NHS

University College London Hospitals

NHS Foundation Trust

uclh

Quality account 2016/17

University College Hospital

National Hospital for Neurology and Neurosurgery

Eastman Dental Hospital

Royal National Throat, Nose and Ear Hospital

Royal London Hospital for Integrated Medicine

1. Statement on quality from the Chief Executive

Our vision is to deliver top-quality patient care, excellent education and world-class research.

We are proud that our mortality rate as measured by the Summary Hospital Level Mortality Indicator is the second lowest in England. A further example of our commitment to safety is the work we have been doing to improve surgical safety. Our philosophy is to educate our theatre teams about 'what goes right' (good catches, strong leadership etc.) as well as 'what could be improved'.

Providing world-class research to improve the quality of patient care remains a major focus for us. In the past year, there have been major funding awards to the University College London Hospitals NHS Foundation Trust (UCLH) Biomedical Research Centre (£111.5m) and our Clinical Research Facility (£6.5m). UCLH and University College London (UCL) will host the new UK Dementia Research Institute to develop new treatments to prevent dementia and help those living with the condition. All these successes build on the strong and expanding collaboration between UCLH and UCL.

But we are not complacent. Our patients, their families and carers rightly ask for evidence of our continuing commitment to quality, and expect us to report with honesty where we do not reach a target as well as pride when our services are as good as we plan. Quality reports use data and measurement but charts and tables do not tell the whole quality story. High quality patient care comes from our hearts and from our values - safety, kindness, teamwork, improving. Our values may not always be precisely measurable, but in the short time I have been at UCLH I have seen them being lived every day.

The latest annual survey of NHS staff shows UCLH staff are more likely than most to recommend their hospital as a place to work or receive treatment. Their answers also show us leading in the coverage and quality of appraisal – an essential tool for developing, motivating and focusing the people working here. Our staff have better than average confidence in reporting unsafe practices, are better than average at reporting errors, near misses and incidents, are more likely than average to believe in the fairness of procedures for reporting errors, near misses and incidents and to feel able to contribute towards improvements at work. A high proportion of our staff also believe that we make good use of patient and service user feedback.

Quality care depends on staff but is also a partnership with patients. We work hard to ensure that we learn from our patients. The theme of learning from patients runs through this report.

The Care Quality Commission (CQC) inspected our core services in March 2016 and published their report in August 2016. The inspection covered University College Hospital including the Elizabeth Garrett Anderson Wing (EGA) and University College Hospital at Westmoreland Street. Whilst some areas for improvement were identified, we were rated as 'good' overall and 'outstanding' for 'well led' in surgery. We face challenges balancing the priority services for our local community with our activities as a specialist centre. Our external stakeholders told us that to be rated as 'good' overall was a real achievement. Nevertheless, we believe we can still do better. Our ambition is for all our hospitals and services is to be rated as 'outstanding'. This drives our work in acting on the CQC's inspection findings.

This report shows how we performed against our 2016/17 priorities, then sets out our priorities for the coming year, followed by an overview of all our key performance indicators and assurance statements The report has been written with our clinical teams. The text has been scrutinised by a group representing our governors and by the board including our non-executive directors to ensure that it paints a fair picture. Measures of quality and performance are, by their nature, less precise than our financial information, with less internal and external scrutiny than the financial information presented in our annual report and accounts. But I believe this report gives an accurate account of quality at UCLH and I hope it will be read widely, by staff as well as by the people who use our services.

With this in mind UCLH has done its best to ensure that, to my knowledge, the information in the document is accurate recognising the matters identified in the report including in respect of the '18 weeks referral to treatment incomplete pathway indicator' and the 'A&E 'maximum waiting time for four hours indicator' as described in section 1.5.

Professor Marcel Levi
Chief Executive
23 May 2017

1.1 About this report

1.1.1 What is a quality report?

Every year all NHS hospitals in England must write a report for the public about the quality of their services. This is called the quality report. A quality report makes your hospital more accountable to you and drives improvement in the quality of our services.

We look at our performance over the previous year, identify areas for improvement and publish that information. We make a commitment to you about how those improvements will be made and checked over the next year. In the report 'year' means April to March (2016/17 or 2017/18).

Quality in healthcare is made up of three dimensions:

- Patient safety - keeping patients safe from harm
- Clinical effectiveness - how successful is the care provided?
- Patient experience - how patients experience the care they receive

1.1.2 What is in our quality report?

This report tells you how well we did against the quality priorities and goals we set ourselves for 2016/17 (this year). It also sets out the priorities we have agreed for 2017/18 (next year), and how we plan to achieve them.

Terms and abbreviations denoted by in the report are explained in the glossary. The report begins with the statement on quality from the chief executive. Thereafter it contains six sections and four appendices:

Part 1.1 An introduction to the report and explains why we publish it and what it is about.
Part 1.2 Sets out where we want to improve in 2017/18.
Part 1.3 Sets out our progress against our 2016/17 priorities.
Part 1.4 Sets out our priorities for improvement in 2017/18.
Part 1.5 Describes how we review and evaluate the quality of the services we provide, including information and data quality. It also describes audits we have carried out, and how we have responded to our stakeholders' comments from last year's quality report.
Part 1.6 Contains mandated statements of assurance from the board.

Annex 1 Provides statements from our commissioners and Healthwatch Camden
Annex 2 Provides our statement of directors' responsibilities
Annex 3 Provides the Independent Auditor's report to the council of governors of UCLH on this quality report
Annex 4 Provides a glossary of terms and abbreviations denoted by in the report

1.2. Where we want to improve

1.2.1 Care Quality Commission Inspection

We underwent the first CQC inspection of our core services that provided a 'rating' for UCLH in March 2016.

The CQC assessed the safety of our care, how effective our care is, how caring, responsive and well led we are, with services rated as 'Good' overall.

Professor Sir Mike Richards, chief inspector of hospitals, said: "My team saw many examples of good care, and were impressed by the dedication shown by staff, the support provided to staff, and the clear emphasis UCLH places on putting patients first. The vast majority of patients spoken to were very positive about the care they received, and staff were proud to work at UCLH and of the level of care they were able to deliver".

The CQC made many positive comments about our care and services in the report, some of which can be found in Table Q1 on page 8.

Our overall rating was 'good'. However, five areas were found to require improvement, three in urgent and emergency services, and two in medical care.

Table Q1: CQC 2016 rating of UCLH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

What the CQC said about us… Some extracts from our inspection report

"In maternity and gynaecology we saw examples of outstanding practice. We saw high levels of support given to staff in an innovative environment with good examples of innovation and best practice."

"Throughout the hospital we saw areas of outstanding practice. We found all staff to be dedicated, caring and supportive of each other and we found patient feedback to be overwhelmingly positive."

"There was outstanding local leadership in the critical care unit with high levels of staff and patient engagement."

"Patients we spoke with were positive about the care they received. Patients told us staff were "excellent" and "highly professional". Patients told us they were always treated with compassion. One patient reported she had complete confidence in the care she had received. All levels of staff, from the cleaners to the consultants, treated her in a caring way."

"Interactions between staff and patients were individual and delivered in a caring and compassionate way. We saw that staff were caring and demonstrated compassion towards patients in one to one interactions. In quieter periods, we observed nurses and doctors welcome patients who were distressed into the acute assessment area calmly and by introducing themselves. We also saw other examples of similarly positive interactions elsewhere in the department. One patient told us that they were very happy with how staff engaged them and said, "Staff have been very nice to me."

"The majority of patients we spoke with were positive about the care they received. Patients told us staff were "excellent" and "highly professional". Patients told us they were always treated with compassion. One patient reported she had complete confidence in the care she had received. All levels of staff, from the cleaners to the consultants, treated her in a caring way."

"Staff recognised the changing needs of the local people and wider population and used a task force to identify and address any gaps in services. A range of support teams, such as translators and the drug and alcohol support team, were available to meet patients' individual needs."

"In outpatients and diagnostic Imaging "patients were treated with compassion, dignity and respect; they were fully involved in decisions about their care and treatment"

"There was a strong focus on improvement from all levels of staff when results were less them (sic) optimum" (Surgery)

"Children were cared for in a caring and compassionate manner. Their privacy and dignity was maintained throughout their hospital stay. Fully trained and registered children's nurses and neonatal nurses throughout the service ensured that children and their families were informed about their care and were fully involved in any treatment decisions".

CQC Recommendations: Emergency Department & medical care

CQC recommended that we check the streaming process in the Emergency Department (ED) and work with our staff to develop a system that shortens the time to assess patients, and the time they have to stay in ED. They said we should make sure we always record early warning scores, sepsis screening and pain management. They recommended that we check emergency cover in the ED to ensure it meets the Royal College of Emergency Medicine (RCEM) recommendations. In the areas relating to 'Medical Care' they recommended that we improve record keeping and ensure all our risks are noted on risk registers.

What have we achieved so far in the Emergency Department?

We have introduced a new ED day unit to treat and assess patients who require further tests and treatment, by specialist teams, but do not require admission to a ward.

We have increased GP resource for patients presenting with primary care conditions during core hours, utilising them to redirect patients to appropriate primary care or community services, supplementing the existing see and treat GP provision within the ED.

We have introduced a rapid assessment and treatment function to reduce the time it takes to hand over patients arriving by ambulance.

We have introduced a 'clinical navigator' at the front of the ED to direct patients to the best area and clinician for their condition.

We have improved how we communicate with patients. The nurse lead for each area updates patients at least every hour on potential waiting times.

We are testing alternative ways of sharing lessons learnt from incidents. For example, discussing them at daily ward 'huddle' meetings and in monthly bulletins.

Although we provide significantly better consultant cover than any other non-major trauma centre in our sector, the RCEM recommend that there is consultant level cover in the ED 16 hours a day on seven days of the week. We achieve this target Monday to Friday. At the weekend, we currently provide 14.5 hours per day and we are working to close that gap.

Improving care walk rounds (ICRs) in the Emergency Department

The ICR team is made up of nurses, hospital volunteers, students, governors, managers, doctors, pharmacists, therapists and dieticians. They act as 'fresh eyes' and a 'critical friend' to help our staff to improve by identifying areas of concern and good practice and by sharing good practice from other parts of our hospitals.

We have carried out three ICRs in the ED since the CQC inspected in March 2016. These have confirmed steady improvement in the areas recommended by CQC for action. For example it was noted that patient flow has improved and the management of medicines is better. Staff gave good feedback about learning from incidents and the ICR team could see that the 'clinical navigator' role is having a positive effect on the patient journey. The staff reported improved staff morale, better culture, good teamwork and improved leadership and that nurses and doctors have a better rapport. Staff were aware of the duty of candour and knew what to do if a relevant incident occurred.

We still have work to do…

We have around 140,000 attendances at our ED each year. We are transforming our urgent and emergency care services by expanding and improving our ED footprint at University College Hospital. This is moving forward as part of a £21.7 million programme to redevelop and improve the facility, while continuing to provide care to patients. As part of this programme of works, the paediatric (children's) emergency department will be redesigned to improve the experience of families attending the ED.

We will be piloting a new 24-hour Mental Health Liaison service, with a mental health nurse specialist to triage (sort) patients and redirect them to appropriate community services.

CQC recommendations trust-wide - other key areas we are working to improve are:

Care of patients with dementia: Although we flag (identify) patients with dementia, the CQC said that this did not appear to be reflected in plans for their care. We are now ensuring that patient needs associated with dementia are included in the nursing assessment and care record. Where the patient or family agree, a 'This is me' card is placed on the patient's bedside table which details what the patients' preferences are if they are unable to communicate them to staff. We aim for at least 90 per cent of ward-based staff to have completed dementia training this year.

Care of patients with learning disabilities (LD): Although we flag (identify) patients with a learning disability (LD), the CQC said that this did not appear to be reflected in plans for their care. We now have thirty trained LD champions across our hospitals. When registered with UCLH patients are flagged on CDR if they have a LD. When a patient with LD is admitted, they are routinely offered a 'Hospital Passport', if they do not already have one. This is designed to help hospital staff understand each patient's needs, likes, dislikes and interests. We monitor this by audit; currently 77 per cent of patients flagged with a learning disability received a 'Hospital Passport'.

Mandatory training: We have developed systems to give our managers up to date reports on the training records of their teams. We are working to ensure suitable and sufficient capacity for classroom training to improve mandatory training compliance.

Pain management: The CQC recommended that we improve pain scoring and documentation. We are building pain recording into vital signs monitoring, with training for nursing staff and nursing assistants.

Monitoring and assurance of our CQC action plans

There is a lead for each area and action from the CQC report. We take assurance from the data in our quality and safety performance book, Exemplar Wardand Essence of Care audits, matrons' walk rounds, ICRs and audits, e.g. the sepsis CQUIN. We are developing an approach to bring the different types of assurances together in one report.

1.2.2 When things do not go well

How we are implementing the duty of candour

However hard we try, sometimes complications happen, or things do not go as planned. We make sure that if patient safety incidents happen where the harm is moderate or greater, patients or their families are told about them. We ensure that the patient or relative receives an apology and is kept informed of the investigation. We also share learning from such incidents to help prevent stop them happening again.

We have worked hard to make sure that our staff are aware of their responsibilities under the duty of candour. We provide extensive training and support to help them to do this and there are named clinicians in each area that our staff can go to for advice.

We measure our success by regularly checking that duty of candour is being applied for relevant incidents, using completion of the relevant fields on our incident reporting system, Datix.

Our monitoring shows that we have made further progress in the last year. Recording the initial apology has risen from 82 per cent (measured in April 2016) to 85 per cent (measured in March 2017) and compliance with sharing the investigation findings has risen from 68 per cent to 80 per cent for the same periods.

We share learning about duty of candour through our quality and safety bulletins. A story published in the July 2016 bulletin described the experiences of a lead investigator sharing the outcome of a serious incident (SI) investigation with a family. The incident involved a patient who had suffered a fall and needed significant ongoing hospital care. The meeting involved an explanation of the SI process and the findings of the report, an opportunity for the family to ask questions and the offer of further support for the family as well as further apologies on behalf of UCLH. Whilst the meeting was very emotional for the family, they thanked the staff, both the ward sister for the care she had provided while the patient was an inpatient and the lead investigator for undertaking the investigation. On reflection the lead investigator described the experience as humbling; it reinforced that the impact of an incident is deeply personal for the people directly affected and that duty of candour is about openness and compassion.

Complaints

The Picker National results scores for the question 'Did not receive any information about how to complain' were 45/100 for 2015 and 48/100 for 2016 (lower scores are better) but we were significantly better in 2016 compared to our peers in the Shelford Group (58/100), London acute teaching hospitals (61/100) and the Picker national average (60/100).

Complainants are asked how they would like their complaint to be handled. Our staff make every effort to respond at the time to things that patients are unhappy about. For example, if the complaints team receive a contact about a current inpatient, the matron, manager or ward sister will visit the patient/family at the earliest opportunity, and will be able to resolve most issues straight away.

Internal auditors looked at the complaints process this year. The audit found 'significant assurance with minor improvement opportunities'. It highlighted that there were processes for learning lessons in place at divisional and trust-wide level. For example, the quality and safety bulletin was used to share lessons from complaints and good complaints handling

practice. Areas for improvement included improving response times and communication with complainants if delay occurred.

An aim in 2016/17 was to improve training in complaint handling and early resolution of concerns. We held six training sessions for staff from all divisions and two forums, which were attended by over 300 staff. We hope this will promote prompt intervention to resolve a concern and more efficient response times.

Our target for the number of complaints responded to within the time frame agreed with the complainant this year was 85 per cent. We responded to 75 per cent in time, an improvement of three per cent on last year; but this requires further attention.

A formal complaint is one in which the patient or relative asks for an investigation and a written response. Where possible, divisions work with the complaints team to resolve issues without a full investigation. For example, concerns about appointments can often be resolved quickly, by the local teams.

In addition to complaints, the complaints team received a further 1122 contacts, an increase of 52 per cent (737) on last year. Contacts can range from someone wanting to know who to speak to about a concern to staff seeking advice on how best to resolve a patient's concern.

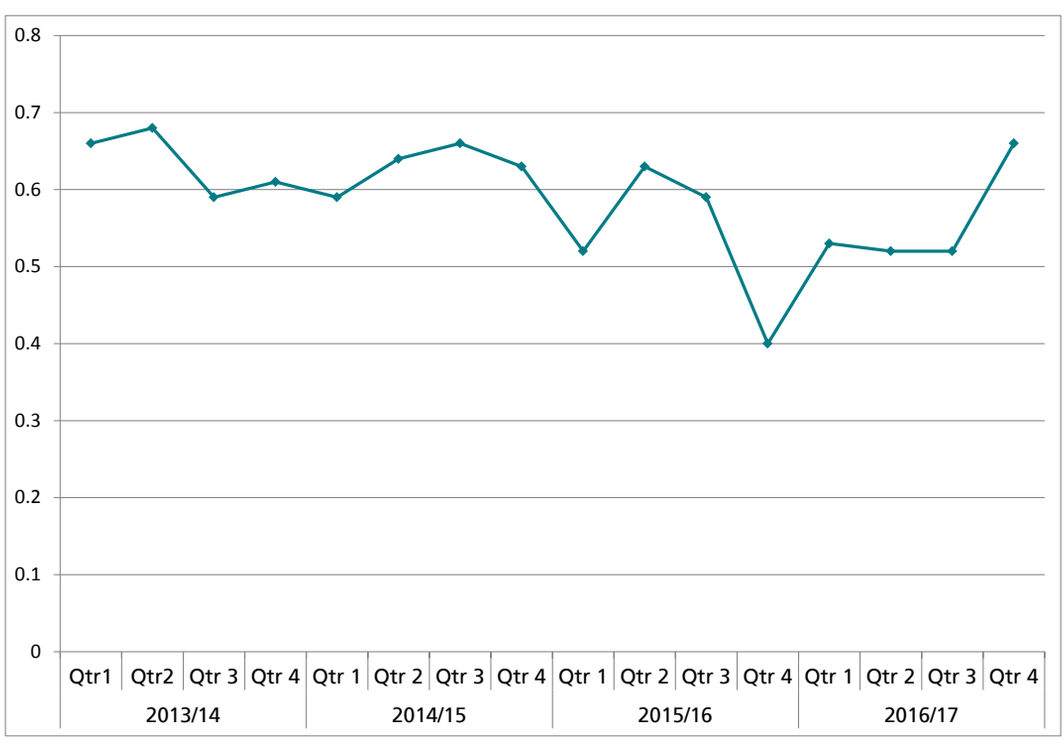
In 2016/17, we received 771 formal complaints in comparison to 712 in 2015/16 (an increase of 59). Chart Q1 shows that while there has been a long-term downward trend in complaints per 1000 patient contacts, there was an upturn in the final quarter of 2016/17 following changes to our patient transport service. 2016/17 saw 64 complaints about patient transport compared with 14 in 2015/16 (an increase of 50), so this accounts for almost all of the increase in total complaints.

We were very concerned to see this increase, which included some very poor patient experiences. This was linked to the new transport provider taking longer than expected to deliver the full service to the quality we required. We are working closely with them to improve the quality of this service. Measures already taken have included working with clinical areas to reduce transport bookings at short notice. The transport team has also been proactive in talking to patients who have had problems and ensuring future travel plans have been checked to avoid similar problems occurring. We have yet to see the impact of this work on the number of complaints

In 2016/17, 739 complaints were closed. Of these 28 per cent were not upheld (not agreed), 47 per cent partially upheld (partly agreed) and 25 per cent upheld (fully agreed) at the time of this report. This is determined by our complaints team.

See the glossary on 'complaints' for more detail.

Chart Q1: Complaints per 1000 patient contacts



Examples of learning from complaints:

A relative bringing a patient with a disability to the hospital complained about disabled parking availability.

Blue badge holders wishing to park on the UCLH site must have a dispensation notice. We changed the rules to enable patients with a disability to obtain a dispensation notice before coming to the hospital. Previously, they would have to make three journeys from their car to the hospital - one to get a notice from reception staff, one to park their car and one to go back to the hospital. Now, visitors with a disability can simply park and get to their appointment. We also now employ parking attendants to ensure that disabled spaces at the hospital are used correctly at all times.

Providing a chaperone

In response to a small number of complaints about the need for a chaperone, we have provided a new policy for staff to follow. We expect staff to explain the nature of any examinations at the earliest point possible in the visit, to ensure that the patient is offered a chaperone and to highlight any difficulties in obtaining a chaperone to the nurse in charge/ matron/manager.

Patients with a learning disability

A patient with a LD recently complained that the complaint response from us was hard to read and 'inaccessible'.

In response, we are now offering an 'easy to read' version of complaint responses along with the original letter for these patients. We expect our staff when writing a complaint response to use easy-to-understand language and to write medical terms in full.

All complaints involving a patient with a LD are shared with our clinical nurse specialist for learning disabilities. This is so that support can be given to the patient and if required, expert advice on any actions required to improve future care, such as additional education for staff, use of the Hospital Passport, help to make an initial complaint or provide support at complaint resolution meetings.

A patient with a rare condition had a number of problems with nurses and doctors during their care pathway

The matron met with the patient and apologised and explained how they had fed back her experience through a series of safety huddles on the ward, and presented an anonymised (confidential) version of her pathway and experience at the local governance group, so that the whole team became aware of the impact on the patient. Formal educational sessions on the patient's rare condition were also arranged for key medical and nursing staff so that future patients would not have the same experience. The patient was very happy with this resolution.

Early response to patient worries

We shared this message with our staff as an example of a patient's response when the division responded quickly to her concerns with a telephone call. This may have averted a formal complaint.

"Morning, I did receive a phone call last night from a senior member of staff from endoscopy which I'm very thankful for, I was able to explain the issues that occurred during my test which was all I needed to do, so it can help with further treatment. I really appreciate everything that yourself and the senior member of staff from the Endoscopy Department have done for me, thank you so much."

Complaints to the Parliamentary and Health Service Ombudsman

Patients unhappy with the outcome of our complaints processes can ask for their complaint to be reviewed by the Parliamentary and Health Service Ombudsman (PHSO). In 2016/17 there were 96* contacts by patients or their relatives with the PHSO. Most of these were considered premature by the PHSO; the complainant had either not made a complaint to us or their concerns were still under investigation. This is a slight increase on the previous year (91 for 2015/6). Of the 96 contacts received by the PHSO, 30 proceeded to investigation, compared to 24 in the previous year, an increase of 25 per cent.

Over the past year, 12 PHSO investigations (some relating to previous years) were partially upheld (partly agreed), with the outcome being an apology, an action plan to rectify the failures that were identified and in some cases a financial settlement. Sixteen cases remain open from 2015/16 and one from 2014/15 at the time of this report.

*Figure based on local data as PHSO official end of year data not available at time of report

Ombudsman's cases

A patient complained to the ombudsman about the results given to them by UCLH, when a different diagnosis was made overseas

The PHSO investigated and concluded that we had carried out tests recognised in the UK as the gold standard for making a diagnosis and these had been negative. The complaint was therefore not upheld (not agreed).

A relative was unhappy with a number of aspects of their relative's care. UCLH's investigation had already partially upheld their concerns.

The PHSO case looked at the consent process for the complex surgical procedure and recommended a review of some of the pre-operative tests and how these were documented. They also recommended improving written patient information and documentation during ward rounds. The consent process had originally been considered appropriate by UCLH. The overall case was upheld (agreed). A payment was provided to recognise the failures identified and an action plan is being developed. This will also feed into the improvement work on consent planned for next year.

Please see the UCLH Annual Complaints reports available on our website for further information.

1.2.3 Supporting our staff

Staff survey 2016

We take part in the annual national staff survey every year and we use the results to help review and improve the experience of our staff. This year responses were received from 44.6 per cent of our eligible staff, compared to 35.8 per cent in 2015. This represented an additional 651 responses, which is a 24 per cent increase on 2015.

Staff engagement

The overall staff engagement score is calculated by NHS England and compares us with other similar hospitals. It is a key indicator for us, taking in how staff feel about being able to contribute to improvements at work; their willingness to recommend the organisation as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work. It is measured as a score out of five. Our staff engagement score for 2016 was 3.89 against the national average score for acute trusts of 3.81. Our 2016 score was higher than our 2015 score of 3.84. Amongst London trusts, we had the second highest score for staff engagement and we were fourth amongst UK trusts.

Overall results

Our results offer us a guide to staff performance, and given the increased response rate, are more likely to represent the view of the majority of our workforce than in previous years.

When ranked against all acute trusts, our results place us in the highest 20 per cent for the following key findings:

- Staff recommendation of the organisation as a place to work or receive treatment (3.99 out of 5 compared to a national average of 3.76 out of 5)
- Percentage of staff who have not experienced physical violence from patients, relatives or service users (88 per cent compared to a national average of 85 per cent)
- Percentage of staff who have been appraised in the last 12 months (93 per cent compared to a national average of 87 per cent)
- Quality of appraisals (3.29/5 compared to a national average of 3.11/5)
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents (3.79/5 compared to a national average of 3.72/5)
- Percentage of staff reporting good communication between senior management and staff (39 per cent compared to a national average of 33 per cent)
- Effective use of patient/service user feedback (3.82/5 compared to a national average of 3.72/5)

When ranked against all acute trusts, our results place us in the bottom 20 per cent for the following key findings:

- Percentage of staff working extra hours (77 per cent compared to a national average of 72 per cent)
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion (78 per cent compared to a national average of 87 per cent)
- Percentage of staff experiencing discrimination at

work in last 12 months (18 per cent compared to a national average of 11 per cent)
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (31 per cent compared to a national average of 25 per cent)
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (32 per cent compared to a national average of 27 per cent)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (33 per cent compared to a national average of 31 per cent)
- Percentage of staff feeling unwell due to work related stress in the last 12 months (39 per cent) compared to a national average of 35 per cent

Our 2016 results show a significant improvement in 14 key findings with no significant change in 18 key findings. Our results have not significantly worsened in relation to any key finding.

Where have we improved

In comparison with the 2015 survey, staff experience has improved most in relation to the following key findings:

- Organisation and management interest in and action on health and wellbeing (3.67/5 in 2016 compared to 3.54/5 in 2015)
- Quality of appraisals (3.29/5 in 2016 compared to 3.13/5 in 2015)
- Percentage of staff satisfied with the opportunities for flexible working patterns (52 per cent in 2016 compared to 48 per cent in 2015)
- Staff satisfaction with level of responsibility and involvement (3.90/5 in 2016 compared to 3.84/5 in 2015)
- Percentage of staff reporting good communication between senior management and staff, which increased from 33 per cent in 2015 to 39 per cent in 2016

We have also seen improvement in relation to a key finding, which we note as an area for concern in 2015; staff confidence and security in reporting unsafe clinical practice has increased to 3.71/5 in 2016 compared to 3.65/5 in 2015.

What are we paying attention to?

There are two key areas where we want to see improvement:

The percentage of our staff who said they experienced harassment, bullying or abuse from other staff has remained at 31 per cent in 2016, the same as 2015.

We are providing in-house coaching and support for our leaders to promote teamwork that is more effective. We are training managers in each division to carry out local conflict resolution supported by an external company with a successful track record. We are one of the first NHS trusts to introduce an independent Guardian Service (external and independent support) which provides a safe route for staff to raise concerns. We are also investing in after-care following a formal employee relations exercise, so that any colleague who experiences bullying and harassment over a prolonged period is proactively supported by trained specialists.

The percentage of our staff who said they believed that UCLH provides equal opportunities for career progression or promotion was 78 per cent – the same as in 2015.

Our 2016 Annual Equality Report identifies our objectives and priorities for 2017/18. These include additional research amongst current Black and Minority Ethnic (BME) staff to better understand the results of the staff survey. We need to know their reasons for feeling that we do not provide equal opportunities for career progression/promotion, before we can consider the further action to be taken. We will also be undertaking further analysis of recruitment data to understand whether there are specific areas, bands or staff groups within which a BME candidate is less likely to be appointed and implement actions to address this. We also plan to offer mentoring and coaching support to staff with protected characteristics to enhance their promotion opportunities, roll out unconscious bias training and further improve the recording of staff demographics relating to disability, sexual orientation and religion/belief.

We have continued the wider rollout of 'what is discrimination?' In partnership with the Royal College of Nursing (RCN) with five additional sessions held in 2016 that were well attended by staff. The first session, which focused on unconscious bias, was filmed and made available to colleagues who were not able to attend the sessions. We are considering how we may further partner with the RCN as we continue our work to tackle discrimination in 2017/18.

1.3 How did we do? Progress against 2016/17 priorities

This section of our quality report provides a look back over the 2016/17 quality priorities at UCLH. We put in place action plans and developed measures for each of the priorities and our performance has been monitored throughout the year by our clinical teams and hospital committees.

1.3.1 Priority 1: Patient experience

In 2016/17, our aims were to maintain our high overall experience ratings (Table Q2) and to improve on seven specific areas detailed in Tables Q3, Q4 and Q5.

1.3.1.1 Maintain our overall patient experience scores as measured by the Friends and Family Test (FFT) questions

A new feedback system was introduced in 2016 to allow us to reach a wider range of patients and ensure we are able to capture a representative view of our services. The new system allows patients to complete surveys in any language and has a 'read aloud' function in both English and other languages. A text resizer, a text simplifier and a screen ruler as well as different colour contrast options are also available. We also now collect feedback via mobile phone and voice calls as well as electronic and paper methods. We are developing easy read paper survey options to suit both patients with learning disabilities and those with dementia.

Table Q2. Progress against FFT priorities

Friends and Family Test area	Patients recommending UCLH 2015/16 score	Target for 2016/17	2016/17 Score	Performance+
Inpatients and day-case patients	97%	97%	95%	↓
Outpatients	92%	92%	91%	↓
Transport	94%	94%	85%*	↓
A&E	95%	95%	95%	no change

*Based on responses from April-June 2016 and January-March 2017
+ Direction of arrows indicates performance compared with previous year.

Our FFT target for 2016/17 was to match 2015/16 performance in four priority areas. We achieved this in A&E despite the challenges faced by our staff with increasing demand and limited space. There were small decreases in our inpatient, day case and outpatient scores and a larger drop in the transport score.

The inpatient/day case patient score was exceptionally high in 2015/16 and the 2016/17 score remains very high at 95 per cent. Small year-to-year fluctuations are to be expected in FFT scores, reflecting not just changes in patient response but also the level of response. Our average response rate for inpatient/day case patient score in 2015/16 was 24.6 per cent per month, whereas our average for 2016/17 was 16.7 per cent. We expected a slight drop in response rates during the switch from the previous feedback system to the new one as staff became familiarised. However, response rates did not return to the previous levels as quickly as expected.

In addition, we changed transport providers in 2016. It was agreed that it would be their responsibility to collect the transport FFT data. However, no data were collected between May and December 2016. Collection resumed in January 2017 and continues. The scores are low however, as there have been a number of issues during the transition - please see complaints section (section 1.2.2).

1.3.1.2 Improve patient experience in priority areas as measured by local and national surveys

We use three survey sources to measure patient experience. The CQC's annual National Inpatient Survey shows how we compare to all other NHS trusts but is only available later in the year. The Picker Institute carries out the patient survey programmes on behalf of the CQC for some trusts which allows us to compare ourselves with other trusts using Picker (83 trusts out of 150 surveyed for 2016/17). We also have an internal patient feedback system, which helps us track our performance continuously through the year. In 2016/17, our aims were to improve in five specific inpatient areas, one outpatient specific area and one cancer specific area. Tables Q2-Q5 show these performance measures using Picker and local feedback data.

Table Q3. Progress against specific inpatient priorities

National Inpatient survey questions	National survey results (Picker) lower scores are better*			
	2015 result	2016 target	2016 result	Performance+
Bothered by noise at night from hospital staff	20%	17%	20%	no change
Rating the hospital food as fair or poor**	40%	36%	40%	no change
Not always getting enough help from staff to eat meals	35%	30%	38%	↓
Not given any written/ printed information about what they should or should not do after leaving hospital	32%	29%	32%	no change
Hospital staff did not discuss need for further health or social care services after leaving hospital	19%	14%	18%	↑

*Problem scores – see glossary for more information on how these are calculated.
** Range = Poor, fair, good and very good
+ Direction of arrows indicates performance compared with previous year.

We have maintained performance in the three of our inpatient priorities, but have fallen short of our improvement targets in all priorities. This is disappointing, as much work has been carried out in the last year. We recognise that some of this has taken place after patients responded to the national survey and so we will continue to monitor progress.

A more detailed look at noise at night was carried out to understand the source of disturbances. Individual areas were given a detailed list of what patients were saying about their area and have developed local action plans. Patient experience is monitored through the Patient Experience Committee (PEC) supported by the Improving Experience Group (IEG) and site-specific sub groups. This means sites can look at, and take action, on local patient experience feedback that is specific to their environment and processes. Other experiences that may occur in a number of areas or across UCLH can be looked at collectively at the IEG.

We have a number of catering suppliers providing food to our patients in our hospitals so improvements are developed and acted on locally. A number of our site-based experience groups have worked to improve hospital food this year. At University College Hospital at Westmoreland Street, a working group was set up with both catering and dietetics to involve patients in the reviewing of menus and making adjustments in response to the feedback. The Royal National Throat, Nose and Ear Hospital (RNTNEH) undertook a review of ward-based food provision with staff and governors, and used Patient Led Assessments of the Care Environment (PLACE) inspections to review the quality of the food. This information was used to make changes to the menu e.g. to remove items that become soggy when microwaved. At the National Hospital for Neurology and Neurosurgery (NHNN), more detailed patient surveys on food provision were carried out and an action plan was developed by the catering supplier. This included raising the awareness of alternative ethnic menus.

To improve patients getting help with their meals, a number of non-clinical staff now volunteer as dining companions on the care of the elderly wards. This has increased the capacity of these wards to help patients with meals where this is most needed. We aim to have volunteers supporting on all wards in the future but have prioritised areas of need, for example with our more elderly patients, and where ward teams have

requested input. To further understand what is important to patients regarding help with meals, we carried out a 'listen at lunchtime' exercise across our hospitals in February 2017. We gathered more detailed feedback about what we needed to do differently at mealtimes to ensure we better understand what help is required, including from those patients who do not need help with being fed. What we heard from patients is how important meal times are and the range of support that is required. We will use this information to improve help with meals in the coming year.

We are looking at standardising and improving the discharge process across UCLH by ensuring adequate information and planning for health and social care post discharge. This has been done in various ways including daily 'huddles' of key staff on the wards to discuss discharge and the use of a comprehensive discharge guide.

Table Q4. Progress against specific outpatient priorities - measured using the UCLH feedback system.

Question – higher scores are better	2015 result	Target 2016	2016 result	Performance+
How long after the stated appointment time did the appointment start? (Percentage of patients who waited 30 minutes or less for appointment to start).	71%	76%	73%	↑

+ Direction of arrows indicates performance compared with previous year.

Our real time score for patient reported outpatient waiting times has improved though we did not meet our target.

We have been taking action to improve waiting times. This has been driven locally based on patient feedback or where clinic capacity needs to be reviewed. At the University College Hospital Macmillan Cancer Centre, a system called 'check and track' has been used to improve the use of clinic rooms and help bring down waiting times. At the EGA, staff looked at demand and capacity and reviewed the way clinics are organised. They also introduced regular updates about waiting times for patients on the day. The RNTNEH set up an outpatient group to identify opportunities for improving waiting times and developed a process to inform waiting patients of delays.

Table Q5. Progress against specific cancer priorities from the CQC National Cancer Patient Experience survey 2016

Question – higher scores are better	2015 result	Target 2016	2016 result	Performance+
How easy is it for you to contact your clinical nurse specialist (CNS)? (Percentage of patients who said they found it easy to contact their CNS.)	63%	68%	80%	↑

However, while the response to this question has improved we remain lower than other London peer trusts and the results are not consistent for each group of patients with different cancers. We aspire to the same high standard for all patients and this will continue to be a focus for 2017/18.

Please note that the national survey questions have been changed based on wider engagement with

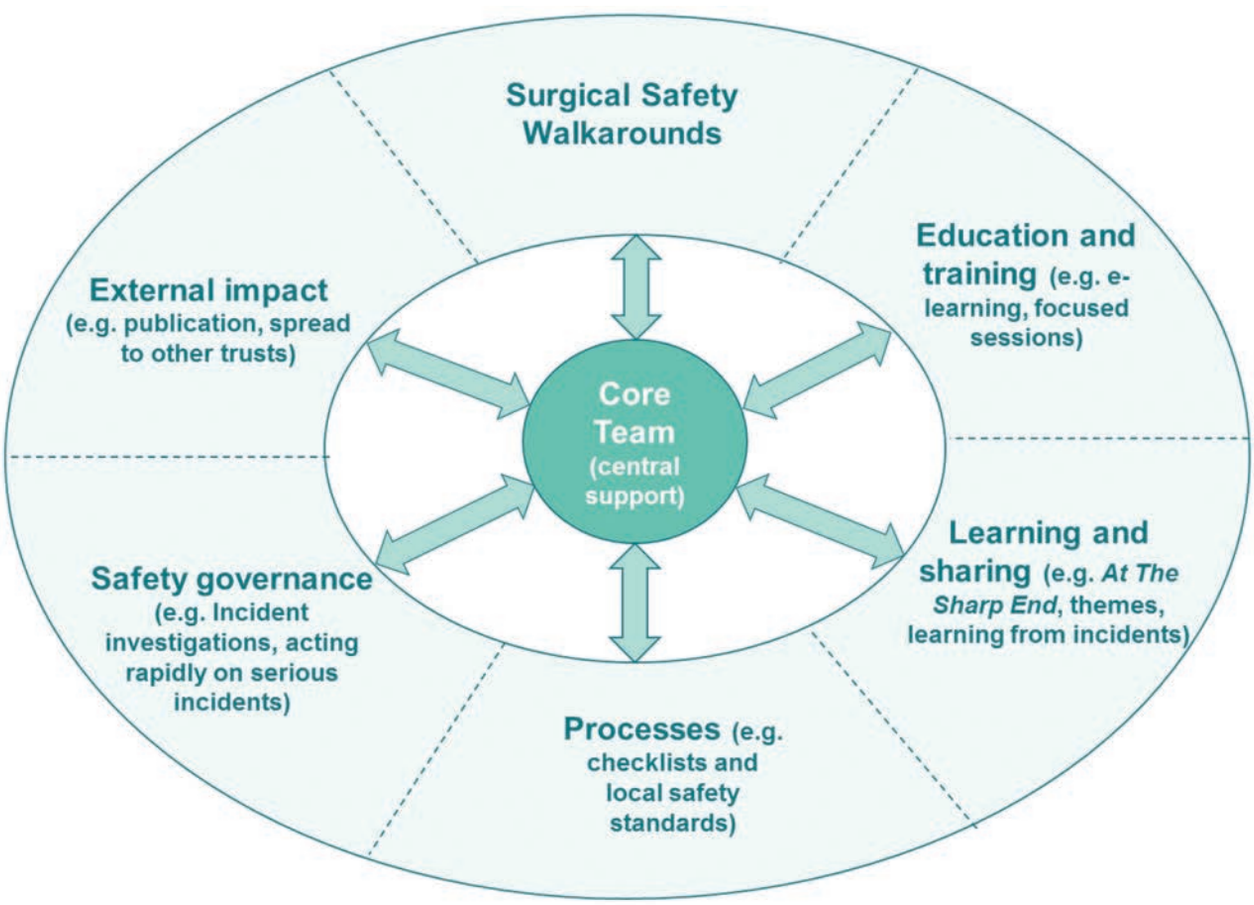
patients. There are fewer questions and many of the response options to questions changed. This has made comparison with previous years' data difficult.

Our improvement initiatives include an increase in the number of lead CNS posts. We have increased the number of Macmillan support worker posts who work as part of the CNS teams and who triage (sort and prioritise) phone calls and messages.

1.3.2 Priority 2: Patient Safety: Continue our focus on reducing avoidable harm

1.3.2.1 Reduce surgery related harm

Our aim was to make surgery safer through better use of the 5 Steps to Safer Surgery (5SSS) a checking process including use of the WHO Surgical Safety Checklist. We wanted to reduce risk and encourage a safer culture by improving teamwork and communication, with every team member feeling confident to speak up and raise concerns. We also wanted to see more incidents and near misses being reported, as an indicator of safety awareness. This diagram shows the project activity to reduce surgery-related harm, described more fully below:



Surgical safety walkarounds: These follow the successful model of Improving care walk rounds used at UCLH since 2014. They focus on improvements across theatres and areas where procedures are carried out outside of theatres such as endoscopy and neuroradiology. Staff taking part come from all areas of UCLH and different disciplines. Walk round teams observe, talk to staff, coach teams, measure practice and help identify improvements, all in one visit. Measuring practice may be quantitative or qualitative. One example is noting whether questions are missed during any of the safety checks (no questions should be missed out). If this occurs, instead of recording it as non-compliance, we would explore why it may have been missed.

As a result, the last year has seen targeted coaching and training, staff engagement activities, redesign of checklists and creation of other materials to assist best practice. In 2016/17 there were 23 surgical safety

walkarounds across 11 geographical areas performing surgery or procedures, with 44 participants ranging from directors to theatre assistants, from anaesthetists to scrub nurses. Ninety-eight patient procedures were observed.

When the CQC inspected our surgical services in March 2014 they issued us with a compliance notice to improve use of the WHO surgical checklist. Since then we have moved it from being a 'tick box exercise' to changing the whole culture around safety in surgery, based on 'human factors interventions'. When the CQC inspected our surgical service in March 2016 they commented that UCLH was well ahead of other trusts in improving the safety culture. As a result of this work we have been nominated for a Health Service Journal patient safety award.

Education and training: We had aimed to create an e-learning module on the 5SSS by the end of 2016/17. We decided to do some real life filming instead of using simulation and this, together with key administrative and specialist staff changes, meant that there were some delays. The work is now making good progress and will be completed in 2017/18. Multidisciplinary face-to-face training is still being provided, as needed.

Processes: We widened the scope of the 5SSS in 2016/17 to areas carrying out invasive procedures outside of theatres such as endoscopy, dentistry, neuroradiology, radiotherapy, pain management and dermatology. We helped to create and review safety checklists and provide custom-made training for these areas.

Safety governance, learning and sharing: Locally, all surgery related incidents and near misses are reviewed by governance leads, and themes are presented at monthly governance meetings. These include a more detailed review of the incidents that led to harm. Monthly governance updates are provided to all theatre staff, including information on incidents, themes and actions taken.

Safety culture surveys have been distributed to staff in theatres and areas doing procedures every six months, looking for improvements against the 2015 baseline. They have not shown an improvement so far, but the number of responses is small and the survey goes to a wide group of staff with differing roles. Results of each survey are fed back to the relevant divisions to discuss and act on, and the free text responses give us useful information about what staff think about safety in their area.

Themes and examples of learning from incidents, near misses, safety culture surveys and observations during Surgical safety walkarounds are fed back

to staff using At the Sharp End, a surgical safety bulletin distributed to all staff working in theatres and procedures. We published seven of these this year.

External Impact: This year our approach was shared with seven other NHS trusts and we provided advice on putting it into practice. The project team also published an article on our approach to reducing surgical harm in the Journal of Perioperative Practice. 'Carthey et al, Implementing an integrated in-situ coaching, observational audit, and story-telling intervention to support safe surgery, Journal of Perioperative Practice, Volume 26, Number 12, December 2016, pp. 267-273(7)'

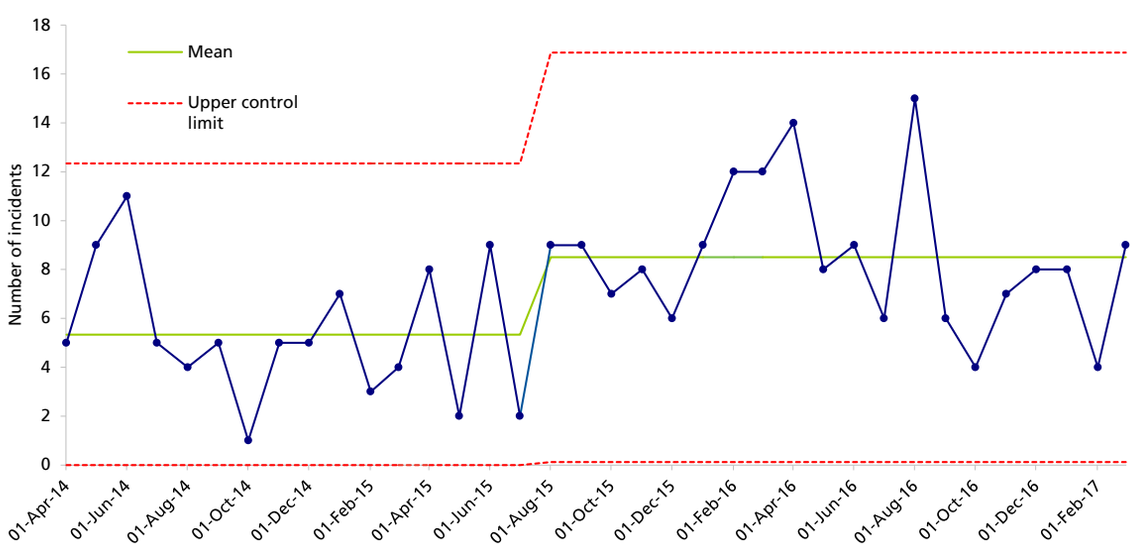
The charts below show progress against our targets for last year. The green line shows the average (mean) number of incidents over time, and the red line shows the control limits that represent the limits of 'normal variation'. When the red and green lines move upwards or downwards this means there has been a significant change.

Progress against targets

- Target: 10 per cent increase in reporting surgical incidents in theatres

Chart Q2 shows a statistically significant increase of 60 per cent in reporting of incidents per month from the 2014/15 baseline of 5.3, to 8.5 in August 2015. This improvement has been sustained over the past year.

Chart Q2: Number of surgery-related incidents reported over time



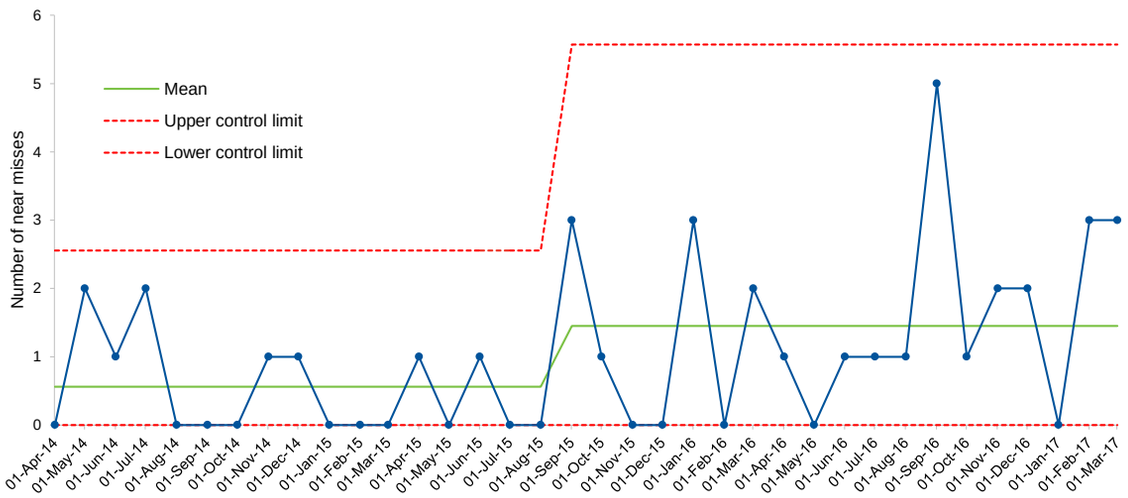
(For definitions of harm and the specific selection of incident classification please see glossary).

- Target: 10 per cent increase in near misses being reported (within the 10 per cent increase)

The number of near misses reported more than doubled between 2014/15 and 2016/17. Taking into account the 60 per cent increase in incident reporting, we have seen a 62 per cent statistically significant increase in reporting of near misses within the same group of incidents since August 2015. This has since been sustained - see Chart Q3.

Reporting of near misses indicates a better safety culture as people are reporting to learn for next time, as well as when things go wrong.

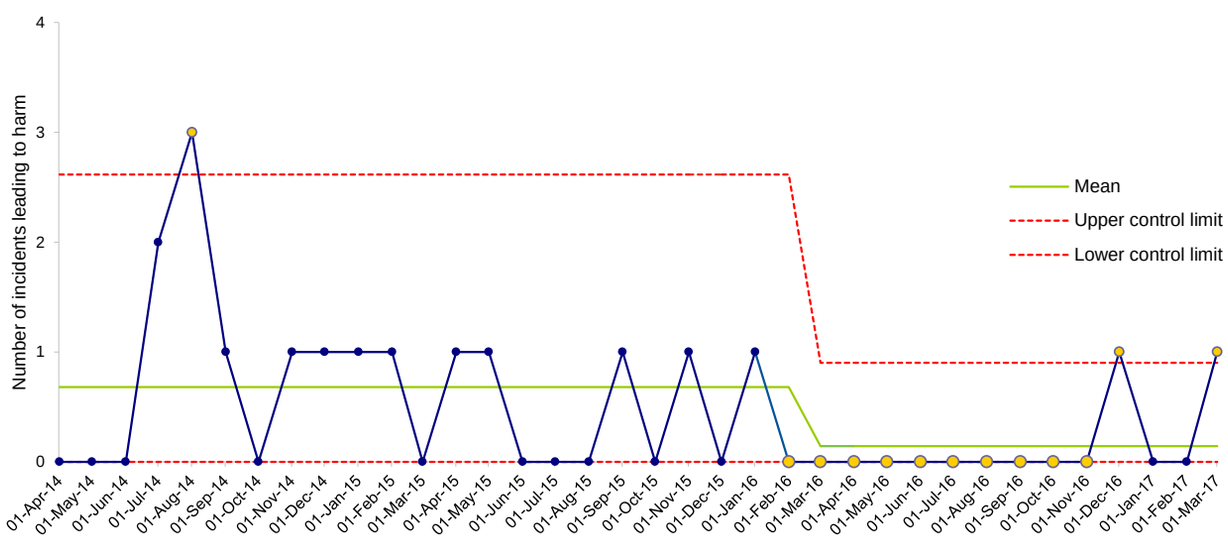
Chart Q3: Number of surgery-related near misses reported over time



- Target: 50 per cent reduction in incidents leading to harm

Even though there has been an increase in reporting of all incidents, we have seen a statistically significant decrease in reported incidents leading to harm per month. The number of incidents reduced from a baseline of 0.68 incidents per month prior to February 2016 to 0.14 incidents per month in March 2016, which has been sustained throughout this year.

Chart Q4: Number of surgery-related incidents leading to harm over time



- Use of observational audits to measure use of the checklist, which over time identify improvements in the use of the checklist and associated behaviour in all our theatres

Unannounced surgical safety walkarounds take place twice a month. During these, participants use an observational measurement tool to measure both 'process reliability' (whether elements of the 5SSS were carried out), and 'behavioural reliability' (whether they demonstrate teamwork, leadership, communication,

situational awareness etc.). They then provide feedback, both in theatre to encourage reflection and improvement, and to local leads via 'hot debriefs' on the same day. A written summary of learning is also provided, for later distribution and discussion. Our philosophy is that teams can learn as much from what goes well as from what needs to improve. Over time, we expect to see a general improvement in safety behaviours, though it is difficult to measure progress when observing different surgical teams, working in different situations on different procedures. Table Q6 and Q7 illustrate the sort of observations being noted.

Table Q6: 'Good catches' observed at sign-in during surgical safety walkarounds

Observation	Why is this important?
"There was no marking on the patient. This was noticed by the anaesthetist and the surgeon called to mark the correct side".	Marking the correct side reduces the risk of 'wrong site surgery' by providing a visual prompt to staff during the procedure.
"The date of birth was incorrect on the consent form (written 10 Oct instead of 01 Oct). This was picked up in the Sign In and a new consent form resigned by the surgeon and patient".	It is vital that the right patient has consented for the right procedure being carried out. If any details are incorrect the identity of the patient and the procedure to be performed needs to be checked and the consent form re-signed.

Table Q7: Other safety behaviours observed during surgical safety walkarounds

Observation	Why is this important?
"The operating department practitioner asked two people to stop and pay attention as they were holding a loud conversation during the checks which was distracting".	Distractions and interruptions must be kept to a minimum during the checks to so that everyone can pay attention, hear all the information and contribute as needed.
'The Time Out was led by a dental nurse. She made a clear announcement, 'Is everyone ready for a Time Out?' and confirmed the whole team's readiness before starting. Every item in the 'Time Out' on the WHO Safer Surgery Checklist was read out loud and was clear. The whole team stopped and focused on the Time Out. Open-ended questions were used to confirm the patient's identity. There was verbal and visual confirmation that the throat pack was in place and this information was immediately written onto the theatre white board so all could see.	This observation comes from a theatre team where one of the nurse's feels supported and empowered to lead the Time Out. The dental nurse who led the Time Out understands the importance of checking other team members' readiness to start. She also understands that using open-ended questions, 'tell me the patient's name/hospital number', is safer than using closed questions. We circulated this good practice and asked for reflection from other teams; 'Do members of your theatre team feel confident and empowered to lead the Time Out (and other safety checks)? Are open-ended questions used when checking patient identity?'

This year there were unfortunately three surgical Never Events (of a total of five,- see section 1.3.2.4) where the wrong tooth was extracted. These incidents should never occur so we strive to learn as much as we can about what went wrong, and take all available steps to prevent them happening again. Following the first incident we immediately brought in an external patient safety consultant to provide intensive support to the dental department, including assistance in investigating the root causes and contributory factors, coaching teams, helping them to redesign their local WHO checklist and providing training and information to staff. This support was well received and we feel this model of focused support from an external expert can work well.

The second two incidents occurred in March 2017 and at the point of writing, investigations are taking place to understand what processes failed and what human factors contributed to these events.

Reducing harm from surgery remains a safety priority for 2017/18. We will continue to carry out regular surgical safety walkarounds and collect regular qualitative data for improvement. For more information see Section 1.4, Priority 2.

1.3.2.2 Reduce harm from unrecognised deterioration

Unrecognised deterioration is where a patient's health becomes worse and this is not picked up and acted on quickly. This year we continued to work on improving the recognition, escalation and management of deteriorating patients. Sepsis, as the most common cause of deterioration, and acute kidney injury (AKI) were both brought into the wider deteriorating patients programme. As a result, the programme's focus moved from working closely with one or two wards to taking a hospital-wide approach to improvement using specific initiatives. We have also looked to learn from serious incidents relating to unrecognised deterioration.

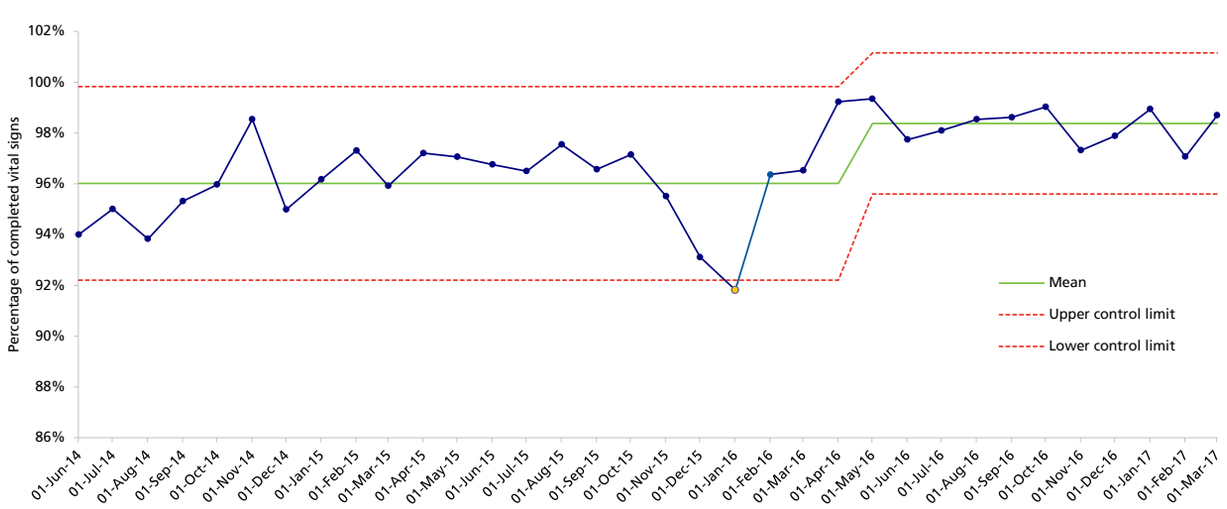
Our aim for the deteriorating patient project was originally to improve safety huddles, National Early Warning Scores, (NEWS) escalation, the use of Situation, Background, Assessment, Recommendation (SBAR) and handovers. Over the last year we have focused on:

- Improving NEWS scoring and vital signs recording, as the most effective tool for identifying at-risk and deteriorating patients
- Improving the measurement and use of SBAR as a tool to improve timely and effective escalation and response
- Improving the prompt and effective treatment of sepsis as the primary cause of deterioration

We learnt that we were not supporting staff to use the communication tool SBAR effectively in escalations, so a working group was set up at the end of the year to design an approach to improve this across our hospitals. An electronic data dashboard was created for measures relating to deterioration, including timeliness of escalation to the Patient Emergency Response and Resuscitation Team (PERRT) and whether SBAR was used in communicating the referral. The data can be presented by ward or hospital-wide, is discussed at every deteriorating patients steering group meeting and is published on Insight, the UCLH website for staff, so teams can use it locally for improvement. Work continues with testing an electronic approach for patient monitoring.

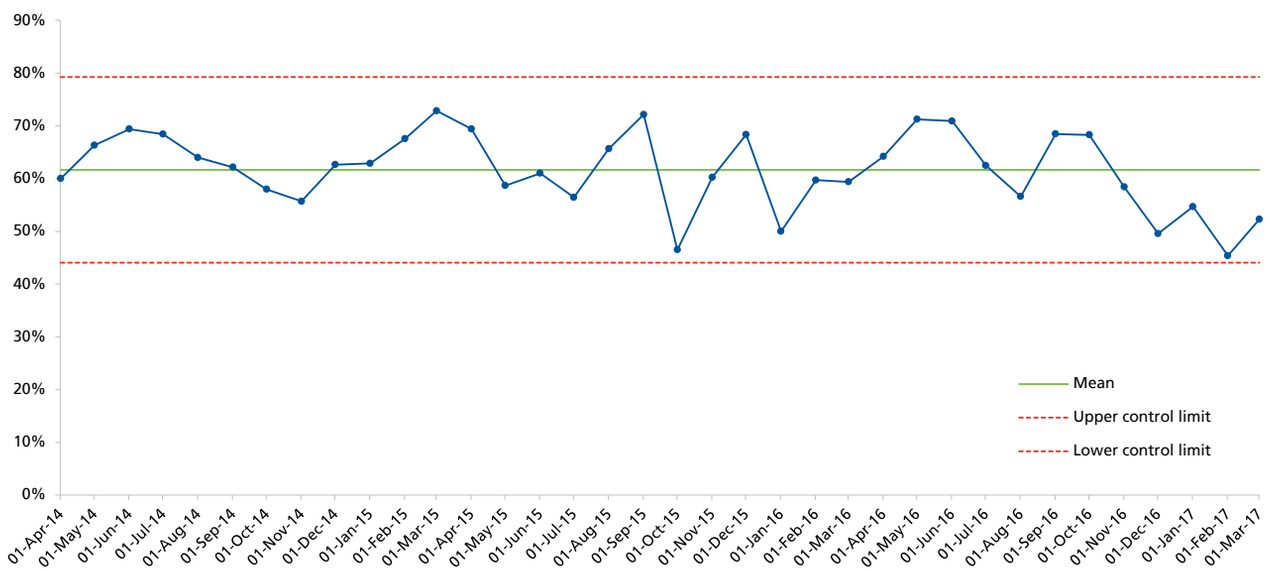
Vital signs: There has been significant progress here. Chart Q5 shows the percentage of vital signs completed based on a locally collected sample of 10 patients per ward per month. Our target was 96 per cent based on what we achieved in 2014/15 - 2015/16, but this year it increased to an average of 98 per cent. This was a statistically significant change, and has been maintained throughout the year.

Chart Q5: Per cent vital signs completed for patient' trust-wide (sample of 10 patients per ward per month) last 12 months



SBAR: Our target was for 90 per cent of referrals to PERRT to be made using SBAR, where SBAR was required to be used. There were 2672 referrals made to PERRT in 2016-17 where SBAR was required, however 'use of SBAR' was only recorded in 49 per cent (1315) of these referrals and within that only 63 per cent recorded this as 'yes'. This was the same as last year i.e. we have seen no improvement in use of SBAR. We have improved our recording of this measure from 31 per cent in 2015/16 to 49 per cent in 2016/17. Improving the use of SBAR in referrals and recording whether it was used are priorities for 2017/18.

Chart Q6: per cent of referrals to PERRT where SBAR was used (where this metric was recorded)



There is no single category for 'patient deterioration' on our incident reporting system so a range of categories are used to capture all relevant incidents (see glossary for more information). We were aiming for a 20 per cent reduction in the number of incidents of deterioration leading to harm (using the categories we defined); however we have seen no statistically significant change in our numbers. As the number of incidents leading to harm has not gone down we could conclude that the initiative is not yet working, but this may also be due to an increase in reporting. The duty of candour requirement has increased awareness about reporting unexpected outcomes, which accounts for 40 per cent of the data.

As we cannot be sure of what this data is telling us, we will look at this in more detail next year and in particular at learning from serious incidents, which are extensively investigated and result in detailed action plans. Reducing harm from unrecognised deterioration remains a safety priority for 2017-18. For more information see section 1.4.2, priority 2.

1.3.2.3 Reducing harm from sepsis

Sepsis is a life-threatening illness caused by the body's response to an infection. It is one of the most common reasons for deterioration in hospital, and as with any deterioration it requires speedy recognition, escalation and treatment. Last year sepsis was a separate disease-specific priority under the Sign Up to Safety Campaign, but since November 2016 the work to reduce harm from sepsis has come under the wider work to reduce harm from all unrecognised deterioration. Over the last year, we have progressed with our work on implementation, education and measurement of sepsis; not just in the ED as originally planned but across all our hospitals, for both adults and children. Sepsis continues to be a patient safety priority at UCLH under the deteriorating patients programme.

Progress against the three elements of our sepsis improvement project is as follows:

Implementation: Clinical guidelines for sepsis in adults were revised, based on the Third International Consensus Definitions published in February 2016. For children and young adults, new sepsis guidelines were created and launched across our hospitals in February 2017. Paediatric Early Warning Score (PEWS) provide the basis for screening of sepsis under these guidelines, in line with our process for recognition of all deteriorating patients. The guidelines for patients under 16 are accompanied by management tools for different age groups. In the paediatric emergency department, a sepsis screening tool was added to the assessment booklet to help early recognition. Maternity-specific guidelines for sepsis were also created this year.

A new patient information leaflet to explain sepsis to patients and families is in draft for publication in 2017/18.

We decided that stickers to promote best practice were not needed for clinical records on the wards because sepsis guidelines are on the inpatient vital signs charts. However, in the ED where different documents are used, stickers are being used to help staff follow our guidelines, improve record-keeping, and review.

Education: A sepsis nurse was recruited to collect and report on all our sepsis data and to provide training and awareness activities across our hospitals. For the moment, we believe that face to face training and awareness activities are more effective than e-learning so a sepsis module has not been created. Nonetheless, one of our sepsis leads is linking with both Health Education England and a commercial e-learning provider as advisor so that their education is informed by our thinking. We are also exploring combined training for topics relating to deteriorating

patients.

Trust–wide communications, ward walk rounds, poster campaigns ('Sepsis: Spot it. Stop it') and a 'stand' in the atrium of University College Hospital all helped to raise awareness of sepsis and the new adult and paediatric guidelines. Targeted training has been designed, and is being rolled out on the wards and in the emergency department via clinical practice facilitators with support from our sepsis nurse.

At the end of 2016/17 UCLH hosted an all-day sepsis master class aiming to share and learn from each other and hear about recent updates in sepsis care. There were 110 attendees (39 from UCLH and 71 from external organisations).

Measurement: In 2016/17 we participated in the national sepsis CQUIN (Commissioning for Quality and Innovation) to measure whether screening for sepsis is happening and antibiotics are being given within one hour, and reviewed within 72 hours. The target for screening for sepsis in ED was 90 per cent of patients and we achieved this in 83 per cent. The target for screening for sepsis in inpatients was 90 per cent and we achieved this. The target for giving antibiotics within an hour in ED was 54 per cent of patients with confirmed sepsis and we achieved 43 per cent. The target for giving antibiotics within an hour for inpatients with confirmed sepsis was 86 per cent and we achieved 66 per cent. The target for review of antibiotics within 72 hours was 90 per cent and we achieved this. These results are averages for the year.

We also collected monthly measures of quality using a measurement strategy agreed by the UCLPartners Sepsis Patient Safety Collaborative, of which UCLH are part. This helps us measure adherence to our clinical guidelines. Our measures now focus on specific aspects of best practice rather than measuring compliance with a 'bundle' of care. Our clinical guidelines also support this approach to measuring how well we are doing.

Incidents with harm from sepsis are not regularly counted as the numbers are so small and because we are unable to extract data from our incident database by diagnosis. When Serious Incidents (SIs) relating to sepsis occur these are investigated using the SI framework and the reports are reviewed by members of the project team, with learning incorporated into the project.

1.3.2.4 Continue trust-wide learning from serious incidents

Monthly quality and safety bulletins to encourage learning from near misses

The quality and safety bulletin contains details of learning and changes to practice from a variety of sources. These include near misses, SI investigations and complaints. We aim to feature a 'good catch' (near miss) every month and to include more learning and changes in practice from investigating near misses. Evidence of good practice is highlighted within the bulletin. We include experiences with respect to the duty of candour and sharing the findings of investigations with patients and families. This continues to be an area of development for individuals and teams and support is offered regularly.

Publication of learning from serious incidents on our trust website

We have started to share learning from SIs internally via Look and Learn. SI reports tend to be complex and highly detailed and front-line staff members are not likely to have the time to read them. Look and Learn summarises serious incidents into an easy to read format including root causes, key learning and actions from the incidents. A new format was launched in January 2017 and allows ease of printing for display on local governance noticeboards.

We have received very positive feedback and continue to share Look and Learn on a monthly basis, as part of our ongoing strategy for sharing learning from serious incidents.

At least two quality forums per year focusing on safety

This year there has been an emphasis on learning from University College Hospital's CQC inspection and preparing for any possible specialist hospitals inspection. To this end one quality forum took place in July at the NHNN with the theme 'improving care and services in line with the CQC fundamental standards of care'. A session on leadership and the CQC took place at the UCLH leadership forum.

Education services will support teams in sharing their learning from After Action Reviews (AARs) more widely. At least two stories based on one or more AARs to be published in the quality and safety bulletin

The Institute improvement team introduces the concept of AAR to all new starters in the trust, delivering a one hour session on learning and improvement as part of every trust induction. AAR Foundation training courses are delivered monthly, open to all, and more advanced AAR conductor training, quarterly, for those who wish to extend their capabilities in leading complex AARs. The Institute improvement team are in the process of re-

establishing the AAR conductor network to provide peer to peer coaching to support individuals routinely using AAR.

The AAR programme is clear in setting out expectations around learning. Capturing learning or actions from an AAR is principally the responsibility of the team or group involved in the AAR, not the AAR facilitator as it is for the team concerned to determine what can and should be shared from their experience, and how it is best communicated to the appropriate audience. When possible the team will contribute to quality and safety newsletters or similar. Occasionally, where appropriate, the Institute will report on AARs and key learning in the UCLH Institute Newsletter. The Institute improvement team is in the process of designing a prototype area on the Institute Insight pages that will allow teams to share learning from AARs.

Learning from an AAR was shared in the August 2016 bulletin. This was about the processes and communication around a patient with a disability who travelled to UCLH for treatment/surgery and for whom it turned out that the surgery was not appropriate and therefore did not go ahead. Learning from an AAR about rapid deterioration in a frail, elderly patient and when to discuss 'do not attempt resuscitation' was shared in the February 2017 bulletin.

Achieve the national guidelines for investigation reports being completed following a serious incident (60 working days)

We reported 56 serious incidents in 2016/17 of which two were subsequently not considered serious after investigation at the time of writing this report. Of the 35 that were due to be completed this year, 24 were completed within the 60 day target set in national guidelines (Serious Incident Framework supporting learning to prevent recurrence April 2015) or after agreeing an extension to the deadline with the commissioners. This means we achieved 69 per cent of reports being submitted within the agreed timeframe. Of those that did not meet the deadline, three were one day late and one was three days late and if these were included the compliance would be 80 per cent.

Have no further 'Never Events' reported

Never Events are a particular type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers (such as physical barriers or systems of double-checking) are available at a national level, and should have been implemented by all healthcare providers. The national requirement and our target is to have zero never events.

Five Never Events occurred in 2016/17 (There was a never event reported in April 2016, However, this incident actually occurred in November 2015 and was included in last year's quality report).

Learning from Never Events

Misplaced nasogastric (NG) tube April 2016

A 60-year-old patient had a nasogastric tube placed and the position checked using the methods described in the UCLH guidelines, and feeding was commenced. The patient clinically deteriorated five to six hours later and the feed was stopped. Chest radiograph (plain x-ray and CT scan) revealed the tube to be misplaced in the lungs. The patient was subsequently transferred to critical care for respiratory support from which he recovered. There were no care or service delivery problems identified during this investigation as the check undertaken, the pH check, was correctly undertaken in line with UCLH policy. However, the policy for insertion of NG tubes was subsequently changed – see later incident.

Wrong site surgery dental (March 2016 identified in July 2016)

The patient was referred for treatment at the Eastman Dental Hospital (EDH) for removal of the Lower Right 8 wisdom tooth roots.

After administering the intravenous sedation, the doctor administered local anaesthesia (numbing medication) to the Lower Left 8 area and raised a muco-periosteal flap. The patient alerted the dentist that it was the wrong side and the flap was sutured (stitched) and the procedure completed on the correct tooth.

The root causes included practices leading to pressure, excessive multi-tasking demands, and distractions and interruptions for the oral dental surgery team who were treating the patient. There was also no white board in place to remind staff of the correct side and there was a disconnect between expected practice, as described in policies and procedures, versus the real clinical world, for example, not taking into account that there may be staff shortages on the day.

Recommendations include that the oral surgery team must ensure additional staff are available to step in and assist with planned lists when team members call in sick. White boards must be implemented in all rooms in the oral dental surgery clinic to provide teams with a shared visual reminder

of the patient's name and the type and site of the procedure. In addition, the EDH must improve the current WHO Surgical Safety checking practice and provide education to support oral dental surgery teams to carry out these checks effectively.

Misplaced NG tube January 2016 (identified in July 2016 as part of an inquest)

The patient presented to the emergency department on 12th January with complex pleural disease and multiple comorbidities. She required enteral feeding via a nasogastric tube (NG tube), which was placed on 13th January 2016 and she was fed. On the 23rd January the ITU consultant observed the tube to be in an unusual position. Radiology review of her chest X-ray showed the tip of the NG tube was lying above the level of the diaphragm (most likely in the pleural cavity (lung). Subsequent chest X-ray and CT scan with the use of contrast confirmed it was in the wrong position. The patient died four days after removal of the NG tube. The case was referred to the coroner, who after hearing the evidence concluded that that the X-ray (for checking that the placement of the tube was correct) was unclear and in hindsight should have been repeated. The coroner's report noted that the misplaced NG tube did not contribute to the death of the patient.

Immediate actions included an instruction to all radiology staff of the need for the X-ray criteria for correct identification of placement of NG tubes to be included in all radiology reports.

UCLH guidelines for the correct placement of NG tubes have been amended to be policy. A number of changes have been introduced including the need for double checking of pH and competency training for all doctors in interpreting X-rays and the need for documentation. The policy also includes specific information related to early identification of possible tube misplacement and deterioration.

Wrong site surgery (dental) February 2017

The patient attended for removal of the retained root of the lower right wisdom tooth. However the lower right second molar tooth was removed instead. This event is being investigated and learning will be identified and actioned on completion of the investigation

Wrong site surgery (dental) March 2017

The patient attended for multiple dental extractions under general anaesthetic including a tooth for which the patient had not been consented. This event is also under investigation.

Consider using rate of recurrence of similar serious incidents (or root causes and contributory factors) as an indication of learning

The quality and safety department has applied a number of processes for reviewing the rate of recurrence of serious incidents in identifying learning, as well as trends in 'near misses' that have been highlighted and escalated, to prevent serious incidents occurring. These have included:

- An external review of information governance incidents related to the sending of confidential data, where the data was not fully anonymised (made confidential) prior to sending. Each of the serious incidents cited "human error" as the root cause
- Recruitment of an external investigator to investigate the second of two Never Events within the space of five months in the same location (EDH) with the same type of surgery (wrong site dental surgery) and similar contributory factors. Actions were implemented with the support of the divisional clinical director.
- A thematic analysis of all SIs relating to deteriorating patients in the last two years

We have also undertaken a thematic analysis of 'near misses' relating to in-hospital cardiac arrests which happened on the same ward in a short period of time. This identified a number of recurring themes including lack of escalation and no 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) orders in place. The themes were discussed and incorporated into an action plan to be implemented within the division.

Continue with improving care walk rounds (ICRs) and the focus on learning, building on the experience of the CQC inspection in March 2016

Improving care walk rounds (ICRs) continue to take place twice a month, however, in January 2017 they were temporarily suspended due to outbreaks of flu and norovirus at UCLH. ICRs resumed in February.

1.3.3 Priority 3: Clinical outcomes

1.3.3.1 To set up a mortality surveillance group and a mortality governance structure

The mortality surveillance group (MSG) has multidisciplinary membership, and is chaired by the corporate medical director. It met six times in 2016/17. NHS Improvement(NHSI) requires all trusts to have a policy in place for learning from deaths by September 2017. A policy is being drawn up by the group based on the guidance issued by NHSI Improvement in March 2017. The policy will include the use of the Structured Judgement Review method of reviewing deaths.

We continue to measure the Summary Hospital-level Mortality Indicator (SHMI)as one of our measures of success and aim to maintain our position in the top 10 per cent of hospitals nationally for mortality rates as measured by this indicator. The MSG has reviewed data on patient deaths using SHMI. The latest SHMI data available (October 2015 to September 2016) shows that we have the second lowest mortality in England at 0.74.

We have designed a prioritisation tool to help us identify deaths for review. For example, we will review all deaths where the patient has undergone elective (planned) surgery or where concerns have been expressed by families about the care of their loved one.

We already have strong systems in place for when a child, or a mother during pregnancy, dies. We are also taking part in the Mortality Review (LeDeR) programme commissioned by NHS England for when a patient with a learning disability dies.

1.4 Priorities for improvement 2017/18

How we consulted on our priorities for 2017/18

In choosing our quality priorities for the coming year, we consulted widely - with our staff, with commissioners, with representatives of local GPs, Healthwatch Camden and UCLH governors on behalf of our patients and the public. The priorities take account of progress against the 2016/17 priorities, described in section 1.3, with some of last year's priorities identified as needing ongoing focus in 2017/18.

The priorities agreed are summarised here:

Table Q8: 2017-18 quality priorities summary

Domains	Priorities
Patient experience	Improve overall patient satisfaction as measured by local and national surveys. We will continue to focus on the same three Friend and Family Test areas – inpatients/day cases, outpatients and transport - as well as specific areas identified by our patients that require work such as our patients experience of waiting and of discharge.
Patient safety	Continue to focus on the priorities of 2016/17 aiming to: Reduce surgery-related harm, focusing on surgery and invasive procedures. Reduce harm from unrecognised deterioration, focusing on failure to recognise, escalate and manage deterioration including sepsis and acute kidney injury Reduce the harm from failure to follow up on radiology results Continue trust-wide learning/continue to focus on learning from serious incidents and also include learning from mortality reviews and learning from things that could have gone wrong but were prevented – near misses.

Domains	Priorities
Clinical effectiveness	Responding and learning when patients die Even though our mortality rate is low, we have chosen this, because there is always more to be learnt when patients die. There is also a national priority to learn from deaths. We have completed our aim from last year, to set up a Mortality Surveillance Group.

1.4.1 Priority 1: Patient experience

1.4.1.1. Improving overall patient experience as measured by the Friends and Family Test (FFT) question.

We know that good patient experience has a positive effect on recovery and clinical outcomes. To continue to improve that experience we have asked patients what is important to them. We have listened to patients and are responding to their feedback. This is central to caring for our patients. The Friends and Family Test (FFT) asks patients whether they would be happy to recommend us to friends and family if they needed similar treatment. We have chosen to focus on FFT because its use is a national requirement.

What we are trying to improve

We will continue to focus on the same four FFT areas – inpatient/day case, outpatients, transport and A&E because we made less progress than we hoped for in 2016/17 for some, and as in previous years have chosen the four areas giving us the widest reported experiences across our hospitals.

What success will look like

We will aim to maintain our scores for A&E and inpatients and day-case patients as these are comparable with our peers. We have set our targets at 95 per cent rather than edging them up slightly because marginal improvements on such a high score would not be very meaningful. However there is more room for improvement on our 2016/17 scores for outpatients and transport and that is reflected in the targets below.

Table Q9. FFT priorities

Friends and Family Test area	Patients recommending UCLH to family & friends in 2016/17	Target for 2017/18
Inpatients and day-case patients	95%	95%
Outpatients	91%	93%
Transport	85%	90%
A&E	95%	95%

1.4.1.2 Improving patient experience in priority areas as measured by local and national surveys

As well as the measures of overall experience, each year we target specific areas where patients have told us that experience could be improved. These are chosen based on performance in the national survey or as measured in real-time feedback from our patients.

Our aim is to improve the experience of patients in those areas where patients continue to experience poorer standards than we would like, or where a particular decline in experience is noted. Some of these priorities have continued from last year so we can ensure the improvements are embedded.

For our inpatients, the initial results of the 2016 Picker survey have shown that the general experience of care is good, but they have a poorer experience at the point of admission and discharge. This feedback is common across the range of patient feedback, including the three main surveys and we have identified a number of themes across them all.

1.4.1.3 Improving our patients' experience of waiting

We have over 1,000,000 outpatient attendances per year and we know that waiting times continue to be one of the biggest issues affecting patients' experience. Waiting was also an issue for some of our inpatients, with waiting to get a bed and cancelled appointments specifically identified in the national survey results.

Table Q10. Specific outpatient waiting priority

Local real time survey question – higher scores are better	2016 Real time survey result	2017 Real time survey target
How long after the stated appointment time did the appointment start? (Percentage of patients who waited 30 minutes or less for appointment to start)	73%	78%

Whilst we did not meet the target for the time patients reported waiting last year, we did improve slightly on the previous year. This remains a priority for us and as we still want to do better we have set a five per cent improvement target. There is no national survey planned again this year so local real-time feedback surveys will be used to measure how we are doing.

Work will continue to improve waiting times through more efficient use of resources e.g. reducing the number of patients who do not attend without telling us. In addition, we will aim to improve the experience of patients while they wait. We will develop standards for the waiting experience across UCLH and take action to ensure these are met. This might include improvements such as the availability of refreshments and

entertainment and making sure patients are kept informed.

The national inpatient survey results from the CQC have yet to be published so we have selected questions based on the Picker survey. These are:

Table Q11. Specific inpatient waiting priorities

National Inpatient Survey questions	2015 result	2016 result* (Picker)	2017 target* (Picker)
Planned admission date changed by hospital	21%	24%	20%
Had to wait a long time to get a bed on a ward	24%	31%	28%

* Problem scores - lower scores are better. See glossary for more information on how these are calculated. The targets chosen are based on scores achieved by similar trusts (in the same survey).

In 2017/18, we are implementing a coordination centre which will provide real-time data on bed capacity and patient demand so we will better manage the flow of patients through University College Hospital, NHNN and EGA. This means we can reduce delays in patient care and prevent cancellations of procedures at short notice as a result of not being assured that there will be a bed for the patient to move in to.

Also, by working with 'TeleTracking', our implementation partner, we will:

- Design and introduce new leading practice and standardised operational processes
- Be able to speed up the most efficient pick up and movement of patients around the hospital, reducing patient delays and times where beds are not being used
- Immediately know where important pieces of medical equipment are on the wards – meaning we can find them as soon as we need them

Staff will be able to spend more time caring for patients, with better, more real-time information. Staff will spend less time looking for equipment or trying to find available beds

How will this work?

Auto-discharge of patients and the triggering of bed cleans: When a patient leaves the hospital the patient badge (worn around the wrist) will be removed and dropped in a 'drop-box'. This will automatically discharge the patient from the system and trigger a cleaning request of their bed.

Automating and streamlining the movement of patients: Porters will be assigned jobs directly by the system based on their proximity to the patient, and the location of any equipment they will need to collect en route. As soon as they have dropped a patient off, they will immediately be able to see their next job on hand-held devices.

Discharge planning and pathway progression: The coordination centre team will have a real-time view of all wards, and the status of each patient. Ward staff will set discharge milestones per patient which will be tracked and monitored on their ward electronic patient status board. The Coordination Centre will have a UCLH-wide view of all the delayed patients, and those that are pending an action. This information will enable the coordination centre team to discuss with ward staff and corresponding teams what action could be taken to reduce the delays, offering help and support. They can help with prioritising supporting services, to ensure those patients who are currently being delayed, are seen first.

Infection control: The Coordination Centre will have a real-time view of all wards and the status of each patient. As relevant 'infection related' positive or negative results flow through from the laboratory system to the status boards, a patient will easily be identified as needing isolation or de-isolation respectively. The coordination centre team can then work with the wards to move patients to the correct bed in real time. The coordination centre with its real-time view of all beds will easily see where side rooms are empty or waiting to be cleaned, so can support rapid movement of patients to and from side rooms.

Planning inpatient elective admissions: The operations team currently has only a view of the next week's

elective programme, which is created from the 'To Come In' (TCI) list, and pulled into a bed list. TeleTracking will provide the ability to view the TCI list as the data is received from the Patient Administration System (PAS) – so will provide the coordination centre team with far greater real-time visibility of future demand. Together with improved data on capacity in the future (delivered by the TeleTracking analytics platform) and within 24 hours, planning for elective patients will be vastly improved.

We will report progress against our performance in the national survey next year.

1.4.1.4 Improving our patients' experience of care

We remain focused on two priorities where have failed to improve as intended, but which remain important to our patients, and where we believe we can improve further.

'Inpatients not getting the right help with meals' continues to be a priority. To further understand what's important to patients, we carried out a 'listen at lunchtime' exercise across our hospitals in February 2017 to gather more detailed feedback about what we needed to do differently at mealtimes to ensure we better understand what help is required. Action plans are being developed based on the feedback received working with clinical teams across UCLH.

Table Q12. Specific inpatient care priorities

National Inpatient Survey questions	2015 result	2016 result* (Picker)	2017 target* (Picker)
Not always getting enough help from staff to eat meals	35%	38%	33%

* Problem scores - lower scores are better. See glossary for more information on how these are calculated.

We recognise that patients who find it easy to contact their named CNS report a better experience overall. While there has been work carried out with CNSs this year and we exceeded our target, it is clear that much more improvement is needed.

The targets chosen are based on scores achieved by similar trusts (in the same survey).

We will report progress against our performance in the national survey next year.

Table Q13. Specific cancer patient care priorities

National Cancer Patient Survey questions	2015 result	National 2016 result (no local result)	National 2017 Target
How easy is it for you to contact your clinical nurse specialist (CNS)?	63%	80%	85%

*Percentage of patients who said they found it easy to contact their CNS.

1.4.1.5 Improving our patients' experience of discharge

The national inpatient survey results have yet to be published so we have selected two questions based on the Picker survey. These priorities are:

Table Q14. Specific discharge priorities

National Inpatient Survey questions	2015 result	2016 result* (Picker)	2017 target* (Picker)
Didn't know what was happening after leaving	Not asked	47%	43%

National Inpatient Survey questions	2015 result	2016 result* (Picker)	2017 target* (Picker)
Staff did not discuss need for additional equipment/home adaptation	20%	25%	21%

*Problem scores - lower scores are better. See glossary for more information on how these are calculated.

Our work for 'safe discharge' planning has been ongoing for the last few years led by the Integrated Discharge Service (IDS). This year we designed and led six 'safe discharge' workshops which were open to both our hospital and community staff (with excellent feedback from attendees). We are standardising our discharge processes. We have designed and published the 'UCLH Safe Discharge Guide' for staff to use as a resource and guide to' safe discharge' policy and procedures. We are encouraging teams to use every opportunity to plan proactively for patients' discharge, involving patients and other partners in the process. We have set standards for daily ward huddles, with the aim of discharging patients by midday. There has been a five per cent increase in pre-12pm discharges this year.

To improve discharge planning and pathway progression we are introducing a Coordination Centre where the team will have a real-time view of all wards, and the status of each patient. This will include a clinical utilisation review to ensure patients are still needing to be in acute level of care, if not we can signpost patients to appropriate level of care e.g. Community services. This is a CQUIN too for 2017/18. Some of these changes were introduced after patients responded to the national survey so we would hope to see an improvement in next year's survey.

The IDS nurse educator has also been working proactively on the wards supporting both individual and small group training with the ward multidisciplinary teams. We are piloting a 'tracker nurse' who is supporting our patients being transferred to rehabilitation units across North Central London commissioning groups.

The work continues next year, with further 'safe discharge' workshops planned. We are discussing with the commissioners and the Community Education Providers Network (CEPN) both for 'safe discharge' to be promoted and accessible for all staff across Camden and Islington (and other North Central London boroughs plus Westminster) and also for assistance with the funds. We are also designing e-learning modules for all staff to support 'safe discharge' practice.

The work on Discharge to Assess (D2A) has commenced and it is planned to pilot the first pathways with Camden and Islington in October 2017.

The targets chosen are based on scores achieved by similar trusts (in the same survey).

We will report progress against our performance in the national survey next year.

Responsible director for Priority 1: Patient experience

Flo Panel-Coates, Chief Nurse

1.4.2 Priority 2: Patient safety

The Sign Up to Safety campaign has been successful in driving forward a number of safety improvements. We are confident that the pledges on honesty, collaboration, and support to staff are embedded and would like to continue to focus on reducing avoidable harm (in surgery and from deterioration, which includes sepsis and learning.

1.4.2.1 Reduce surgery-related harm

Why we have chosen this priority

Since starting this initiative in April 2015 we have improved our incident reporting rates in theatres whilst seeing a reduction in the numbers of incidents of harm. Despite this, our observations during surgical safety walkarounds show that there is still progress to be made in ensuring best practice is followed for the 5SSS in every area, with every team, for every list and every patient.

What we are trying to improve

We are pleased that we have achieved our 2016/17 planned objectives and sustained these improvements. However as the numbers of incidents are low they provide us with a limited picture of safety in

2017/18 we will be looking at different measures of success based on providing and sustaining safety improvement interventions, in particular our Surgical safety walkarounds.

We have started working with other areas performing invasive procedures outside of theatres to improve their use of the 5SSS through review or creation of new surgical safety checklists, providing training and practical support. Next year we will start to include more of these areas in Surgical safety walkarounds, whilst continuing over time to visit as many teams in theatres as possible to provide assurance of good practice. Importantly, we will also continue to revisit teams that require more support to achieve standards, in order to work with teams and monitor improvement efforts.

We also intend to continue to share our approach with other NHS trusts to help spread improvements in surgical safety across the sector.

This year we will:

- Continue to undertake regular surgical safety walkarounds to improve safety in all surgery and invasive procedures, increasing the frequency in areas requiring more support
- Repeat the safety culture survey in theatres and procedures and compare results over time
- Complete an interactive e-learning module to provide training for all relevant staff on what 'good' looks like
- Continue to share learning throughout UCLH through publication of At the Sharp End surgical safety bulletins
- Continue to share our approach and learning with other NHS trusts by offering training and resources

What success will look like:

- As we achieved significant increases in reporting surgical incidents in theatres (59.5 per cent) and near misses (169 per cent) and we reduced the number of incidents leading to harm by 80 per cent (see section 1.2.1) we will sustain this level of incident reporting
- Undertake at least 18 Surgical safety workarounds across all hospital sites as relevant to support safer surgery, which will use observational measures to record how the checklist is used in practice, including relevant safety behaviours
- To improve sustainability, we aim to see surgical safety workarounds start to be led by a wider group of staff, both managers and clinicians rather than just the project team.
- Publication of at least two surgical safety bulletins in the trust

How we will monitor progress

Our performance will be measured by the reducing surgical harm project team, and reported to the QSC.

1.4.2.2 Reduce harm from unrecognised deterioration

Why we have chosen this priority

Reducing harm from unrecognised deterioration remains a safety priority for 2017/18. We have created an overarching steering group for deteriorating patients that now includes sepsis and acute kidney injury (AKI), which are key reasons for patient deterioration.

Reducing harm from unrecognised deterioration remains a safety priority for 2016/17. We have created an overarching steering group for deteriorating patients that now includes sepsis and AKI, which are key reasons for patient deterioration.

What we are trying to improve

We want to improve early recognition of patients at risk of deterioration and so reduce patient harm. We will continue with this project to improve timely recognition, escalation and management of deteriorating patients. We will make sure that vital signs are being reliably recorded, that escalation to medical, senior nursing staff and PERRT is quick and effective so that urgent action can be taken when needed, and that patients with sepsis and AKI are treated quickly according to clinical guidelines.

To summarise, our work this year will focus on:

Recognition of deterioration
Improving vital signs and NEWS compliance

Escalation of a deteriorating patient
Improving the use of SBAR (Situation, Background, Assessment, Recommendation) in escalations

Management of a deteriorating patient
Improving recognition and treatment of sepsis
Improving recognition and treatment of AKI

SBAR is a standard, recognised communication tool used in healthcare. We learnt that for it to be used effectively at UCLH we needed to provide more support. We designed and distributed a survey to find out staff views and their understanding of SBAR, and provide us with a baseline from which to improve. 95 per cent of staff who responded knew what SBAR was, 90 per cent knew what it stood for, but only 58 per cent said they had received training. From this feedback we identified the need to provide more training to staff and provide materials such as stickers and posters to support staff to use SBAR and to document when patients have been escalated. Staff also said that during escalations staff did not always introduce themselves, and that there was sometimes no conclusion when using SBAR. As a result, we will add I (Identify) and D (Decision) to the beginning and end of SBAR, so it will now be ISBARD.

What success will look like

- Maintain our average hospital-wide vital signs compliance of 96 per cent, based on a sample of one in five patients on every ward, every month. We have changed the sampling from last year to take account of different ward sizes*
- A 10 per cent relative increase inpatients escalated to PERRT using the communication tool (SBAR/ISBARD) from the 2015/16 baseline of 63 per cent to 69 per cent; and a 10 per cent relative increase in recording of this metric by PERRT] from the 2016/17 baseline of 49 per cent to 54 per cent of referrals. (The review of this year highlighted that our target of 80 per cent was too challenging to achieve in one year so we have set ourselves an improvement plan with a 10 per cent relative increase this year)
- Improve average compliance with provision of antibiotics within one hour of diagnosis for all sepsis patients from our 2016/17 baseline average of 56 per cent to the 2017-18 CQUIN target of 72.5 per cent, unless deviation is clinically appropriate and documented in the medical notes
- Undertake a clinical review of antibiotics within 72 hours of giving the first dose in 90per cent of patients with sepsis to determine if it is still needed, and if so, if the appropriate antibiotic is being used

*We said we would continue to measure vital signs in 2016/17 based on a sample of 10 patients per

ward per month. This measure is part of an audit of all elements of the fundamentals of our nursing care. Our Exemplar Ward Accreditation programme is a scheme that enables us to understand all elements of performance in inpatient wards and target support where it is most needed. As part of this launch we reviewed the audits undertaken and decided to measure more metrics in each patient and for the number of audits to be proportionate to the ward size were selected. It was agreed by the Exemplar Programme Board and Nursing and Midwifery Board that a ratio of one in five patients would be appropriate. This was implemented in February 2016. Where results fall below the expected standards local improvement plans are developed and as part of this wards can increase either the sample size or the frequency of audits.

Work last year showed 100 per cent of acute admissions with AKI were being recognised within the target of four hours of arrival, and an average of 75 per cent treated within the STOP targets defined by the London Acute Kidney Injury Network (Treatment for sepsis within one hour, for toxicity within 12 hours, for obstruction within 36 hours, and for primary renal disease within 72 hours). Next year we will start work to better understand how well we are recognising and treating AKI in patients who develop AKI while inpatients, and see where any improvement work may be needed both in inpatients and acute admissions.

As we cannot be sure of what the incident data is telling us, we will look at this in more detail next year and in particular at learning from serious incidents, which are extensively investigated and result in detailed action plans. We will use these action plans to identify measures of improvement.

How we will monitor progress

Our performance will be measured and monitored by the Deteriorating Patient Steering Group, and reported to the Quality and Safety Committee (QSC).

1.4.2.3 Reduce the harm from failure to follow up on radiology results

Why we have chosen this priority

A Safer Practice Notice in 2007 in relation to radiological imaging recommended that systems were put in place to ensure that all results are reported and that there is a policy for reporting on abnormal and unexpected findings. It also recommended that there should be 'safety net' procedures within specialities to ensure results are read and acted upon. In 2015 UCLH introduced a new system where unexpected results could be clearly identified on the radiology system by a 'flag' indicating that the result should be looked at urgently to help with this. However, recent serious incidents and results from a review undertaken by the Clinical Audit and Quality Improvement Committee (CAQIC) looking at which specialities have processes in place to follow up on imaging results have shown that there is still work to be done. (The audit checked that divisions have 'safety nets' in place for checking results).

What we are trying to improve

We want to ensure that the flagging of unexpected results in radiology is happening effectively. Audits in radiology have shown that not all significant and unexpected findings are being identified with the 'urgent result alert'. We also want to be assured that specialties have a local system in place for checking that all results have been received and read and that this has been shown to be effective. Specialities will be expected to report on this and how they are assured, for example via audits. This is a continuation of the work we undertook this year where we asked specialities what systems they had in place, to establish a baseline.

What success will look like

Every specialty will have a formal written process in place to follow up on results. Assurance will be provided that these systems are working effectively via evidence supplied by the specialities such as audits.

Although harm is usually measured using incidents, in practice measuring harm from results not followed up is a poor measure as this is not a specific category on the Datix incident reporting system, at the moment. Various categories could be used instead but these are not easy to recognise or find. We will look into rationalising some of our categories to make this clearer. In addition we will be looking at actions from SIs to monitor their implementation as an additional initiative.

How we will monitor progress

Our progress will be monitored through the CAQIC reporting to the QSC.

1.4.2.4 Continue trust-wide learning

Why we have chosen this priority

Last year we focused on learning from SIs and we would like to continue this but also to include learning from mortality reviews (see the priority for clinical effectiveness) and learning from things that could have gone wrong but were prevented - 'near

misses'. Many of the initiatives for learning are well embedded but we think there is more that we could do.

What we are trying to improve

We are trying to improve the learning and subsequent changes in practice from SI investigations and other sources of learning, such as mortality reviews. We want to ensure that all actions arising from SIs are completed and fully implemented. In order to do this we will review and where necessary strengthen existing approaches for the monitoring of these actions. Last year we started to look at whether we could use the rate of recurrence of similar serious incidents or analysis of root causes and contributory factors as an indication of learning and we will continue that work this year.

What success will look like

- We will set up a Patient Safety Committee (PSC) to develop further our learning across the divisions and UCLH as a whole. The membership will consist of a variety of staff including divisional matrons and managers and the deputy chief nurses. It replaces the Patient Safety and Risk Steering Group and will report to the QSC
- We will continue to publish monthly quality and safety bulletins with a regular focus on learning from near misses to encourage reporting and action from near misses.
- We will continue (ICRs) and the focus on learning. We will review the ICR methodology in view of learning from the March 2016 CQC inspection, the findings of our internal auditors and changes to the CQC inspection methodology.
- We will continue to aim to achieve the national guidelines for investigation reports being completed following a serious incident (60 working days)
- Have no further occurrence of 'Never Events'
- Use the analysis of root cause and contributory factors to help with learning

How we will monitor progress

This will be undertaken by the PSC reporting to the QSC quarterly.

Responsible director for Priority 2: Patient safety

Professor Tony Mundy, Corporate Medical Director

1.4.3 Priority 3: Effectiveness - clinical outcomes

1.4.3.1 Responding and learning when patients die

Why we have chosen this priority

Even though our mortality rate is the second lowest in England, we have chosen this because there is more to be learned about when patients die. It also fits with the national priority.

NHS England is promoting a common, systematic approach to potentially avoidable deaths. A review of our systems identified that meetings where deaths are discussed were not happening systematically across our hospitals. We are setting up systems to ensure that we are learning as much as possible from deaths is order to improve safety and care.

We have completed our aim from last year, which was to set up a Mortality Surveillance Group (MSG). We will continue with this in order to implement new NHSI guidance on identifying, reviewing and learning from deaths.

What we are trying to improve

Learning from deaths to improve safety and patient care

What success will look like

- We will publish and implement a UCLH policy on learning from deaths, including patients with learning disabilities, which will describe how we will identify deaths for review, how the reviews will be undertaken and how we will learn from them
- We will identify the skills required and deliver training
- We will identify a formal process for engaging with bereaved families and carers if they have any concerns about the care of their loved one
- We will publish information on deaths quarterly
- We will publish this information in our 2017/18 quality report

How we will monitor progress

The MSG will monitor progress against this priority and report to the QSC.

Responsible director for Priority 3: Clinical outcomes

Professor Tony Mundy, Corporate Medical Director

1.5 Overview of quality performance

1.5.1 Table Q15: Progress against locally chosen priorities

The following table provides information against a number of national priorities and measures that in conjunction with our stakeholders we have chosen to focus on and which forms part of our continuous review and reporting. These measures cover patient safety, experience and clinical effectiveness. Where possible we have included historical performance and where available we have included national benchmarks or targets so that progress over time can be seen as well as performance compared to other providers.

In the following table the benchmark used is the comparison with the national average or comparable UCLH or local target and relates to 2016/17 unless otherwise stated.

We have chosen to measure our performance against the following metrics:	2014/15	2015/16	2016/17	Benchmark	V
Safety measures reported					
Falls per 1000 bed days +	3.4	4.2	4.2	6.63	E (i a
Inpatient falls with moderate harm, severe harm and death per 1000 bed days	0.11	0.08	0.07	0.19	A
Cardiac arrests	59	42	59	We don't have a local target but we want to see a continuing fall in numbers	L
Surgical site infections +	6.88%	5.5%	5.6% (data up until Dec 2016)	0.0%	N c L
Clinical outcome measures reported					
Summary Hospital-level Mortality Indicator (SHMI) – Rolling one year period, six months in arrears+	0.79	0.75 Oct 14-Sep 15	0.74 Oct 15- Sep 16	1	L e
Stroke mortality rates (Based on diagnoses 161x, 164x, P101, P524)	7.87%	6.82%	7.30%	We don't have a local target but we want to see a continuing fall in numbers	L
Percentage of elective operations cancelled at the last minute (on the day) for non-clinical reasons +	0.52	0.57	0.75	0.6 This is a target, not a benchmark. No benchmark is available.	L
Clinical outcome measures reported					
Percentage of last minute cancellations operations readmitted within 28 days +	97.7	97.2	99.4	95 This is a target, not a benchmark. No benchmark is available	H
28 day emergency readmission rate + (readmissions to UCLH)	3.0%	3.2%	3.5%	7.8% (CHKS national peer group average)	L

What this means	Notes
Benchmark is from the Royal College of Physicians (RCP) reporting on falls rates across most hospitals in England in the calendar year 2014. Lower scores are better	The methodology for counting falls changed in 2014-15, with unwitnessed falls now being included. Inpatient falls with harm has become per 1000 bed days. The RCP audit did not run in 2016-17 but will run in 2017/18 with a different methodology.
As above	As above
Lower numbers are better	Only includes cardiac arrests as per the criteria for a deteriorating patient by UCLP and excludes those in critical care areas, theatres, ED and catheter labs.
Number of surgical site infections/number of operations. Ideally there should be no infections. Lower scores are better.	
Lower scores are better. See glossary for explanation of indicator	
Lower scores are better.	This indicator looks at the number of patients with these codes who died in the trust in that time period compared with the total number of patients discharged with the same codes. The numbers of deaths for this indicator are relatively few and confidence limits for this indicator can be provided on request
Lower scores are better.	
Higher scores are better.	This is the percentage of patients cancelled on the day of surgery for non-clinical reasons, who then have their operation within 28 days.
Lower numbers are better.	

We have chosen to measure our performance against the following metrics:	2014/15	2015/16	2016/17	Benchmark	V
Safety measures reported					
Studies approved (NHS permission) UCLH by calendar year and Study type	272 (94 clinical trials + 178 other studies)	326 (131 clinical trials + 195 other studies)	320	No local target	H
Number of trial participants	21,363	12,704	19,986	No local target	H
Academic papers, which acknowledge NIHR (National Institute for Health Research).	693	754	662	No local target	H
Percentage of patients on diagnostic waiting list seen within six weeks+	93.6	95.2	96.4	99	H r
The percentage of inpatient discharge summaries e-messaged to GPs within 24 hours of discharge for those patients with NHS numbers.			97 for Camden and Islington patients	No benchmark but the standard NHS contract states that hospitals are required to send discharge summaries by direct electronic or email transmission for all inpatient, day case or A&E care within 24 hours.	P u
Patient Experience – national inpatient survey – 2016/17 data or a current benchmark is not available until 31 May 2017					
Overall satisfaction rating +	8.1	8.4			H
How many minutes after you used the call button did it usually take before you got the help you needed? +	6.0	6.2			M s
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand? +	8.9	8.9			H

What this means	Notes
Higher numbers are better.	The number of new clinical research studies approved to take place at UCLH categorised by the type of study
Higher numbers are better.	The number of subjects (usually patients) consented to take part in clinical trials at UCLH - it is important for UCLH to have many studies and good recruitment of patients to studies because they are indicators of the level of engagement with research across UCLH, for how research active UCLH is and for how integral research is within UCLH's clinical departments
Higher numbers are better.	The number of research papers published in journals and the number of times that the papers have been cited in other journal articles (citations are a measure of the importance of the paper amongst the academic community - this is important as a measure of the quality of our research and therefore affects our reputation and the likelihood of further research opportunities).
Higher numbers are better. The benchmark is the national target.	
Prompt discharge summaries enable GPs to follow up hospital care efficiently and safely.	Currently, this data is only collected for patients with GPs in Camden and Islington. Work is underway to extend the service to other CCGs 98 per cent of UCLH patients have an NHS member at discharge. This is a new indicator so there is no previous data.
Higher numbers are better	Weighted aggregated score based on a rating scale of 0-10 where is 0 is the lowest score.
More points for answering in less time. Higher scores are better.	Score based on an aggregate of the following responses: 0 minutes/straight away 1-2 minutes 3-5 minutes More than 5 minutes I never got help when I used the call button I never used the call button
Higher numbers are better	Score based on an aggregate of the following responses: Yes, completely Yes, to some extent No I did not want an explanation Not applicable

We have chosen to measure our performance against the following metrics:	2014/15	2015/16	2016/17	Benchmark	V
Safety measures reported					
After the operation or procedure, did a member of staff explain how the operation or procedure has gone, in a way you could understand?+	7.7	8.1			H
Staff Experience Measures – national staff surveys					
Appraisal +	93%	89%	93%	87%	H r
Staff would recommend the trust as a place to work +	3.97	3.91	3.99	3.76	H a a
If a friend or relative needed treatment, I would be happy with the standard of care provided by this trust +	83%	82%	84%	70%	H r
Staff engagement +	3.87	3.84	3.89	3.81	H a a

Table notes

+ These indicators use nationally agreed definitions in their construction. Otherwise, indicators are necessarily locally defined.

What this means	Notes
Higher numbers are better	Score based on an aggregate of the following responses: Yes, completely Yes, to some extent No
Higher numbers are better. Benchmark is the national average	Per cent of staff reporting that an appraisal has taken place in the last 12 months.
Higher numbers are better. The score is the average out of five. Benchmark is the national average	This question allows respondents to strongly disagree, disagree, neither agree nor disagree, agree or strongly agree
Higher numbers are better. Benchmark is the national average	Per cent of staff who 'strongly agree' with the statement.
Higher numbers are better. The score is the average out of five. Benchmark is the national average	The overall score is calculated by using the scores for the following key findings: Staff members' perceived ability to contribute to improvements at work (key finding 7), their willingness to recommend UCLHs as a place to work or receive treatment (key finding 1), and the extent to which they feel motivated and engaged with their work (key finding 4).

1.5.2 Table Q16: Progress against the risk assessment framework and the single oversight framework

This section provides details of performance against indicators based on the risk assessment framework and the single oversight framework

Indicator	Threshold 2015-16	Actual 2015-16	Threshold 2016-17	Actual 2016-17
Access				
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	94.2%	92%	93.4%
A&E: Maximum waiting time of four hours from arrival to admission/ transfer/discharge	95%	92.4%	95%	88.3%
Cancer 62 Day Waits for first treatment (from urgent GP referral for suspected cancer)	85%	67.2%	85%	70.1%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	79.6%	90%	85.6%
C.difficile – meeting the C.difficile objective				
C.difficile due to lapses in care (YTD)	72.75	25	97	8
Total C.difficile ytd (including: cases deemed not to be due to lapse in care and cases under review)	-	90	97	90
C.difficile cases under review (YTD)	-	31	16	16

We undertake extensive validation work on the data underpinning our performance reporting for RTT, 6 week diagnostics and A&E access standards. Along with the rest of the NHS, we need to carry out this validation to ensure that data collected by a wide range of clinical and non-clinical staff is put on to our systems accurately, and then processed in line with rules that are sometimes complex to follow.

As a result of this validation work and the quality account external audit review we are aware that our reported RTT performance figures in particular will not include all pathways that fall within the remit of the policy, and that the figures also include patient pathways where the patient was no longer waiting for treatment. We have,however, made good progress in the last year in reducing the number of these inaccuracies in our reported numbers, as demonstrated in particular by this year's external audit review.

There do, however continue to be clinical and administrative data entry errors in the management of these pathways. To address these we continue to use and develop a set of operational reports which help clinical teams closely manage waiting lists. We have operational meetings at all levels of the organisation to ensure that waiting lists are scrutinised at least weekly. Teams have a suite of data quality reports, including identification of where errors occurred, to help pinpoint issues.

In 2016/17 we introduced regular checks of electronic records against paper records to identify any common sources of error. These sample audits have been particularly useful in developing training for staff to avoid the data quality issues that we find. We have also introduced support for clinicians so that they can provide the information needed to manage patients along their RTT, diagnostic and emergency pathways.

We need to do more work to improve how we document and provide assurance on waiting times in the ED. We have improved validation processes and introduced monthly audits of how staff are documenting waiting times. While these have demonstrated no systematic inaccuracies in the waiting times that we report

for individual patients, this year's external audit has again shown that we do not consistently have documented evidence for the waiting times that we have reported. We will need to make further improvements to our record keeping and validation mechanisms so that we can provide full assurance on the accuracy of our recorded waiting times.

1.5.3 Core indicators for 2016/17

Amended regulations from the Department of Health require trusts to report performance against a core set of indicators using data made available to UCLH by NHS Digital. These mandated indicators are set out below, and are as at the time of this report and may not reflect the current position. Where the required data is made available by NHS Digital, a comparison has been made with the national average results and the highest and lowest trusts' results.

Table Q17: Summary hospital level mortality indicator and patient deaths with palliative care

UCLH considers that this data is as described for the following reasons: UCLH has a robust process for clinical coding and review of mortality data so is confident that the data is accurate.

	UCLH Performance Oct-13 to Oct-14	UCLH Performance Oct-14 to Sep-15	UCLH Performance Oct-15 to Sep-16	National Av Oct-15 to Sep-16	Highest Performing trust Oct-15 to Sep-16	Lowest Performing trust Oct-15 to Sep-16
Access						
The value and banding of the summary hospital – level mortality indicator ('SHMI') for UCLH for the reporting period	0.795 (Band 3)	0.748 (Band 3)	0.738 (Band 3)	1	0.689 (Band 3)	1.163 (Band 1)
The percentage of patient deaths with palliative care coded at either diagnostic or speciality level for UCLH for the reporting period.	34.2	34.1	32.5	29.7	0.4	56.3

UCLH has taken the following action to improve this percentage and so the quality of its services by:

- Monthly review of specialty level mortality at local and trust level
- Patient level clinical and coding review of any specialty or conditions, which show as mortality outliers when compared with national data
- Presenting a monthly report to the QSC detailing the percentage of patient deaths with palliative care coding. UCLH has also set a local target to monitor its rate of palliative care coding and any large variances

are investigated by the clinical coding team

Table Q18: Patient Reported Outcome Measures (PROMs)

UCLH considers that this data is as described for the following reasons: UCLH has processes in place to ensure that relevant patients are given questionnaires to complete. However, it has no control over their completion and return.

Adjusted average health gain (EQ-5D)	UCLH performance 2013/14 (final)	UCLH performance 2014/15	UCLH performance 2015/16	National average 15/16	Lowest performing trust 2015/16	Highest performing trust 2015/16
Access						
Groin Hernia	0.06	n/a	0.09	0.09	0.02	0.16
Hip-Primary	0.42	0.46	0.44	0.44	0.32	0.51
Hip-Revision	*	n/a	*	0.29	0.23	0.04
Knee - Primary	0.24	0.27	0.30	0.32	0.20	0.40
Knee - Revision	*	n/a	*	0.26	0.19	0.33
Varicose Vein	0.09	0.09	0.07	0.10	0.02	0.15

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

- Monitoring performance and agreeing actions with appropriate specialties through the PROMs Steering Group, chaired by a consultant lead and with consultant representatives from all relevant specialties
- Undertaking a more detailed review of the updated PROMs total knee arthroplasty (TKA) data due to UCLH having a lower than average score, to understand the reasons for the low scores. The more detailed review revealed that UCLH is no longer an outlier. UCLH is slightly lower than average (the majority of patients with poor scores at six months have two or more significant co-morbidities and comorbidities at UCLH are under reported). UCLH is reassured by the data review findings.

Table Q19: 28-day emergency readmission rate

The percentage of patients aged:	UCLH performance 2009/2010	UCLH performance 2010/11	UCLH performance 2011/12	National average amongst our peers 2011/12	Lowest performing trust 2011/12	Highest performing trust 2011/12
Access						
(i) 0 to 15	6.87	7.22	6.32	9.49	14.94	3.75
(ii) 16 or over	10.65	10.73	11.72	11.31	17.15	6.48

Update from NHS Digital

Work to investigate methodological issues relating to the emergency readmissions indicators has been completed. However, a review of the indicator sets in which these indicators are published is currently underway. Pending the completion of this review, the development of these indicators has been paused and we have no update as to when the indicators will next be released. The latest available data for 2002/03 – 2011/12 for emergency readmissions to hospital within 28 days/30 days of discharge are available via the NHS

Digital Indicator Portal https://indicators.hscic.gov.uk

Despite the fact that recent national data is not available, we monitor locally each month and this monitoring has informed our actions to reduce 28 day emergency readmissions.

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

- Undertaking an audit of re-admissions in 2016/17 to gain a richer understanding of the drivers for this
- Collaborative working with primary care and other secondary care providers across patient pathways
- Admissions avoidance – providing a team in the ED and Acute Medical Unit for the avoidance of preventable or inappropriate admission of patients to hospital
- Specialist nurse discharge support – UCLH will continue to enhance the skills of its established discharge and admission avoidance team to optimise patient care across organisational boundaries.

Table Q20: Responsiveness to personal needs of patients*

UCLH considers that this data is as described for the following reasons: undertaken independently as part of the annual national inpatient survey.

National inpatient survey*	UCLH performance 2014/15	UCLH performance 2015/16	National average 15/16	Lowest performing trust 15/16	Highest performing trust 15/16
The trust's responsiveness to the personal needs of its patients during the reporting period	67.7	72.4	69.6	58.9	86.2

*Responsiveness to personal needs of patients is a composite score from five CQC National Inpatient Survey questions.

The five questions are:

- Were you as involved as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

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

- Monitoring performance using 'Envoy', our real-time survey tool through regular discussion at quality huddles and agreeing local action plans
- Ensuring all patients' lockers have a 'call for concern' sticker to give 24 hours a day, seven days a week, contact details for patients and families who, after speaking to ward staff and PALS, feel that their concerns are not being addressed.
- Improving our discharge processes through the introduction of daily ward based discharge huddles around the Patient Status At A Glance (PSAAG) board, which focuses on 10 key elements that are essential to discharging patients at the right time.

Table Q21: Staff recommendation of the Trust as a provider of care to their family or friends

UCLH considers that this data is as described for the following reasons: survey undertaken independently as part of the annual national staff survey.

National staff survey	UCLH performance 2015/16	UCLH performance 2016/17	National average of acute trusts 16/17	Lowest performing acute trust 16/17	Highest performing acute trust 16/17
The percentage of staff employed by, or under contract to the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	81.7	83.8	69.8	45.0	93.0

UCLH has taken the following actions to improve this percentage and so the quality of its services. Please refer to 3.1 on how we are working to improve patient care.

Table Q22: Friends and Family Test for Accident and Emergency

UCLH considers that this data is as described for the following reasons. Data collection is undertaken independently.

Friends & Family Test	UCLH performance Apr 15 - Mar 16	UCLH performance Apr 16 - Dec16	National average Dec 16	Lowest performing trust Feb 16	Highest performing trust Feb 16
A&E survey	94.6%	94.8%	86.0%	47.4%	99.0%

The above data are the percentages of patients asked who said they would recommend the service

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

- Continuing to develop our ambulatory care pathways, with direct streaming from the point of triage
- Mobilising 'a primary care service at the front door, with access to the patients primary care record, to see them , treat them and redirect patients back to their GP or appropriate community services
- Refurbishment of the Emergency Day Unit: increased cubicle space and additional washroom facilities, two en-suite side rooms, plus increasing clinic capacity from two to five rooms
- Commencing Phase six of the ED Redevelopment programme, to create increased cubicle and clinic room capacity and a co-located CT scanner
- Implementing a clinical navigator at the front door to stream patients directly to the most appropriate area, ensuring patients are seen by the right clinician at the start of their pathway
- Implementing a 'Rapid Assessment and Treatment' model for ambulance conveyance, to ensure handover and assessment of patients arriving by ambulance is undertaken by senior staff promptly on arrival, reducing delays

Table Q23: Rate of admissions assessed for Venous Thromboembolism (VTE)

UCLH considers that this data is as described for the following reasons: UCLH has a robust electronic process for measuring VTE risk assessment of patients

Risk Assessment for VTE	UCLH performance Oct 2015 to Dec 2015	UCLH performance Oct 2016 to Dec 2016	National average Oct 2016 to Dec 2016	Lowest performing trust Oct 2016 to Dec 2016	Highest performing trust Oct 2016 to Dec 2016
Percentage of admitted patients risk-assessed for VTE	95.1	96.0	95.6	76.5	100.0

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

- Monitoring as part of the key performance indicators from ward up to board level
- Identifying and taking action in low performing areas

Table Q24: Clostridium difficile rate

UCLH considers that this data is as described for the following reasons: the data has been sourced from NHS Digital and compared to internal UCLH data and data hosted by Public health England.

C. difficile	UCLH performance 2014/15	UCLH performance 2015/16	National average 2015/16	Lowest performing trust 2015/16	Highest performing trust 2015/16
Infection rate per 100,000 bed days amongst patients aged two or over	40.5	36.2	14.9	66	0

This refers to all UCLH attributable *Clostridium difficile (C. difficile)*infections including those subsequently appealed and under review. Our threshold, set by Public Health England, is to have less than 97 patients suffering from C difficile whilst in our hospitals in 2016-17, and we had 90 cases.

The threshold is based on patient characteristics and previous performance of UCLH and our threshold is higher because we have a high number of cancer/haematology patients and other high risk groups. The transfer into the hospital of haematology/oncology services last year was predicted to increase our numbers by 40 cases but our threshold was not changed to reflect this. However, we still had fewer cases than the threshold set. This year fewer than 10 per cent of the C difficile cases were related to lapses in care.

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

- Ensuring a multidisciplinary review of all cases of toxin positive C difficile is undertaken (root cause analysis - RCA). The RCA is then reviewed with the commissioners and any lapses in care identified. Lapses include delays in isolation, sampling and treatment
- Ensuring a detailed action plan is in place and monitored regularly which is based on learning from the RCAs
- Ensuring there is a constant focus on ensuring the basics of infection prevention are communicated and understood
- Continuing focus on antibiotic stewardship to optimise practice and patient outcome

Table Q25: Incident reporting

UCLH considers that this data is as described for the following reasons: data have been submitted to the National Reporting and Learning System (NRLS) in accordance with national reporting requirements.

Patient safety incidents	UCLH performance October 2014 - March 2015	UCLH performance October 2015 - March 2016	National average October 2015 - March 2016	Lowest performing trust October 2015 - March 2016	Highest performing trust October 2015 - March 2016
Number of patient safety incidents reported within the trust during the reporting period	4439	4505	4407	334	11998
The rate of patient safety incidents reported within the trust during the reporting period	32.81	35.27	38.97	14.80	75.90
The number of such patient safety incidents that resulted in severe harm or death	14	15	17.4	94	0
The percentage of such patient safety incidents that resulted in severe harm or death	0.3	0.3	0.5	3.37	0

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

- Continuing to encourage incident reporting through the monthly quality and safety bulletin, which shares learning on reporting from incidents, information related to duty of candour (including positive feedback or experiences) and encourages the reporting of near misses
- Promoting learning from serious incidents by introducing a monthly report in the form of Look and learn which includes learning and actions and distributing this via email directly to front-line staff members and governance leads
- Continuing to share the quarterly report on incident trends and learning and commending high reporters
- Amending Datix reporting to make it easier to report as well as improving the duty of candour fields to make them easier to understand by providing prompts and information as “pop-ups”
- Creating and developing dashboards for wards to allow review of their incidents at local level.

1.6 Board assurance statements

1.6.1 Introduction

All providers of NHS services are required to produce an annual quality report 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 (QSC).

This is the key committee for monitoring and assuring on quality and safety. The committee seeks assurance that issues of quality and safety are addressed. For example, the committee requested assurance following a small number of potential high value claims and serious incidents in the spinal service. As a result, the neurosurgery team presented a report on quality and safety within the spinal surgery service, from which QSC took assurance. This included changes to the spinal injury pathway where arrangements were made to improve access to MRI scanning. The committee also identified some concerns as a result of a small number of SIs in the maternity service and the division attended to provide assurance. The committee has also requested regular updates on the 'vein to vein' project, which aims to improve the safety of blood transfusion.

The audit committee is responsible on behalf of the board for independently reviewing the systems of governance, control, risk management and assurance. The board of directors receives a regular 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 (outcomes).

In addition, the Board receives quarterly reports in areas such as serious incidents, and quarterly and annual reports in areas such as child safeguarding and complaints. The board is further assured by reviews undertaken by internal audit which this year has included risk management – looking at the timeliness of risk reviews; complaints – looking at the processes including developing action plans; duty of candour – looking at divisions with good and less good compliance to learn about best practice; dissemination of guidance including that related to clinical effectiveness – how this done; and serious incidents – looking at the processes for reporting serious incidents and key factors in time delays in submitting reports.

In addition, board members including the chairman and chief executive, medical directors, chief nurse, and non-executive directors, regularly undertake walkabouts around UCLH talking to staff and patients. We are fortunate to have seven board members who are practising clinicians including six doctors. They focus on the CQC key questions of safe, effective, caring, responsive and well-led care. These visits, and what is learned provides additional assurances on services. There are other visits, matrons undertake 'quality rounds' and the governors visit clinical areas.

1.6.2 A review of our services

During 2016/17 UCLH provided and/or subcontracted 69 relevant health services. UCLH has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by UCLH for 2016/17.

1.6.3 Responding to our stakeholders comments

When our quality report was published last year we invited our commissioners, Healthwatch Camden and the Adult Social Care Scrutiny Committee to comment on it. These are our responses to those comments:

NHS Camden Clinical Commissioning Group (CCCG)

The CCCG suggested that we looked how to strengthen our learning from Never Events to reduce recurrence.

Please refer to section 1.3.2.4 on Never Events

The CCCG suggested that we report on improvements to patient experience in relation to waiting times.

We have made progress in some areas to improve waiting times in outpatients and work will continue in the year ahead. This is one of our priorities in the coming year – see the section on patient experience priorities for more information

The CCCG suggested that we commit to improvements to the patient experience for those with cancer and in our maternity services.

Both these areas are discussed extensively with our commissioners at the CCCG meetings with a focus every quarter on both cancer and maternity. The content of the reports from UCLH are continually under review to reflect the concerns and queries of the commissioners

The CCCG suggested that wemake improvement to resilience planning to ensure sustainable patient access and experience.

We have strengthened our service resilience across a range of areas in order to sustain or improve access to our services. We have sustained delivery of referral to treatment times performance through the year, making sure that our patients do not wait too long for their planned treatments. We have now also delivered the standard that patients do not wait more than six weeks for a diagnostic test. We have improved access to cancer services, and we are now achieving the standards that patients should wait no longer than 14 days for their first appointment following a referral for suspected cancer, and that once a patient receives a confirmed diagnosis of cancer, they should receive treatment within 31 days. We have made significant improvement against the standard that cancer patients should wait no longer than 62 days from referral to treatment, although we are not yet fully there yet.

The CCCG suggested that we demonstrate positive results in 2016/17 that reflect 'an improvement in the quality of services provided to patients with a focusing on ensuring services are well led, caring, responsive, safe and effective.

Please see section 1.2.1 for our update on the CQC inspection.

Healthwatch Camden and Adult Social Care Scrutiny Committee

Healthwatch Camden and the Adult Social Care Scrutiny Committee (ASCSC) asked us to show that the local community is a priority for the hospital and that the financial reports demonstrate that local income as a percentage of the overall budget is not reducing each year.

The hospital board has recently discussed and reaffirmed the importance of the services that we provide to our local community. It is essential to our strategy that we continue to provide excellent local services, just as much as providing more specialist services, teaching, training and research and development. We are currently implementing a new musculo-skeletal service for patients in Camden that sees us, for the first time, taking responsibility for the management of a patient population. This gives us an excellent opportunity to deliver joined-up care for local patients.

Whilst financial information is not the best measure of commitment to our local community (as it is affected, for example, by technical issues such as tariff changes), we provided reports to Healthwatch Camden and the ASCSC showing that for the last two years income from Camden commissioners has been stable at £69m per year.

Healthwatch Camden and the ASCSC asked us to demonstrate how we are working to make sure that patients do not have wait more than 30 minutes after their booked appointment.

We have invested in a new patient feedback system, 'Envoy' that will soon allow us to text every patient following an outpatient appointment to find out how long they waited in the department before being seen. This will allow us to pinpoint more accurately the clinics that have problems with their waiting times and to learn from the clinics that see their patients on time. The University College Hospital Macmillan Cancer Centre has seen a 20 per cent increase in outpatient activity in 2016/17 compared to 2015/16. Whilst this growth is a welcome it puts constraints on our capacity and in some cases, for example when clinics are overbooked, leads to longer waiting times. We have set up an outpatient's improvement group with representatives from the five divisions that run clinics. This group will focus initially on freeing up capacity to meet the growth in demand and thus improve patient waiting times. This will be done by identifying and reallocating rooms that are given up for planned reasons such as annual and study leave.

We will then work with patient representatives to look at how we can best improve patient waiting times in the cancer centre. We have identified 10 outpatients' improvement measures to work through over the next 24 months and many of these will improve patient waiting times. We will use our Check and Track system to identify at doctor and clinic code level the number of patients who actually wait more than 30 mins. The intention is to share this data with clinical teams and to be able to measure improvements.

Outpatient waiting times is one of our patient experience priorities in the year. See section 1.4.1

Healthwatch Camden and the ASCSC asked us to demonstrate how we are capturing feedback relating to frustration with the outpatient booking and communications processes, which is not captured in the current reporting. See section 1.4.1

Healthwatch Camden and the ASCSC commented that there is still room for improvement in the quality report in terms of tailoring the content and style

of the report for a public readership and saying more about how it has engaged with the public, patients and governors in setting its priorities as a manifestation that serving the local community and being reportable to the local community is a strong priority for the organisation.

This year we have engaged much earlier in the year with Healthwatch Camden in discussing the quality priorities and have maintained our working relationship with the governors.

We have tried to improve the readability of the quality report for all, but this is a challenge. We have used the 'Flesch Reading Ease score' throughout the document to improve its clarity but words such as ' quality, priorities, safety, outcomes, governors and reporting' are regarded as 'hard' words and push the score down considerably. A score of 60-69 is regarded as standard or average, but with 'hard' words, it is difficult to bring the score above 45. In addition, there are sections where the content is mandated and technical and this limits our ability to make it easily readable throughout.

1.6.4 Participation in national audits

Clinical audit evaluates care against agreed standards, providing assurance and identifying improvement opportunities. UCLH has a yearly programme of clinical audits in three categories – national, corporate and local. For national audits, we aim to participate in all that are applicable to us. Corporate audits are based on UCLH priorities and all specialties are expected to undertake them. Local audits are set up by clinical teams and specialties to reflect their own priorities and interests. Audit findings are reviewed by clinical teams in quality and safety (governance) meetings, as a basis for peer review and for targeting or tracking improvements.

The CAQIC oversees the corporate clinical audit programme and activity, and reports directly to the board's QSC.

During 2016/17, 37 national clinical audits and nine national confidential enquiries covered relevant health services that UCLH provides. During that period, UCLH participated in 97 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries, in which it was eligible to participate. The one audit, National Core (part of National Diabetes Audit - Adults), where data was not submitted was related to internal IT systems and work is ongoing to resolve this.

The national clinical audits and national confidential enquiries that UCLH was eligible to participate in during 2016/17 and the national clinical audits and national confidential enquiries that UCLH participated in, and for which data collection was completed during 2016/17 are listed below, alongside the number of cases submitted to each audit and enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Table Q26 lists the national audits and shows UCLH participation. Table Q27 does the same for national confidential enquiries.

Table Q26:National Clinical Audits

	Audit	UCLH eligible	UCLH participation	Percentage of cases submitted
1	Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	Yes	100%
2	Adult asthma	Yes	Yes	100%
	Adult cardiac surgery	No	N/A	
3	Asthma (paediatric and adult) care in emergency departments	Yes	Yes	58%
4	Bowel cancer (NBOCAP)	Yes	Yes	Data collection in progress
	Cardiac Rhythm Management (CRM)	No	N/A	
5	Case Mix Programme (CMP)	Yes	Yes	100% (1 April 2016-31 December 2016)
	Chronic kidney disease in primary care	No	N/A	
	Congenital Heart Disease (CHD)	No	N/A	
	Coronary angioplasty/national audit of percutaneous coronary interventions (pci)	No	N/A	
6	Diabetes (Paediatric) (NPDA)	Yes	Yes	100%
7	Elective surgery (National PROMs Programme)	Yes	Yes	Groin Hernia: 88.9% Hip Replacement: 86.4% Knee Replacement: 100%. Varicose Vein: 72.1% (April 2016- Jan 2017)
	Endocrine and thyroid national audit	No	N/A	
8	Fracture Liaison Service Database (part of Falls and Fragility Fractures Audit programme (FFFAP)	Eligible for the facilities audit component only	Yes, participating in the facilities audit component	New. Data collection in progress.
9	Inpatient falls (part of FFFAP))	Yes	No data collection requested by the national team between 1 April 2016 and 31 March 2017. Data collection in May 2017.	
10	National hip fracture database(part of FFFAP)	Yes	Yes	100%
11	Head and neck cancer audit	Yes	Yes	Data collection in progress.
12	Inflammatory Bowel Disease (IBD) programme	Yes	Yes	100%

	Audit	UCLH eligible	UCLH participation	Percentage of cases submitted
13	Major trauma audit	Yes	Yes	100%
	Mental health clinical outcome review programme	No	N/A	
14	National audit of dementia	Yes	Yes	Case notes: 100% Carers Paper Questionnaire: 50% Carers online: 0% Staff paper questionnaire: 66% Staff online questionnaire: 100%
	National audit of pulmonary hypertension	No	N/A	
15	National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
	National Chronic Obstructive Pulmonary Disease (COPD) audit programme		N/A	
	No	N/A		
16	National comparative audit of blood transfusion - audit of patient blood management in scheduled surgery	Yes	Yes	80%
17	National foot care audit (part of national diabetes audit – adults)	Yes	Yes	100%
18	National diabetes inpatient audit (part of national diabetes audit - adults)	Yes	Yes	100%
19	National pregnancy in diabetes audit (part of national diabetes audit - adults)	Yes	Yes	Data collection in progress
20	National diabetes transition (part of national diabetes audit - adults)	Yes	No data collection 2016/17: Central Linkage Project	
21	National core (part of national diabetes audit - adults)	Yes	No	Not participating as current diabetes database not suitable for data collection. Ongoing work with Infoflex team to aid participation
22	National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
23	National heart failure audit	Yes	Yes	100%

	Audit	UCLH eligible	UCLH participation	Percentage of cases submitted
24	National Joint Registry (NJR)	Yes	Yes	100%
25	National Lung Cancer Audit (NLCA)	Yes	Yes	100%
26	National neurosurgery audit programme	Yes	Yes	91%
	National ophthalmology audit	No	N/A	
27	National prostate cancer audit	Yes	Yes	100%
28	National vascular registry	Yes	Yes	100%
29	Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
	Nephrectomy audit	No		
30	Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Data collection in progress.
	Paediatric Intensive Care (PICANet)	No	N/A	
31	Paediatric pneumonia	Yes	Yes	Data collection in progress.
	Percutaneous Nephrolithotomy (PCNL)	No	N/A	
	Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	
32	Radical prostatectomy audit	Yes	Yes	100%
	Renal replacement therapy (renal registry)	No	N/A	
33	Rheumatoid and early inflammatory arthritis	Yes	The national team is not collecting data in 2016/17	
34	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100% (up to Nov 2016)
35	Severe sepsis and septic shock – care in emergency departments	Yes	Yes	100%
36	Specialist rehabilitation for patients with complex needs	Yes	The national team is not collecting data in 2016/17	
37	Stress urinary incontinence audit	Yes	Yes	100%
	UK cystic fibrosis registry	No	N/A	

Table: Q27 National Confidential Enquiries

	National Confidential Enquiry	UCLH eligible	UCLH participation	Percentage of cases submitted
1	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Mental health in general hospitals	Yes	Yes	100%
2	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Acute Pancreatitis	Yes	Yes	100%
3	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Non-invasive ventilation	Yes	Yes	100%
4	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Chronic Neurodisability	Yes	Yes	91% (study still open - data collection in progress)
5	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Cancer in Children, Teens and Young Adults	Yes	Yes	12% (study still open - data collection in progress)
6	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Young People's Mental Health	Yes	Yes	Study in progress – cases required to be confirmed by NCEPOD
7	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Acute Heart Failure	Yes	Yes	Study in progress – cases required to be confirmed by NCEPOD
8	Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	Yes	100%
9	Maternal, Newborn and Infant Clinical Outcome Review Programme MBRRACE programme	Yes	Yes	100% Separate leads for neonatal / newborn and maternal MBRRACE programmes Ongoing reporting and completion of audit process as required (as cases arise)

The reports of seven national clinical audits and 12 local clinical audits were reviewed by UCLH in 2016/17 and UCLH intends to take the following actions to improve the quality of healthcare provided:

Table Q28: Examples of actions from National Clinical Audits

Royal College of Emergency Medicine - VTE risk in lower limb immobilisation in plaster cast clinical audit 2015-16 The audit looked at current performance in emergency departments against two standards – a requirement that there should be written evidence of referral for thromboprophylaxis (clot busting) in patients unable to walk and that a patient information leaflet should tell such patients to seek medical advice if they develop symptoms of a clot. We will be addressing these recommendations.
Women's Health - National Neonatal Audit Programme (NNAP) The overall aims of this audit are to assess whether babies requiring specialist neonatal care receive consistent, high quality care across England and Wales in relation to the audit questions and to identify areas for improvement in relation to service delivery and the outcomes of care. Overall results showed that UCLH was above the national average for most of the indicators. We also scored well on data completeness and quality issues. We will continue with monthly reporting on the Neo Natal Unit scorecard and use of the 'BadgerNet' dashboard to monitor performance and ensure early identification of issues.
Gastrointestinal Services - audit on sedation for endobiliary procedures and its effect on patient satisfaction and endoscopy outcomes The audit highlighted that whilst endobiliary (within the bile duct) procedures under conscious sedation used dosages of fentanyl (painkiller) which were higher than the recommended dosages these did not result in adverse outcomes. It also found that 50 per cent of patients having procedures under conscious sedation would also like to be offered the sedative and relaxant Propofol. Recommendations have been made for sedation options to be considered as part of discussions with patients during clinic appointments and for local guidelines to be developed to support best practice. This will be informed by further clinical analysis, which is already underway.

3.6.5 Participation in Corporate Audits

Our corporate clinical audit programme aims to help UCLH meet its top 10 objectives, provide assurance to commissioners, demonstrate compliance with recommendations from the National Institute for Health and Care Excellence (NICE) and help manage risk. A summary of the programme is below. Although they are not clinical audits per se, patient surveys are included because they are an important part of quality improvement and the best indicator of patient experience.

Table Q29:

Objective	Quality priorities	Supporting Corporate Audit activity

Improve Patient Safety	Deliver 'Sign up to Safety' campaign pledges so that we further reduce harm to patients
	Achieve hospital acquired infection targets
	Ensure that we check and action all patient test results
		• Local systems for radiology Imaging results
		• NG tubes correct documentation and placement
		• Non-delegated consent
		• Harm free care – Hospital Acquired pressure ulcers & falls feature at UCLH
		• Blood transfusion
		• Safeguarding
		• Tracheostomy care
		• Resuscitation
		• IV catheter care
		• Nutrition screening
		• Medication safety and medicines management
		  ▸ Prescribing documentation
		  ▸ Secure storage
		  ▸ Dose omissions
		  ▸ Discharge prescriptions
		• Antimicrobial prescribing

Deliver Excellent Clinical Outcomes	• Maintain upper decile Standard Hospital Mortality Indicator results • Agree an integration strategy with CCGs • Avoid increase in levels of emergency admissions	• Outcome and safety of new interventional procedures • Readmissions reported monthly via the performance pack

Deliver high quality patient experience and customer service excellence	• Maintain patient survey satisfaction ratings
	• Reduce the number of outpatient cancellations
	• Avoid increase in the number of inpatient cancellations
		• Patient Surveys:
		  ▸ Inpatients
		  ▸ Outpatients
		  ▸ Cancer
		  ▸ Maternity
		• Pre and post-operative patient reported outcomes
		• End of life care
		• Audit of care given to patients with learning disabilities
		• duty of candour*

*Some of these audits will be reported in 2017/18

1.6.6 Local clinical audit and quality improvement (QI)

The importance of clinical audit in stimulating quality improvement stems from a willingness to use the information obtained to make improvements. This year we want to highlight the work undertaken by the Clinical Audit and Quality Improvement Committee (CAQIC) to educate and support clinical audit leads to use QI methodologies in their audit activity.

From January 2017 UCLH has partnered with the British Medical Journal (BMJ) in a pilot study which hopes to demonstrate better QI methodology, better reporting (in line with international standards), opportunities for training and opportunities for publication and showcasing what we do to a wider audience.

BMJ Quality is an online workspace that supports individuals and teams through healthcare improvement projects and on to publication. The necessary interactive workbooks, learning modules, tools and resources are provided to help make healthcare improvement simple.

The CAQIC has been given 17 licenses (one for each division), each allowing one quality improvement project to be developed within the BMJ Quality Reports portal. This online tool guides users through the process of quality improvement by allowing authors to complete a structured template which develops as the project evolves, finally becoming a completed paper which will go through a publication process and is most likely to result in publication in the journal.

The aim is to engage all UCLH divisions, allowing each to nominate a quality improvement project for online development and hopefully publication. By the end of 2017, we aim to have up to 17 publications in the journal.

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

Examples of improvement resulting from local clinical audit

Throat, nose and ear surgery for children

A report published in 2016/17 looked at the outcomes and patient experience of 87 children having minor, ear or nose surgery or having their tonsils and/or adenoids (T&As) removed at the RNTNEH during September and October 2015. We also followed up 72 of the children after their operation.

We looked at current anaesthetic and surgical techniques and at the need for medication such as pain relief or anti-sickness treatment in the recovery room or on the ward. We asked about the adequacy of pain relief after discharge and we looked at any late complications such as bleeding after surgery. We assessed the level of support required after discharge and what the experience was like for children and their parents and what we could improve.

We found that overall pain was controlled in the majority of children and, on average it took just under five days for them to return to normal activities. However, a third of children who had their T&As removed felt their pain was not well controlled. A number of parents sought medical advice for their children after discharge from their general practitioner, from the staff on the ward or by attending Accident and Emergency. Of the 41 children who underwent a T&As, 19 required further advice.

Almost all families felt well supported after discharge and all would recommend the Royal National Throat, Nose and Ear hospital to other families.

Table Q30:

What did we learn	What are we doing to improve
We must work to improve the admission procedure for children.	• We are doing this by explaining the process at pre-assessment and again on the day of admission.
We must explore how to make having an anaesthetic less distressing.	• We are doing this by ensuring 1:1 time with the nurses and the play specialist, and by using an iPad and other distraction therapy. We are providing an honest explanation of what to expect for older children.
We should take into consideration that parents would like to be with their child in the recovery room.	• At RNTNEH, the ethos is that as soon as a child is awake and their airway is safe after surgery they are brought to their parent, on the ward. The rest of the child's recovery happens on the ward. On any occasion where a child needs further supervision in the recovery room then their parent is taken to recovery.
Families would like us to find solutions for children crying on the ward which other children find distressing.	• We aim to explain the reasons for crying to all families to alleviate distress.
A routine follow-up phone call to the family following throat, nose and ear surgery may be supported by this audit.	• We are working to set up a telephone follow-up clinic by summer 2017.
Routine follow-up of children who have undergone a tonsillectomy might reduce the care burden on GP and district general hospital services.	• Our nursing staff provide focused 1:1 advice after surgery which is followed up with written information. This includes pain relief medication, when pain relief should be given and what to do in an emergency with emergency contacts telephone numbers.

Paediatric & Adolescent Services

The Royal College of Paediatrics and Child Health (RCPCH) has led the Situation Awareness For Everyone (SAFE) two year programme in partnership with paediatric units from 28 hospitals across England to develop and trial a suite of quality improvement techniques. These aim to improve the safety of children in hospital, reduce mistakes and avoidable death in paediatric departments throughout the UK.

Examples of improvement techniques include the 'huddle' which is a 10 minute, free and frank exchange of information between clinical and non-clinical professionals involved in a child or young person's care. The huddle encourages information sharing and equips professionals with the skills to spot when a child's condition is deteriorating and escalate appropriate treatment.

UCLH chose to focus on a number of priorities to reduce deterioration and avoidable harm. These were:

- Identify deterioration by recording vital signs and calculating an early warning score for treatment escalation
- Staff safety huddles and review of the early warning score
- Responding to deterioration – review of our response to raised early warning scores.
- Improve through learning using staff safety attitudes, patient/parent feedback and review of 2222 calls using RECALL tool (Rapid Evaluation of Cardio-respiratory Arrests with Lessons for Learning)

What did we learn?

We introduced a daily staff huddle using a 'script' to follow the daily ward round at 11.45am. A review of these huddles undertaken in February 2016 showed that:

- Huddles were more efficient when led by the nurse
- Pharmacists attended if the huddles were held on time
- The paediatric early warning scores (PEWS) were discussed every day
- All staff think huddles have helped in the recognition of the deteriorating child

Our baseline audit of practice showed that we are 96 per cent compliant with recording vital signs and accurate calculation of early warning scores. Documentation that we responded appropriately to raised early warning scores was only evident 70 per cent of the time. Review of our 2222 calls showed very good outcomes.

We also looked at handover and a review of patient handovers in January 2016 showed that:

- Consultants were always present
- Nurses were not present
- All aspects were discussed except the bed status and nursing staffing levels
- The communication tool Situation,

Background, Assessment and Recommendation (SBAR) was used in almost 70 percent of handovers and the average length of time for handover is 42 minutes.

An Experience of Care survey of patient and parents was carried out in January 2016 for children aged nine to 18 years. Over 80 per cent of parents either strongly agreed or agreed that the ward has a healthy patient safety culture. The majority of patients and parents felt they were listened to by staff, their views/worries were taken seriously, staff knew how to help, information about help available was given and staff worked together to help.

What are we doing to improve? Our plans for Situation Awareness For Everyone (SAFE) going forward include:

- Exploring the potential for night time huddles
- Introducing SAFE huddles on other paediatric wards
- Sharing learning across UCLH
- Using an electronic joint handover sheet and meeting at the huddle as nursing and doctors handovers do not occur at the same time
- Introducing SBAR training for staff (this is a quality priority for 2017-18)
- Training for staff, using simulation
- Monitoring and reviewing all emergency calls (for urgent deterioration), in real time, to learn lessons
- Improving the documentation of escalation from 70 per cent by completing the PEWS chart at the huddle
- Ongoing surveys from patients, parents and staff

Emergency services

A lumbar puncture is a procedure where a needle is inserted into the lower part of the spine to test for conditions affecting the brain, spinal cord or other parts of the nervous system. Lumbar punctures are often used to exclude sub-arachnoid haemorrhage (SAH) in patients presenting with 'thunderclap headache'.

Normally computed tomography (a CT scan) of the patients' head is the first examination carried out; if this is negative a lumbar puncture is then carried out.

However, there is lack of consistency and consensus amongst experts about when to perform a lumbar puncture. In order to develop local guidance we carried out a clinical audit of such procedures to find out:

- If there is any national guidance
- What the current practice is on the UCLH Acute Medical Unit (AMU)
- How many patients underwent lumbar puncture
- Usefulness of the lumbar punctures in making the diagnosis

The audit of current practice on the AMU included patients admitted between 27th August 2015 and 11th November 2015 with a sudden onset headache suggesting the patient had suffered an SAH.

What did we learn?

The findings were that there is no national guidance in England. We also found that local practice is not consistent, that we may be doing more lumbar punctures than are required.

What are we doing to improve?

An action plan was put into place to:

- Develop a local protocol for assessment of 'thunderclap headache' with normal neurology,

including seven ‘red flags’
- Include the assessment when taking the patient’s history on admission
- Refrain from changing clinical practice, until fully validated
- Re-audit to assess if the clinical picture in patients bears correlation with investigations undertaken

1.6.7 Our participation in clinical research

A key focus for the National Institute for Health Research is the development and delivery of high quality, relevant, and 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, ensuring studies, which take place at UCLH, are relevant to, 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 April 2016 - March 2017 a total of 320 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. There are currently 1482 studies involving UCLH patients that are open to recruitment or follow-up. Of these, approximately 64 per cent of studies are adopted onto the National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio of research.

The number of patients receiving relevant health services provided or sub-contracted by UCLH in 2016/17 that were recruited during the period to participate in research approved by a research ethics committee was 19,986.

UCLH is recognised as one of 11 leading centres for experimental medicine in England. In partnership with University College London, UCLH has National Institute of Health Research Biomedical Research Centre (BRC) status. During 2016/17 further funding was awarded to renew this status for the next five years and to support new research in hearing and deafness, oral health, mental health, obesity and dementia (replacing the Dementia Biomedical Research Unit), and to introduce cross-cutting platforms to support and enable research across disease areas. This is in addition to the BRC’s traditional focus on four broad areas of world-class strength for innovative, early phase research in cancer, neuroscience, cardiometabolic diseases and infection, immunity and inflammation.

UCLH’s commitment to research is further evidenced by the fact it is part of UCLPartners, one of five Academic Health Science Partnerships. UCLPartners itself has a director of quality committed to sharing best practice across the partnership.

1.6.8 CQUIN payment framework

Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments to hospitals based on agreed quality improvement and innovation work.

A proportion of UCLH’s income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between UCLH and its commissioners through the Commissioning for Quality and Innovation payment framework.

Through discussions with our commissioners, we agreed a number of improvement goals for 2016/17 that reflect areas of improvement interest nationally, within London and locally. The total of income conditional upon achieving quality improvement and innovation goals for 2016/17 is £10,894,497*.

A high-level summary of the CQUIN measures for 2016/17 is shown in the following table together with the forecast income taking into account performance against each CQUIN target.

* This figure is still provisional. A final figure will not be available until all activity has been billed through at the beginning of June.

Table Q31: CQUIN measures 2016/17

CCG CQUINs	Forecast full year income
Introduction of health and wellbeing initiatives	£657,000
Healthy food for NHS staff, visitors and patients	£657,000
Improving the uptake of flu vaccinations	£328,500
Timely identification and treatment for sepsis in the Emergency Department	£176,569
Timely identification and treatment for sepsis in inpatients	£209,419
Reduction in antibiotic consumption	£105,120
Empiric review of antibiotic prescriptions	£131,400
Obesity prevention and management in hospital settings	£142,350
Nutrition and hydration	£142,350
Nutrition and hydration - discharge on oral nutritional supplements (ONS)	£186,150
Reasons for delayed discharges	£394,200
Discharge medication for the 'frail elderly'.	£394,200
Discharge information for GPs	£246,375
GP e-messaging	£394,200
Discharge pre-mid-day	£320,288
Provision of accessible discharge plan	£219,000
Communication and access	£219,000
Improve elective LD pathway	£219,000

NHSE CQUINs	Forecast full year income
Enhanced supportive care for advanced cancer	£432,500
Cancer dose banding	£324,262
Clinical utilisation review tool	£176,000
Adult critical care timely discharge	£0
Patient activation management	£324,262
Telemedicine	£378,306
Discharge CQUIN: Discharge by mid-day	£175,642

NHSE CQUINs	Forecast full year income
Discharge CQUIN: Reasons for delays to discharges	£243,197
Nutrition & hydration management	£175,642
Nutrition and hydration – on ONS	£183,749
Local critical care CQUIN	£162,131
Reduction in unnecessary appointments	£172,940
Reduction in Did Not Attends (DNAs)	£194,557

Further details of the agreed goals for 2016/17 and for the following 12-month period are available on request from:

Performance Department
2nd Floor Central,
250 Euston Road
London, NW1 2PG

Email: directors@uclh.nhs.uk
Phone: 020 344 79974

1.6.9 Care Quality Commission (CQC) registration and compliance

UCLH is required to register with the Care Quality Commission (CQC) and its current registration status that all UCLH locations are fully registered with the CQC, without conditions.

The CQC has not taken enforcement action against UCLH during 2016/17.

UCLH has contributed to a number of inspections of linked providers by the CQC during the reporting period. These included the inspection of the Gamma Knife Centre at NHNN in November 2016, the City of London Children Looked After and Safeguarding Review in October 2016 and the inspection of Independent Ambulance Services in December 2016.

We underwent the first inspection of our core services that provided a 'rating' for UCLH in March 2016. The services inspected were:

- Medical care
- Urgent and emergency services
- Surgery
- Critical care
- OPD and diagnostic imaging
- Children and young people
- Maternity and gynaecology

The inspection rated UCLH overall as 'good'. No services were rated as 'inadequate' but there were five areas that 'require improvement' for which action plans are in place. Further detail is available in section 1.2.1.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

1.6.10 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, coding improvement and medical records improvement groups.

1.6.11 NHS number and general medical practice code validity

UCLH submitted records during 2016/17 (December) to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 96.3 per cent for admitted patient care
- 96.1 per cent for outpatient care
- 80.4 per cent for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 95.4 per cent for admitted patient care
- 96.1 per cent for outpatient care
- 80.7 per cent for accident and emergency care

1.6.12 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 UCLH Information Governance Assessment Report overall score for 2016/17 was 80 per cent and was graded green.

1.6.13 Clinical coding error rate

UCLH was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

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 will be taking the following actions to improve data quality:

- The continuation of a systematic training and audit cycle that underpins high quality coding within the coding department
- Ongoing engagement with clinicians and clinical divisions in the validation of coded activity ensuring accuracy between coding classifications and clinical care provided
- Clinical coding engagement programmes and roadshows to maintain coding awareness and support activity recording standards
- Peer comparative benchmarking to ensure coding quality continues to fall within the upper performance decile

Annex 1: Statement from Commissioners and Healthwatch

Statement from NHS Camden Clinical Commissioning Group

Camden Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from University College London Hospitals (UCLH) NHS Foundation Trust on behalf of the population of Camden and surrounding boroughs. Camden CCG has worked closely with UCLH to ensure we have the right level of assurance in relation to these commissioned services. During 2016/17 we have undertaken quality assurance visits in UCLH and seek assurance regarding the quality of services at the Clinical Quality Review Group (CQRG) meetings.

CCG welcomes the opportunity to provide this statement on UCLH Trust's Quality Accounts.

We have taken particular account of the identified priorities for improvement for UCLH and how this work will enable real focus on improving the quality and safety of health services for the population they serve. We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in April 2017). We confirm that the document received complies with the required content as set out by the Department of Health or where the information is not yet available a place holder was inserted. 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 shared with NHS Islington, NHS North West London CCGs, NHS Haringey, NHS Enfield and NHS Barnet Clinical Commissioning Groups, NHS England and by colleagues in NHS North and East London Commissioning Support Unit for their review and input.

It is assuring to see the significant work the Trust has undertaken in the early identification, treatment and ongoing management of patients where sepsis has been identified. UCLH has worked in collaboration with UCLPartners, to review the current evidence base to inform their clinical guidelines in the treatment of adult and paediatric patients diagnosed with sepsis. The Trust held a Sepsis Masterclass in March 2017 to showcase this work, with internal and external clinical colleagues. We are pleased to see that this remains a Trust priority for 2017/18.

As part UCLH's ongoing priority to reduce harm by early recognition of the deteriorating patient, we expect the Trust to at least maintain their 2016/17 performance in relation to the monitoring and recording of patient vital signs.

Whilst we recognise the work undertaken by UCLH to reduce avoidable harm during 2016/17, it is disappointing to note that the Trust has reported five Never Events. We expect to see significant improvements throughout the coming year and in reducing avoidable harm to patients.

UCLH have committed to establishing a patient safety committee which will facilitate organisational wide learning from all incidents and near misses. This work will be further enhanced by the Trusts commitment to undertake a minimum of 18 surgical safety walkarounds across all hospital sites during 2017/18, using observational measures to provide assurance that 5 Steps to Safer Surgery methodology (5SSS) is being applied consistently.

UCLH has enhanced the method for collecting real time patient feedback through the procurement of a new system. We envisage this will help support patient experience as the system allows for surveys to be completed in any language, has a 'read aloud' function in different languages, a test resizer and colour contract options which are compliant with the NHS Accessible Information Standard.

We acknowledge the work undertaken to support patients at meal times through the provision of dining companions within some areas of the hospital. UCLH accept that this work needs to be strengthened across the organisation to ensure that all patients are getting the help they need at meal times.

It is recognised by the Trust that failure to share relevant information with other health care professionals or patients may lead to delays in safe discharge and may impact on patient safety. UCLH has sought to address this through the introduction of the Exemplar Discharge Programme. Camden CCG expect to see improvements in discharge planning and a provision of appropriate information provided to patients, their carers/families, and other health care professionals as part of this programme.

UCLH has acknowledged that they need to improve the time taken to respond to complaints to allow for timely learning and service changes to be implemented. Camden CCG continue to monitor against the Trust trajectory at CQRG. UCLH have noted that they need to continue with improving patient experience in relation to waiting times. It is expected that UCLH has robust business continuity plans which are regularly reviewed and reflect the changing service requirements to support patient flows.

There are still areas for improvements to be made, such as information technology, data quality, discharge communication and e-Referral systems, and as commissioners, we will continue to work with UCLH. At the time of writing this statement, Camden CCG cannot authenticate the achievement of 2016/17 CQUINs.

Overall, this is a positive Quality Account and

we welcome the vision described and agree on the priority areas.

Statement from Healthwatch Camden, incorporating comments from North Central London Joint Health Overview and Scrutiny Committee

We congratulate all at UCLH for another strong year, including a patient safety award and a CQC 'outstanding' rating for 'well-led' in surgery. The Quality Account provides a recognition that UCLH has many areas of good or excellent clinical practice and has clearly identified throughout this report areas where improvement needs to be made. One area where it is less clear is on how improvements within the A&E service would be made and tracked over the next year, in response to the CQC rating of UCLH in 2016 which identified the A&E as requires improvement in 3 out of the 5 areas.

We note that patient satisfaction issues will remain a priority for the coming year. We are pleased to see a focus on patient experience. We were disappointed that improvements in the specific measures set for the current year have not been achieved. Under the heading of Patient Experience, the Trust is actually doing reasonably well with the area of concern with the Transport service problems having already been identified as issues relating to a new provider and actions put in place. The Friends and Family test is a useful starting point but the Trust could look at further ways of exploring patient issues in more depth. We think that all the work on patient experience could be supplemented by a stronger sense of working in partnership with patients – the remedial measures described all sound like staff working to come up with solutions for patients, rather than staff and patients working together to design solutions.

We have highlighted issues around equal treatment in the past, and we note that this issue was also highlighted by CQC. We are pleased to see further efforts to ensure that patients who are 'flagged' as having dementia or learning disabilities get the tailored treatment that they need.

We have highlighted issues with outpatient appointments in the past, and we are pleased to note a programme of work to address the problems identified, including the use of a Check and Track system to monitor the time people spend in Outpatients. We know that referral to treatment times continue to be a challenge in some specialisms. We hope that the system improvements you are introducing will help to get these back on target.

We note the initiative to increase staff awareness of complaints. We also note that a high percentage of people whose complaint is not upheld then approach the Ombudsman for help. At Healthwatch Camden we are contacted by some of these patients, who often say that their poor experience is compounded by a slow or unfeeling response. We cannot emphasise strongly enough the value of swift and sympathetic complaints responses, even where the decision is not to uphold a complaint.

The NCL JHOSC made some specific comments on Patient Safety:

This had clear areas of concern within it however the graphs and explanation on' near misses' didn't fully explain the assumption that the increased rate of reporting was down to better reporting or whether this indicated an actually rise in near misses. The fact that actual rate of harm was down by 50 per cent was given as proof that this is the case however, near misses are different to actual harm being done. Further analysis of the near misses would be helpful within this report to make this clear.

Under Patient Safety, sepsis is identified as a clear issue and a proactive approach to identifying the risk of sepsis early on is clear but, as the Trust identifies, there seems to be problems in measuring this outcome as the patient numbers are too small. One easily identifiable measurement is' Improve average compliance with provision of antibiotics within 1 hour of diagnosis for all sepsis patients from our 2016/17 baseline average of 56 per cent to 61per cent (a 10per cent increase)' This appears to be a low target as administration of antibiotics within the hour of diagnosis would seem to be a 'must'.

UCLH note: Please note this statement is in response to an early draft allowing 30 days to respond (as required by the legislation). Therefore some of these comments have already been addressed.

Annex 2: Statement of Directors' Responsibilities

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period 1 April 2016 to 24 May 2017
  - Papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017
  - Feedback from the commissioners dated 16 May 2017
  - Feedback from the governors between 25 November 2016 and 17 May 2017
  - Feedback from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee dated 11 May 2017
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23 September 2016
  - National patient survey dated January 2017
  - National staff survey dated 7 March 2017
  - The head of internal audit's opinion over the trust's control environment dated 23 May 2017
  - CQC inspection report dated 15 August 2016
- 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;
- here are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report

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

By order of the Board

Chairman
23 May 2017

Chief Executive
23 May 2017

Annex 3: External audit limited assurance report

Independent auditor's report to the council of governors of University College London Hospital 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 2017 (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 2017, 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, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement ("NHSI"):

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

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' and supporting guidance issued by NHSI.

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' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; 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 supporting guidance 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 supporting guidance, 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:

- Board minutes and papers for the period 1 April 2016 to 24 May 2017
- Papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017
- Feedback from the commissioners dated 16 May 2017
- Feedback from the governors between 25 November 2016 and 17 May 2017
- Feedback from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee dated 11 May 2017
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23 September 2016
- National patient survey dated January 2017
- National staff survey dated 7 March 2017
- The head of internal audit's opinion over the trust's control environment dated 23 May 2017
- CQC inspection report dated 15 August 2016

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;
- reviewing the process flow of the indicator with management;
- 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' and supporting guidance to the categories reported in the quality report; and
- 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 affect 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 of these criteria, 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 and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

As set out in the Review of Quality Performance section of the Trust's Quality Report, the Trust identified a number of issues in the referral to treatment within 18 weeks for patients on incomplete pathways indicator and percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator reporting during the year that was supported by our testing.

Issues identified for 18 week referral to treatment included:

- the clock having started on the wrong date due to an input error in one case
- the duplication of a pathway in one case in the reporting metric
- a systemic issue being identified, which impacts a large portion of the population, with 2 cases identified where pathway clock starts being sent from local referral management centres were incorrect by a few days, leading to pathway times and breaches being understated. The Trust has been aware of this issue from its own internal audit work and is working with the referral management centres and NHS Digital to understand the cause of the issue and then consider the best way of resolving.

As a result of the issues identified, we have concluded that there are errors in the calculation of the 18 week Referral-to-Treatment incomplete pathway indicator. We are unable to quantify the effect of these errors on the reported indicator for the year ended 31 March 2017.

Issues identified for A&E four hour wait included:

- Our testing identified that the trust does not retain an audit trail for adjustments made following validation of apparent breaches;
- Instances where supporting documentation was

not available to substantiate the discharge date and time;
- Patient files indicating journey times after the discharge time noted on CareCast
- Seven files not being available for testing.

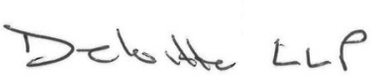
As a result there is a limitation upon the scope of our procedures which means we are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting A&E four hour waiting times for the year ended 31 March 2017. Furthermore, we are unable to quantify the effect of the errors identified on the reported indicator for the year ended 31 March 2017.

The Trust's Quality Report summarises the actions the Trust is taking post year end to address the issues identified in relation to the documentation of its validation processes.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement Detailed requirements for quality reports for Foundation Trusts 2016/17; 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' and supporting guidance.



Deloitte LLP
Chartered Accountants
St Albans
23 May 2017

Annex 4: Glossary of terms and abbreviations

- **Acute Kidney Injury (AKI):** A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days.
- **After action review (AAR):** A structured review or de-brief process for analysing what happened, why it happened, and how it could be done better
- **BadgerNet:** A live patient database used by most of the neonatal units in the UK.
- **Care Quality Commission (CQC):** The independent regulator of all health and social care services in England
- **Cardiac Arrest:** A collapse when the heart stops beating
- **Carter productivity programme:** Operational productivity and performance in English
- **NHS acute hospitals:** Unwarranted variations An independent report for the Department of Health by Lord Carter of Coles
- **CDR- Clinical Data Repository:** Where we store all patients' details electronically
- **CHKS:** A provider of healthcare intelligence and quality improvement services, using data from the NHS Secondary Uses Service to enable trusts to review performance and benchmark
- **CNS:** Clinical nurse specialist
- **Commissioners:** The local and national bodies contracting to buy care for UCLH patients
- **Complaints:** A complaint is upheld (fully agreed) by UCLH when it is agreed that action(s) need to be taken to prevent the subject of the complaint occurring again. It is partially upheld (partly agreed when some aspects of the complaint require action and not upheld (not agreed) when no action is required. Patients are always offered an apology.
- **CQUIN:** Commissioning for Quality and Innovation –a framework that allows commissioners to make payments to hospitals for agreed improvement work
- **Deteriorating patient:** An evolving, predictable and symptomatic process of worsening physiology towards critical illness (worsening of the patients' condition)
- **Discharge to Assess (D2A):** A service run by NHS England Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
- **Duty of candour:** The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out the legal obligation for health service bodies to act in an open and transparent way in relation to care and treatment provided. The aim of the legislation is to ensure that patients/their families/representatives are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences.
- **DNACPR:** Do not attempt cardio-pulmonary resuscitation
- **Essence of care audits:** DOH guidance on standards of care which should be delivered to patients
- **Exemplar Ward:** A ward accreditation scheme that seeks to measure and celebrate excellence in ward standards.

5 Steps to Safer Surgery (5SSS): The 5SSS should be performed for every patient undergoing an invasive procedure, and are designed to improve performance at safety critical time points within the patient's intraoperative care pathway. The five checks are:

- **Team brief** – the team to identify themselves and their role, discuss what procedures are planned, what is required and what problems may be anticipated to ensure that any issues may be dealt with early
- **Sign in** – includes confirmation of correct patient identity and procedure prior to anaesthesia or sedation
- **Time out** – the theatre team make final checks prior to the procedure commencing
- **Sign out** – to check that all information has been recorded, equipment, swabs and specimens are accounted for and to ensure there is an ongoing plan for patient care
- **Team debrief** – to discuss what went well, what needs attention and any learning

- **Friends and Family Test (FFT):** Is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
  It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

Harm definitions

- **No Harm:** Incident reported but no harm was experienced by the person involved/affected
- **Low harm:** Person affected required extra observation or minor treatment as a result of the incident
- **Moderate harm:** Person affected required a moderate increase in treatment; the incident caused significant but not permanent harm to the person. Moderate increase in treatment includes an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care)
- **Prolonged psychological harm:** Incident that appears to have resulted in psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days
- **Severe harm:** Incident that appears to have resulted in permanent harm to the person affected. This means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage that is related directly to the incident and not related to the natural course of the person's illness or underlying condition
- **Death:** Incident that directly resulted in the death of the person affected rather than as a result of their underlying medical condition

- Hot debriefs: Carried out immediately after an incident or event to obtain immediate feedback from staff or partner agencies participating in the incident/event

- **Incident classification:** For incidents counted under 'surgical incidents' for University College Hospital's theatres (see reduction of surgical harm priority)

  - List order changed
  - Consent form not signed by patient
  - Anaesthetics – difficult/failed intubation
  - Intra/post operatively – foreign body left in situ post procedure
  - Intra/post operatively – incorrect surgical procedure
  - Intra/post operatively – incorrect surgical site
  - Intra/post operatively – swab/needle/ instrument count issue
  - Operation performed on incorrect patient
  - Incorrect implant prosthesis
  - Observations not acted upon
  - Verbal communication – general poor communication
  - Verbal communication – interpreter not available
  - Verbal communication – within the MDT
  - Written communication – incorrect information
  - Written communication – procedure or process issue
  - Equipment checks not completed

- **Incident classification:** For incidents with harm caused by unrecognised patient deterioration

  - Observations not acted upon
  - Failure to rescue
  - In-hospital cardiac arrest
  - Delay due to abnormal observations not acted upon
  - Delay in resuscitation
  - Unexpected outcome/deterioration/death

- **Improving care rounds:** At UCLH, multidisciplinary and multi-level teams visit a clinic, ward, or facility to observe with fresh eyes and give feedback, using the same questions as the Care Quality Commission (Is care safe, effective, caring, responsive and well led?)
- **Matron quality rounds:** Quality, environmental and patient/staff experience reviews by groups of UCLH Matrons, outside of their own clinical areas, with instant feedback via a 'huddle'.
- **NHSI:** NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
- **Never Event -:** Patient safety incidents which have the potential for, or cause severe harm, and which should not occur if relevant preventative measures are put in place.
- **Ombudsman:** The Parliamentary and Health Services Ombudsman can consider complaints against NHS trusts which local processes have failed to resolve
- **Patient pathway:** The route that a patient will take from first contact with the NHS, through referral, to the completion of treatment.
- **PERRT:** Patient Emergency Response and Resuscitation Team
- **Problem scores (Picker survey):** Shows the percentage of patients for each question who, by

their response, indicated that a particular aspect of their care could have been improved. Problem scores are calculated by combining response categories. Lower scores are better.

- **Root Cause Analysis (RCA):** An investigation into why specific patient safety incidents happen and identify areas for change to make care safer
- **Safety huddles:** Daily meetings on the ward to highlight safety and quality issues and promote discussion among team members.
- **SBAR:** A communication tool process to improve providing information and decision-making when urgent referrals are made - Situation, Background, Assessment and Recommendation.
- **Shelford:** The Shelford Group is made up of 10 leading NHS multi-specialty academic healthcare organisations. They are dedicated to excellence in clinical research, education and patient care.
- **Summary hospital-level mortality indicator (SHMI):** The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It includes deaths, which occur in hospital, and deaths, which occur outside of hospital within 30 days (inclusive) of discharge. NHS Digital release the external SHMI every quarter but there is a six-month time lag.
- **SSI:** Surgical site infections

- **Text resizer, text simplifier and a screen ruler**- 'Envoy Browsealoud' lists their features as follows:

  - Text-to-speech with choice of reading speeds and highlighters to enhance reading comprehension
  - Translate web pages into 99 languages; speak translated text aloud in 40 languages
  - On-screen text magnifier helps users with visual impairments
  - MP3 generator converts text to audio files for offline listening
  - Screen mask blocks on-screen clutter, letting readers focus on text being read
  - Web page simplifier removes ads and other distracting content for easier reading
  - Custom settings that are built in to suit individual user needs and preferences

- **UCLH future:** UCLH programme that aims to improve patient and staff experience by embedding a culture of continuous improvement and innovation. The programme delivers this through introducing new ways of working, supported by significant investment in technology and staff development.
- **UCLH trust values:** Safety, kindness, teamwork, improving

- **Vital Signs:** describes six physiological parameters:(measurements)
  1. Respiratory rate
  2. Oxygen saturation
  3. Pulse rate,
  4. Blood pressure
  5. Level of consciousness
  6. Core body temperature
  7. The requirement for supplemental oxygen (by mask or nasal cannulae)

- **VTE:** Venous thromboembolism (blood clot)
- **WHO Surgical Safety Checklist:** Safety checks before anaesthesia ("sign in"), before the incision of the skin ("time out") and before the patient leaves the operating room ("sign out").

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We are committed to delivering top-quality patient care, excellent education and world class research

Safety
Kindness
Teamwork
Improving