits.
*** Since publication of the 10-11 Quality Account, measurement of this question has been revised to a score out of 5.

+ These indicators use nationally agreed definitions in their construction. Otherwise indicators are necessarily locally defined.
**** Inpatient Survey scoring methodology changed in 2011/12 from a percentage to a score out of 10
~ Overall falls reporting has been replaced with falls with harm since 2011-12.
++ 12-13 figures are provisional
< 12/13 Local targets used as 12/13 benchmark figure

## New indicators for 2012/13

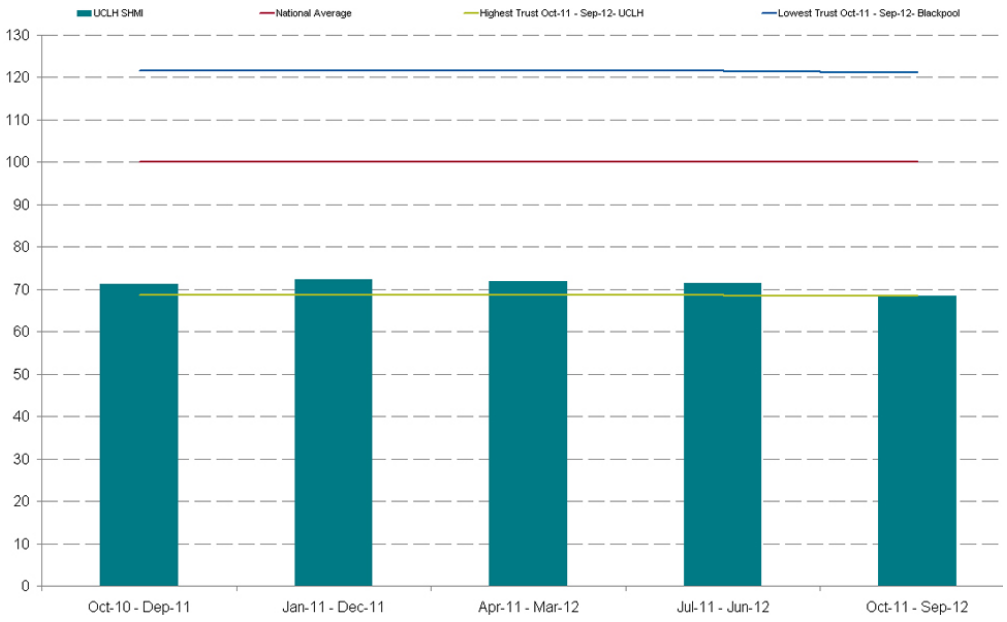
Amended regulations from the Department of Health require trusts to include a core set of quality indicators in 2012/13 Quality Accounts. These mandated indicators are set out below. Where available, data has been drawn from the Health and Social Care Information Centre.

### Summary Hospital-level Mortality Indicator

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| | Oct-10 – Dep-11 | Jan-11 – Dec-11 | Apr-11 – Mar-12 | Jul-11 – Jun-12 | Oct-11 – Sep-12 |
|---|---|---|---|---|---|
| UCLH SHMI | 71.3 | 72.3 | 71.9 | 71.4 | 69 |
| National Average | | | | | 100 |
| Best Performing Trust Oct-11 – Sep-12- UCLH | | | | | 69 |
| Lowest Trust Oct-11 – Sep-12- Blackpool | | | | | 121 |

#### Summary Hospital-level Mortality Indicator




UCLH has taken the following actions to improve this rate, and so the quality of its services, by the improvement actions as described on page 105.

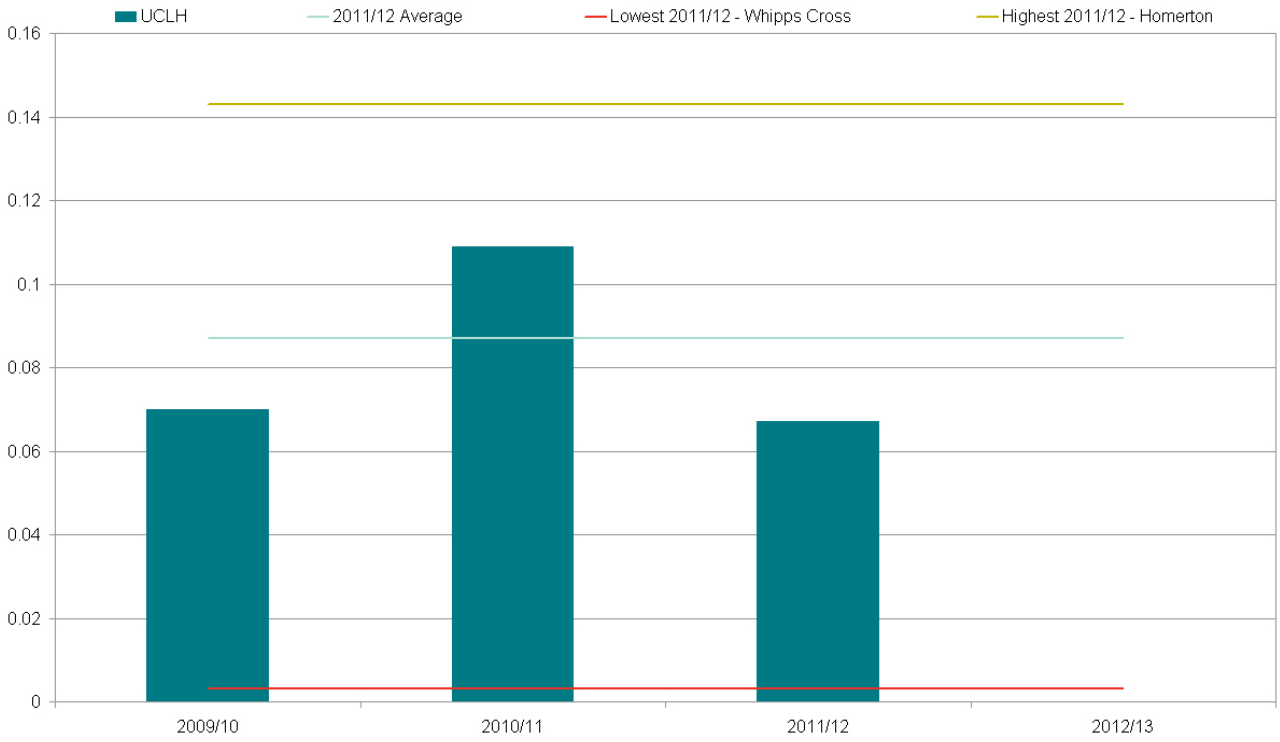
The summary Hospital level mortality indicator is produced by the Department of Health using deaths recorded in hospital combined with the information received by the Office of National Statistics (ONS) for patients who died within 30 days following discharge. Processing of this data takes some months due to the time allowed to register a death and to match individual records where relevant to hospital discharge episode data. The latest position that has been released and published via NHS Choices is October 2011 – September 2012. Data up to and including December 2012 is not expected until June 2013 . We are able to internally produce a SHMI value for patients who die in hospital and this is routinely included in monthly performance reports to give an indication of changes in mortality risk. This however is a lower value than the published data as it will not include those patients who subsequently die following discharge.
Patient Reported Outcome Measures

## Patient Reported Outcome Measures

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

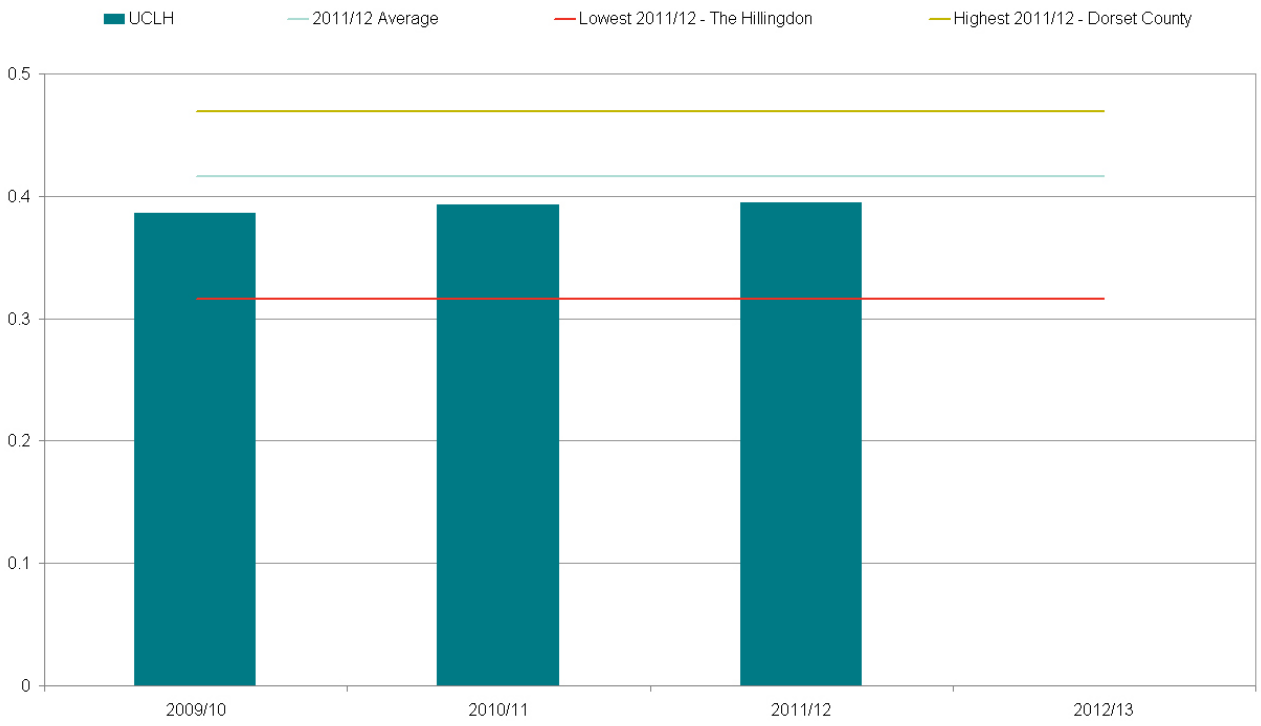
| Groin Hernia | EQ-5D index casemix adjusted health gain<br>Adjusted average health gain | | | |
|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
| UCLH | 0.07 | 0.109 | 0.067 | N/A |
| 2011/12 Average | | | 0.087 | |
| Lowest 2011/12 – Whipps Cross | | | 0.003 | |
| Best performing 2011/12 – Homerton | | | 0.143 | |

### Patient Reported Outcome Measures – Groin Hernia



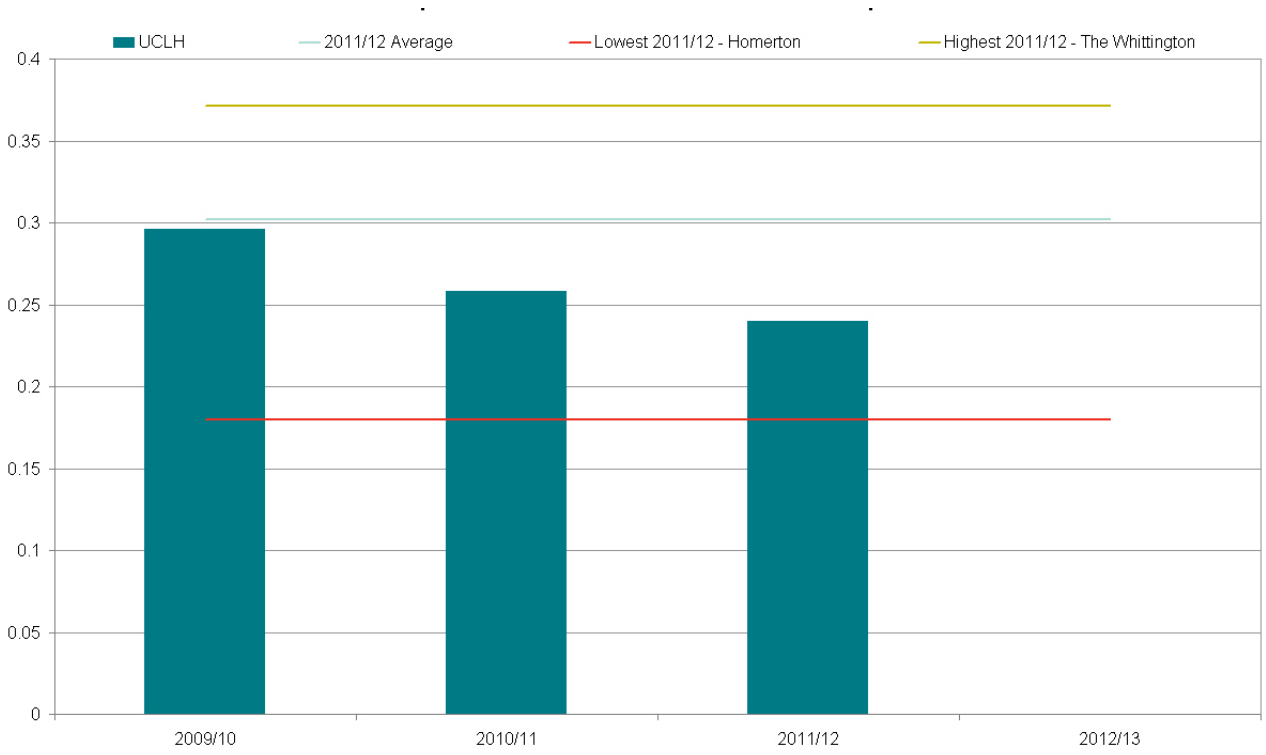
| Hip Replacement | EQ-5D index casemix adjusted health gain<br>Adjusted average health gain | | | |
|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
| UCLH | 0.386 | 0.393 | 0.395 | N/A |
| 2011/12 Average | | | 0.416 | |
| Lowest 2011/12 – The Hillingdon | | | 0.316 | |
| Best performing 2011/12 – Dorset County | | | 0.469 | |

## Patient Reported Outcome Measures – Hip Replacement



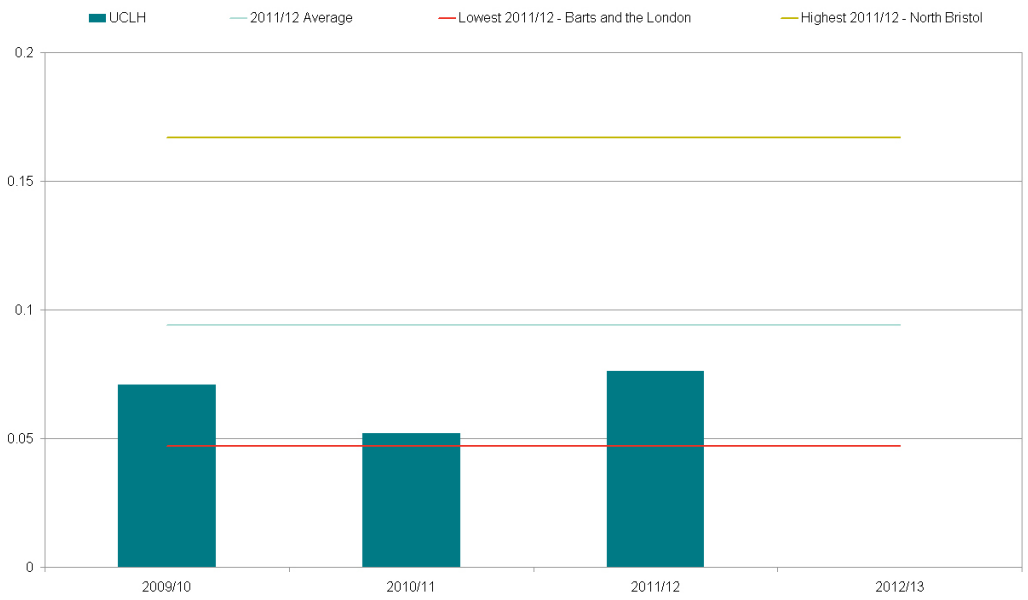
| Knee replacement | Adjusted average health gain | | | |
|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
| UCLH | 0.296 | 0.258 | 0.24 | N/A |
| 2011/12 Average | | | 0.302 | |
| Lowest 2011/12 – Homerton | | | 0.18 | |
| Best Performing 2011/12 – The Whittington | | | 0.371 | |

## Patient Reported Outcome Measures – Knee Replacement



| Varicose Vein | EQ-5D index casemix adjusted health gain<br>Adjusted average health gain | | | |
|---|---|---|---|---|
| | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
| UCLH | 0.071 | 0.052 | 0.076 | N/A |
| 2011/12 Average | | | 0.094 | |
| Lowest 2011/12 – Barts and the London | | | 0.047 | |
| Best Performing 2011/12 – North Bristol | | | 0.167 | |

## Patient Reported Outcome Measures – Varicose Vein




* HSCIC and Trust local data not available for 2012/13

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

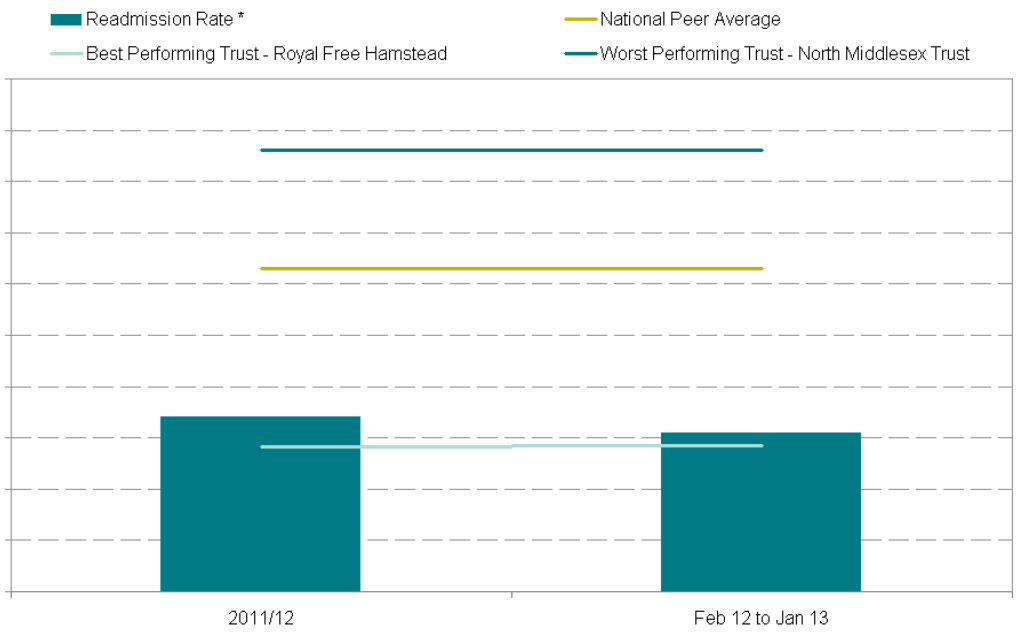
- A PROMs Steering Group has been developed with a clinician chair to assess Trust performance and agree actions with relevant specialties

## 28 day Emergency Readmission Rate

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| | 2011/12 | Feb 12 to Jan 13 |
|---|---|---|
| Readmission Rate * | 3.4 | 3.1 |
| National Peer Average | | 6.3 |
| Best Performing Trust – Royal Free Hampstead | | 2.84 |
| Worst Performing Trust – North Middlesex Trust | | 8.61 |

### 28 day Emergency Readmission rate




- Data from CHKS 28 day readmission rates

UCLH has taken the following actions to improve this rate, and so the quality of its services, by the improvement actions as described on page 129.

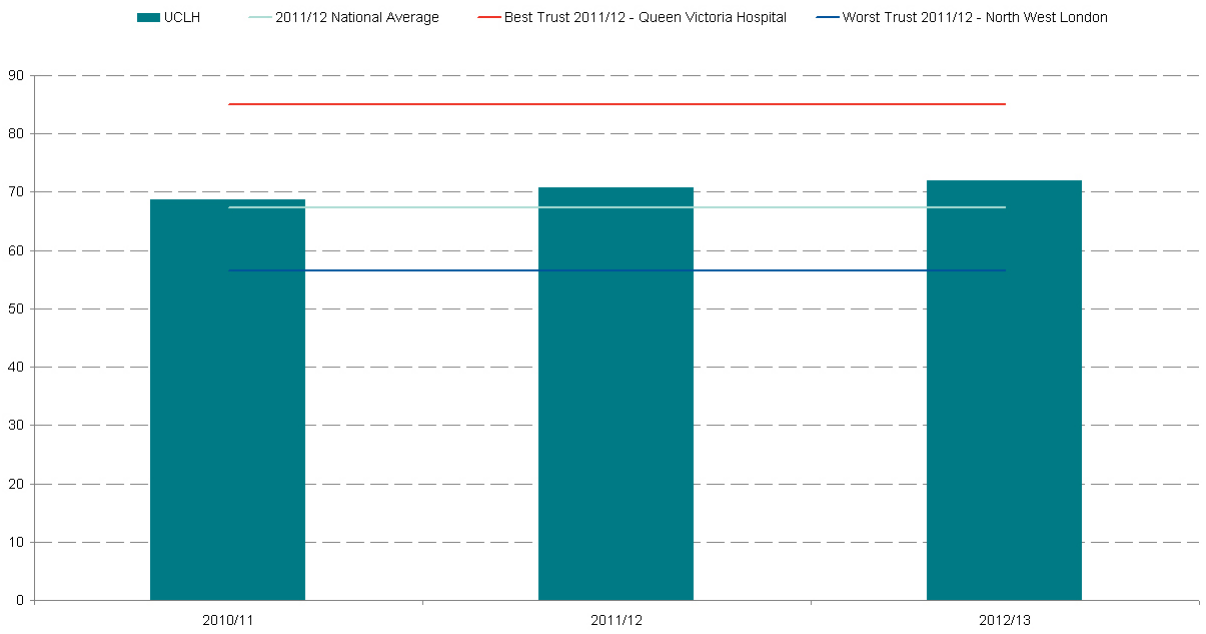
The indicator currently reports a position to January 2013 . To include the data for benchmarking showing the trusts with the highest and lowest readmission rates, we require access to the national Hospital Episode Statistics (HES) data which the Department of Health releases. This is always at least 3 months in arrears, to ensure that all providers organisations have submitted their data and that the HES team have undertaken the appropriate validation and cleansing processes prior to publication.

## Responsiveness to Personal Needs of Patients

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| UCLH | 68.7 | 70.8 | 71.9 |
| 2011/12 National Average | 67.4 | 67.4 | 67.4 |
| Best Trust 2011/12 – Queen Victoria Hospital | | 85 | |
| Worst Trust 2011/12 – North West London | | 56.5 | |

### Responsiveness to Personal Needs of Patients




UCLH has taken the following actions to improve the score, and so the quality of its services, by:

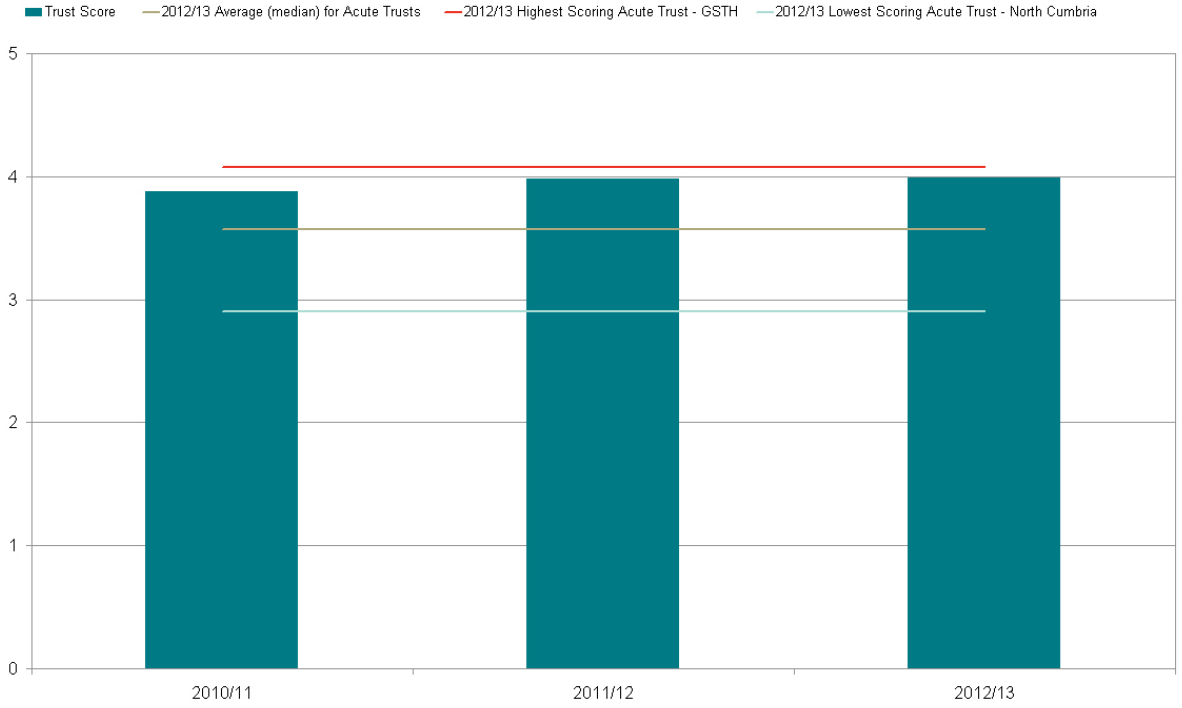
- using real time patient feedback
- identifying trends at ward level
- developing ward level improvement plans

## Staff recommendation of the trust as a place to work or receive treatment (KF24 2012 Survey)

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| Trust Score | 3.88 | 3.98 | 3.99 |
| 2012/13 Average (median) for Acute Trusts | | | 3.57 |
| 2012/13 Best Performing Acute Trust – GSTH | | | 4.07 |
| 2012/13 Lowest Scoring Acute Trust – North Cumbria | | | 2.90 |

### Staff recommendation of the trust as a place to work or receive treatment



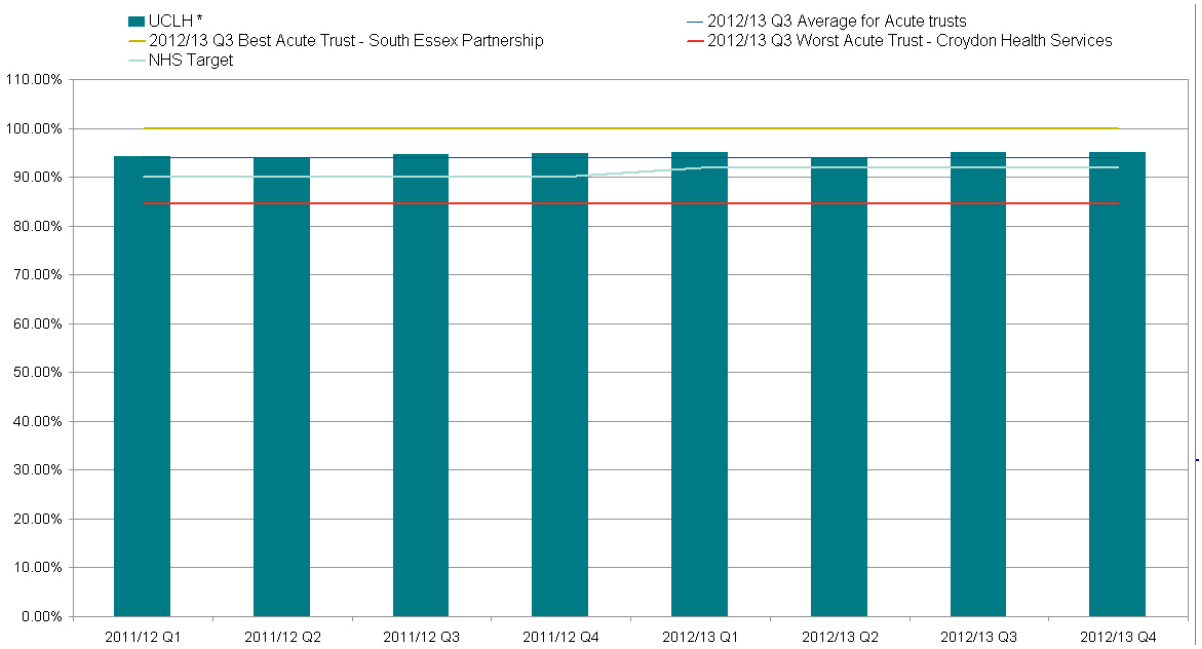

UCLH has taken the following actions to improve this percentage, and so the quality of its services, by improvement actions as part of the 'Making a Difference Together' programme.

## Rate of admissions assessed for VTE

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| | 2011/12 Q1 | 2011/12 Q2 | 2011/12 Q3 | 2011/12 Q4 | 2012/13 Q1 | 2012/13 Q2 | 2012/13 Q3 | 2012/13 Q4 |
|---|---|---|---|---|---|---|---|---|
| Trust Score | 94.21% | 93.70% | 94.59% | 94.93% | 95.06% | 93.82% | 94.99% | 95.11% |
| 2012/13 Q3 Average for Acute trusts | | | 3.57 | | | | 94.10% | 94.10% |
| 2012/13 Q3 Best Acute Trust – South Essex Partnership | | | 4.07 | | | | 100.00% | 100.00% |
| 2012/13 Q3 Worst Acute Trust – Croydon Health Services | | | 2.90 | | | | 84.60% | 84.60% |
| NHS Target | 90% | 90% | 90% | 90% | 92% | 92% | 92% | 92% |

### Rate of admissions assessed for VTE




* Using local data sources

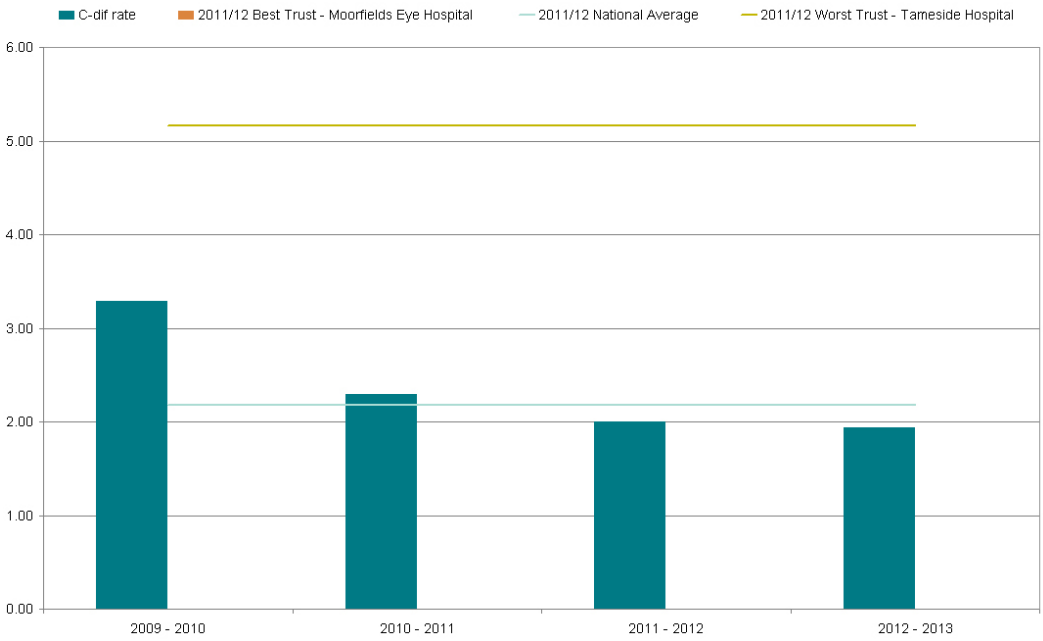
UCLH has taken the following actions to improve this rate, and so the quality of its services, by improvement actions as described on page 123.

## C Diff Rates

UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| | 2009 – 2010 | 2010 – 2011 | 2011 – 2012 | 2012 – 2013 |
|---|---|---|---|---|
| C-dif rate | 3.29 | 2.29 | 2.00 | 1.93 |
| 2011/12 National Average | | | 2.18 | |
| 2011/12 Worst Trust – Tameside Hospital | | | 5.16 | |
| 2011/12 Best Trust – Moorfields Eye Hospital | | | 0 | |

### C-dif rates per 10,000 bed-days




* Rate of C difficile – 12-13 figure obtained by using total number of C-diff cases on HPA website, 12-13 bed days calculated using uplifted 10-11 bed days

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

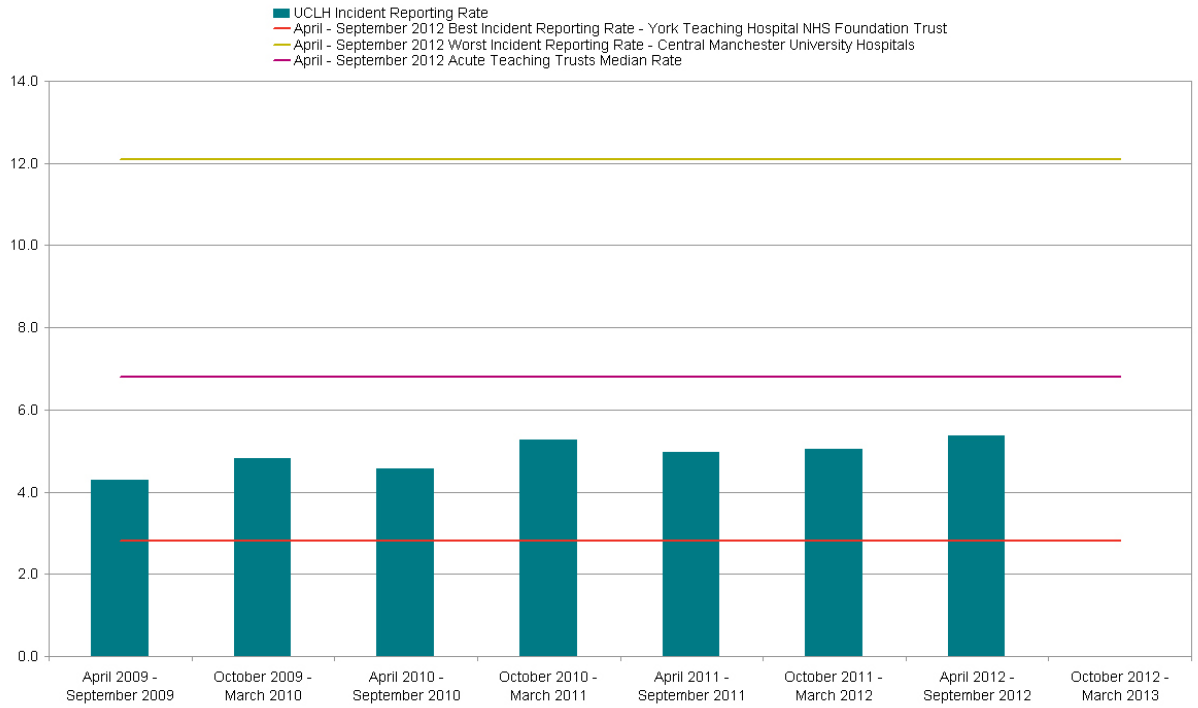
- scrutinising antibiotic usage
- timely isolation
- cleaning and disinfection of environment
- optimal hand hygiene
- learning from Root Cause Analysis on all cases

## Incident Reporting

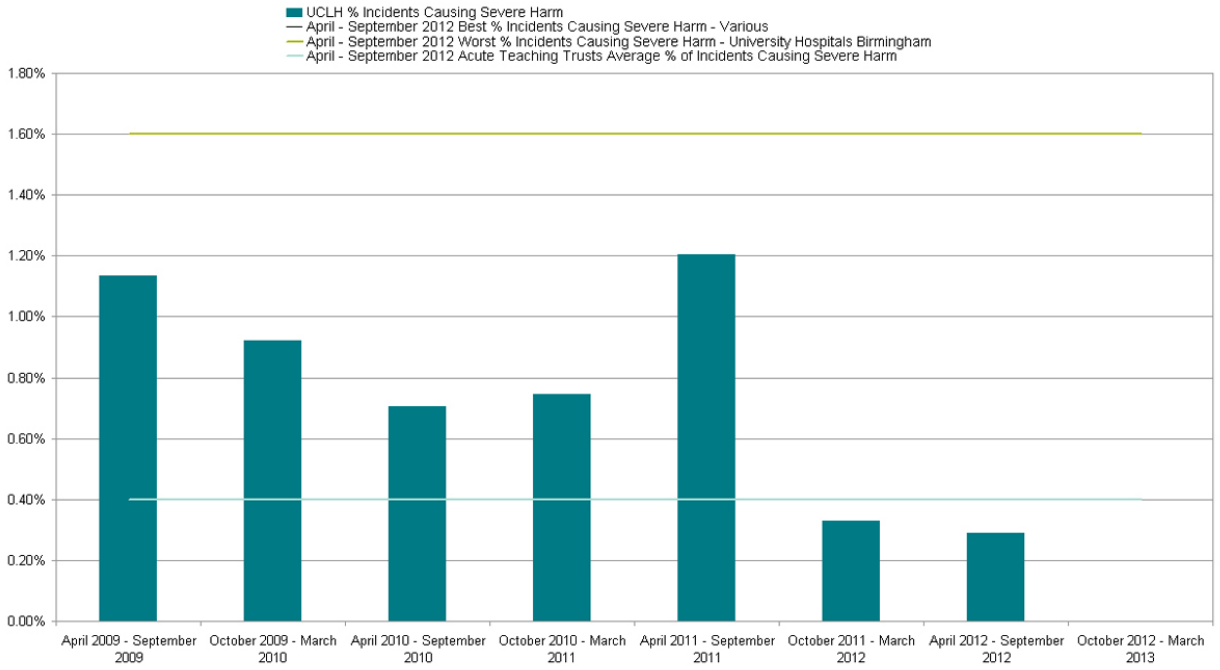
UCLH NHS Foundation Trust considers that this data is as described for the following reasons

| Incident Reporting | From Health and Social Care Information Centre | | | | | | | From local Trust data |
|---|---|---|---|---|---|---|---|---|
| | April 2009 – September 2009 | October 2009 – March 2010 | April 2010 – September 2010 | October 2010 – March 2011 | April 2011 – September 2011 | October 2011 – March 2012 | April 2012 – September 2012 | April 2012 – March 2013 |
| None | 1982 | 1934 | 2018 | 2301 | 2297 | 2312 | 2753 | 5685 |
| Low | 312 | 440 | 343 | 358 | 384 | 397 | 392 | 784 |
| Moderate | 59 | 97 | 163 | 262 | 269 | 310 | 309 | 583 |
| Severe | 27 | 23 | 18 | 22 | 36 | 10 | 10 | 32 |
| Death | 0 | 5 | 5 | 4 | 3 | 1 | 4 | 8 |
| Total | 2380 | 2499 | 2547 | 2947 | 2989 | 3030 | 3468 | 7092 |
| UCLH Incident Reporting Rate per 100 admissions | 4.3 | 4.8 | 4.6 | 5.3 | 5.0 | 5.0 | 5.4 | 5.02% |
| UCLH % Incidents Causing Severe Harm or death | 1.13% | 1.12% | 0.91% | 0.89% | 1.30% | 0.36% | 0.41% | 0.56% |
| April – September 2012 Worst Incident Reporting Rate – York Teaching Hospital NHS Foundation Trust | | | | | | | 2.8 | |
| April – September 2012 Best Incident Reporting Rate – Central Manchester University Hospitals | | | | | | | 12.1 | |
| April – September 2012 Acute Teaching Trusts Median Rate | | | | | | | 6.8 | |
| April – September 2012 Best % Incidents Causing Severe Harm – Various | | | | | | | 0 | |
| April – September 2012 Worst % Incidents Causing Severe Harm – University Hospitals Birmingham | | | | | | | 1.60% | |
| April – September 2012 Acute Teaching Trusts Average % of Incidents Causing Severe Harm | | | | | | | 0.40% | |
| April – September 2012 Best % Incidents Causing Death – Various | | | | | | | 0 | |
| April – September 2012 Worst % Incidents Causing Death – Oxford University Hospitals | | | | | | | 0.50% | |
| April – September 2012 Acute Teaching Trusts Average % of Incidents Causing Death | | | | | | | 0.10% | |

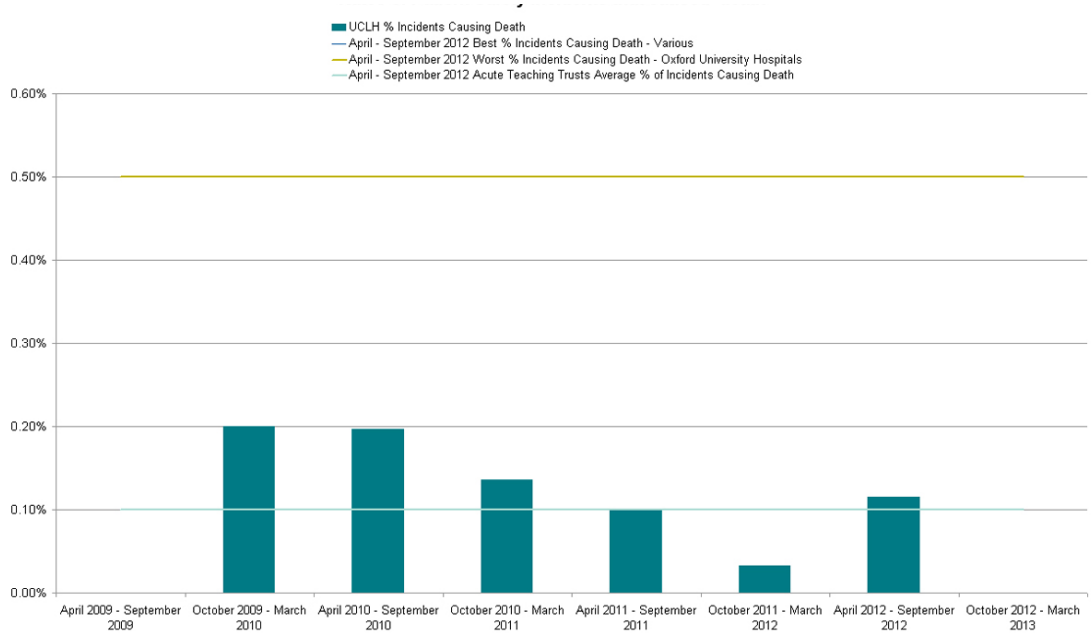
## Number of Patient Safety Incidents reported and rate per 100 admissions




## Rates of Patient Safety Incidents that caused severe harm



## Rates of Patient Safety Incidents that caused death




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

- encouraging reporting
- building an open culture
- analysing themes
- identifying improvement projects

This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. All patient safety incidents resulting in severe harm or death have to be reported to the Care Quality Commission and this is done via the National Reporting and Learning System (NRLS).

UCLH aims to maintain a very timely approach to reporting incidents to the NRLS and performs a daily upload of incident details. As a consequence of this, the harm level may either increase or decrease after the incident has been reported, as a result of the patient's condition or the findings of an investigation. When this happens UCLH will change the harm grading on NRLS, but at any given time there may be minor discrepancies in the number of incidents reported on NRLS and on UCLH's local system.

| | Threshold 2012/13 | 2011/12 | 2012/13 |
|---|---|---|---|
| Care Quality Commission Targets estimated performance :+ | | | |
| Existing commitments<br>National targets<br>Core standards | | N/A<br>N/A<br>N/A | N/A<br>N/A<br>N/A |
| Clostridium difficile year-on-year reduction † + | 44 | 54 | 54 |
| MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level † + | 5 | 5 | 5 |
| 18-week maximum wait from point of referral to treatment (admitted patients) + | 90.0% | 93.6% | 93% |
| 18-week maximum wait from point of referral to treatment (non-admitted patients) + | 95.0% | 97.2% | 96.9% |
| 18-week maximum wait from point of referral to treatment – 95th percentile (admitted patients) # | No longer reported | | No longer reported |
| 18-week maximum wait from point of referral to treatment – 95th percentile (non-admitted patients) | No longer reported | | No longer reported |
| Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge + | 98.0% | 96.1% | 95.4% |
| People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack) | Service is not provided in this trust. | Service is not provided in this trust. | Service is not provided in this trust. |
| 62-day wait for first treatment from urgent GP referral to treatment: all cancers + | 85.0% | 86.7% | 91.1% |
| 62-day wait for first treatment from consultant screening service referral: all cancers + | 90.0% | 86.5% | 91% |
| 31-day wait for second or subsequent treatment: surgery + | 94.0% | 99.4% | 98.2% |
| 31-day wait for second or subsequent treatment: anti-cancer drug treatments + | 98.0% | 99.9% | 99.8% |
| 31-day wait for second or subsequent treatment: radiotherapy + | 94.0% | 99.4% | 99.6% |
| 31-day wait from diagnosis to first treatment: all cancers + | 96.0% | 99.0% | 99.0% |
| Two-week wait from referral to date first seen: all cancers + | 93.0% | 93.8% | 93.6% |
| Two-week wait from referral to date first seen: breast symptoms | 93.0% | 95.6% | 94.4% |

# Measurement of indicator by Monitor introduced in Q4 2010
† Trust Attributable cases only
+ These indicators use nationally agreed definitions in their construction. Otherwise indicators are necessarily locally defined.
# 95th percentile targets apply to 2011/12 only

# Annex 1: Statement from commissioners, LINks and OSC

## Statement from Camden Health Scrutiny Committee

The Committee is not meeting until mid May so will not be providing formal comment this year. The Quality Account was submitted informally and circulated electronically to members in case they wish to add any issues onto their work plan for the future. They will amend their committee meeting dates for next year in case the Committee wish to make comments on Quality Accounts. The Committee will be considering how they work in future with the CQC and Healthwatch to identify performance concerns that they may wish to raise over the course of the year with individual Trusts so that they can make meaningful comments on the Quality Accounts, and also in light of the Mid Staffordshire review.

## Statement from Healthwatch

Healthwatch Camden will not be providing a statement of inclusion this year.

## Statement from Commissioners

NHS Camden Clinical Commissioning Group welcomes the opportunity to provide this statement on UCLH Trust's Quality Accounts. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have taken particular account of the identified priorities for improvement for UCLH Trust and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of the quality of care at UCLH. We have discussed the development of this Quality Account with UCLH over the year and have been able to contribute our views on consultation and content.

This Account has been reviewed within NHS Camden Clinical Commissioning Group and by colleagues in NHS North and East London Commissioning Support Unit.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with UCLH to continually improve the quality of services provided to patients.

# Annex 2: Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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 2012/13;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to May 2013;
  - Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
  - Feedback from the commissioners dated May 2013
  - Feedback from the governors between November 2012 and February 2013
  - Feedback from Local Healthwatch organisations dated April 2013
  - The trust's complaints report published under regulation 18 of the Local Authority
  - Social Services and NHS Complaints Regulations 2009, dated October 2012 and quarterly reports during the year
  - The national patient survey report 2012
  - The national staff survey report 2012
  - The Head of Internal Audit's opinion over the trust's control environment dated May 2013
  - Care Quality Commission quality and risk profiles dated April 2012 to May 2013
- 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, 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) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annuareportingmanual)

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

Chairman
Date: 24 May 2013

Chief Executive
Date: 24 May 2013

# Annex 3: External audit limited assurance report

Independent Auditor's Report to the Council of Governors of University College London Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of University College London Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of University College London Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of University College London Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting University College London Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University College London Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

## Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Cancer 62 day waits
- C.Difficile

We refer to these national priority indicators collectively as the "indicators".

## Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

## Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting

documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University College London Hospitals NHS Foundation Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Deloitte LLP
Chartered Accountants
St Albans, UK
24 May 2013

# Annex 4: Glossary of terms and abbreviations

- **Care bundles** – consist of a group of precautionary steps which, when combined and executed reliably for a specific treatment, have proven to significantly reduce untoward outcomes.
- **Care Quality Commission (CQC)** – the independent regulator of all health and social care services in England
- **CNS** – clinical nurse specialist
- **Commissioners** – the organisation, NHS North Central London, that commissions care for UCLH patients
- **CQUIN** – Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work
- **CVC** – central venous catheters
- **Dr Foster Hospital Guide** is a provider of healthcare information in the UK, monitoring the performance of the NHS and providing information to the public.
- **Governors** – staff representatives on the Governing Body, which helps to shape the services UCLH provides and reflects the needs and priorities of patients, staff and local communities.
- **GTT** – global trigger tool; It is used to identify the types and scale of adverse events. It involves patient case note reviews to identify adverse events which may lead on to complications of care and adverse outcomes.
- **NHSLA** – National Health Service Litigation Authority. Organisation responsible for assessing how effectively trusts manage risk.
- **Ombudsman** – the Parliamentary and Health Services Ombudsman consider complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.
- **SSI** – surgical site infections
- **Thromboprophylaxis** – the use of blood thinning drugs and/or elastic stockings to prevent blood clots in those that are at risk of developing them
- **VTE** – venous thromboembolism (blood clots)

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