Croydon Health Services NHS

NHS Trust

Quality Account 2016-17

Contents

INTRODUCTION

Getting to "Good" if not better

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

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

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

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

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

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

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

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

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

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

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

Mike Bell
Chairman

PART 1
INFORMATION ABOUT THE QUALITY ACCOUNT

Statement on quality from the Chief Executive

Proud of Croydon Health Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

John Goulston
Chief Executive

Executive summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key achievements last year

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

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

Examples of good practice include

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

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

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

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

We achieved Joint Advisory Group (JAG) accreditation.

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

We were featured in NHS 100 stories for LiA work.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• Viewing it on NHS Choices

• Viewing it on Croydon Health Services NHS Trust website

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

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

PART 2

Priorities for improvement and statement of assurance from the Trust Board

Priorities for Improvement 2017/18

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

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

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

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

Priorities 2017/18

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

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

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

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

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

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

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

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

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

Statement of Directors responsibilities in respect of the Quality Account

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

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

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

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

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

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

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

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

Chairman **By order of the Board Chair**

Mike Bell **28 June 2017**

Statement of assurance from the Board of Directors

Review of Services

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

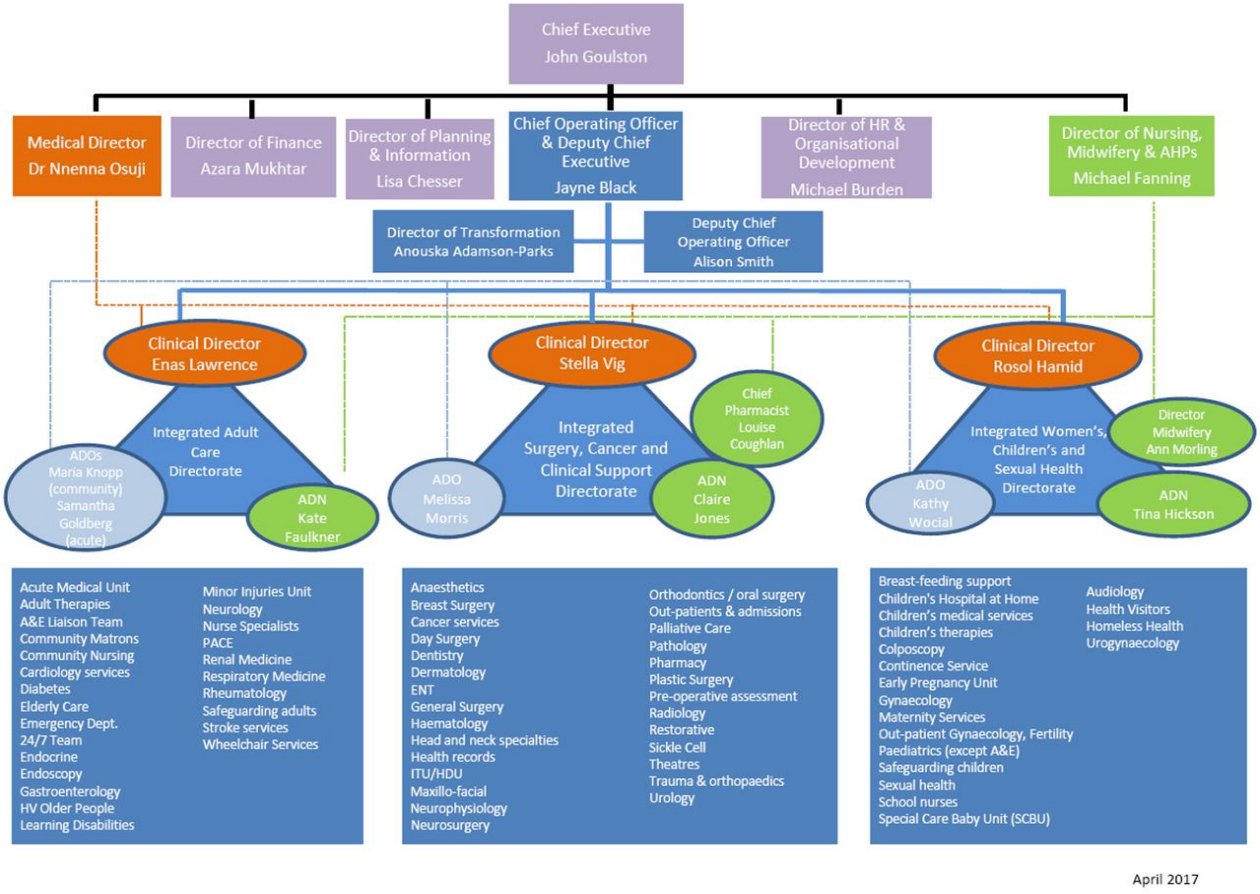
There are three Clinical Directorates within the Trust and each Directorate reviews service provision through Quarterly Quality and Performance meetings with the Chief Operating Officer and reporting to the Quality and Clinical Governance Committee, monthly Quality Boards and Clinical Governance meetings.

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

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

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

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



April 2017

Service and quality accreditations

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

Participation in national clinical audits and National Confidential Enquiries

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

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

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

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

The national clinical audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Some areas have been marked as in progress and this means that the data is currently being submitted which includes the data gathered during the period of 2016/17.

National Audits participation

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

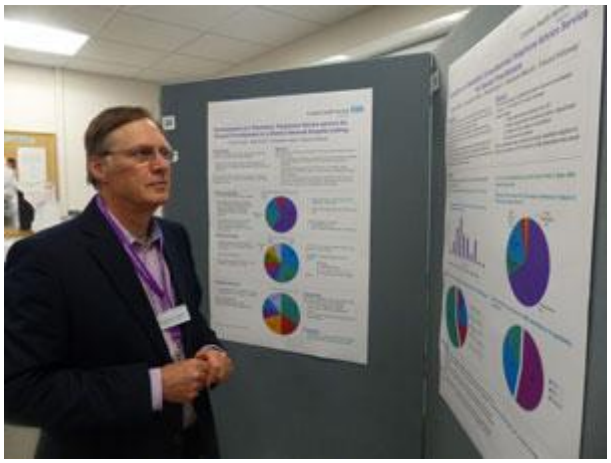
National Clinical Audit for inclusion in quality report	Data collection completed in 2016/2017	Number of cases submitted	% submitted
programme: 2015 PBM in patients undergoing elective, scheduled surgery			
National Diabetes Audit-Adults	√	32	100%
National Emergency Laparotomy Audit (NELA)	√	85	100%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

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

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

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

Research 2016 - 2017



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The National CQUINS for 2016/17 were as follows:

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

Local CQUINS agreed

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

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

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

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

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

Statements from the Care Quality Commission (CQC)

Overall rating	Requires Improvement

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

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

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

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

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

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

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

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

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

Health and Safety Executive

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

Patient Led Assessment in the Care Environment audit (PLACE)

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

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

Data Quality

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

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

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

Information Governance

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

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

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

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

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

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

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

Reporting against core indicators (Department of Health mandatory indicators

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

Reporting against core indicators (Department of Health mandatory indicators)

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

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

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

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

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

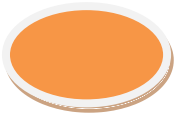
Part 3
Review of Quality Performance 2016-17

Review of Quality priorities 2016-17

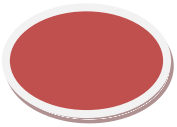
This section demonstrates the Trust's achievements throughout 2016-17 in the areas of patient safety, clinical effectiveness and patient experience. Performance against the priorities in our 2016 -17 Quality Account is included in each section.

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

indicates that we met our objectives for the year



made good progress but did not quite reach our objective



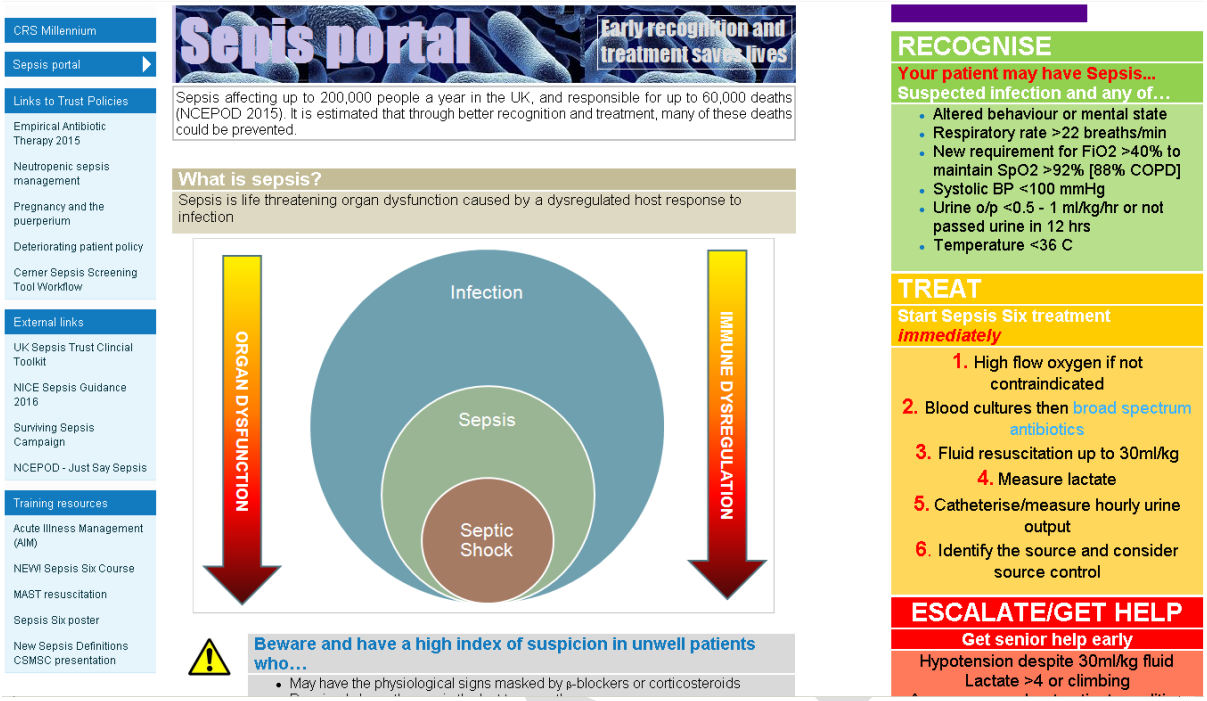
means we did not meet the objective and further work is required and will be undertaken

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

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

Sepsis Task force

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



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

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

Medications safety

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

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

Maintaining improvement with Harm Free Care

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

Pressure ulcers

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

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

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

This has been achieved by:

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

Greater number of patients assessed for risk of malnutrition.

Sustained improvement in the reduction of falls

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

Overall Croydon performed well against other Trusts regarding:

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

- Mobility assessments undertaken
- Call bell within reach

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

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

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

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

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

Reduce catheter infections

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

100% root cause analysis completed on VTE

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

Maintaining low hospital standardised mortality ratios

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

Monitoring how patient's food and nutritional needs are met

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

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

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

There have been a number of achievements to date:

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

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

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

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

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

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

The Saving Babies’ Lives Care Bundle consists of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improvement in Paediatric Surgery where by:

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

Improvement in Paediatric Medicine:

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

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

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

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

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

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

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

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

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

Improving our Friends and Family Test response rate

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

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

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

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

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

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

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

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

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

Refurbishment of theatres - full business case in place

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

90% of staff receives up to date training in safeguarding

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

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

Performance against national priorities

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

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

Infection control

C. difficile target

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

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

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

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

MRSA target

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

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

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

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

Influenza and Norovirus

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

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

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

GRE (Glycopeptide Resistant Enterococci)

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

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

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

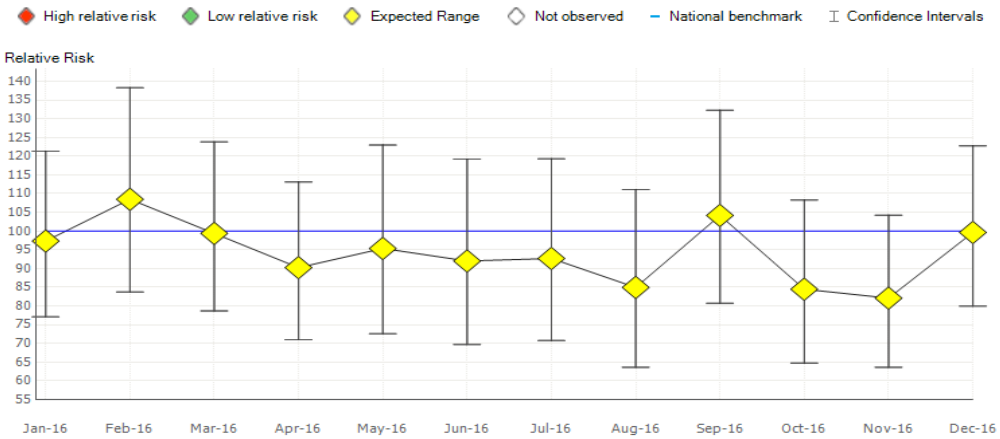
Mortality

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

According to the most recent Dr Foster report,

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

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



CQC Mortality Outlier Alert

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

Progress update following Mortality reviews

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

Patient Safety Incidents

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

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

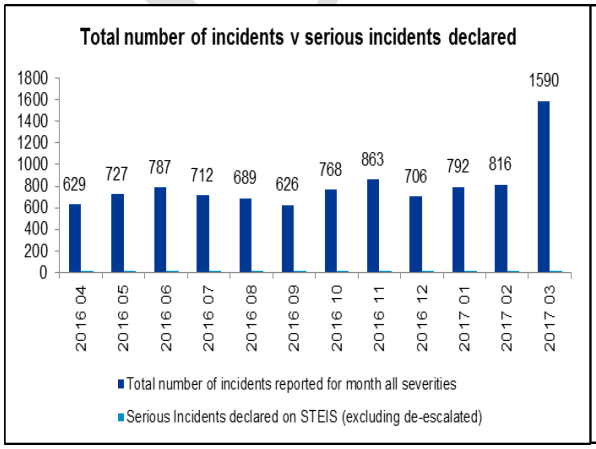
The Trust's Datix system is electronically linked to the National Reporting and Learning System (NRLS) and patient safety incidents are uploaded to this central reporting and analysis centre. Local investigation of all adverse events is supported within the Trust to ensure that appropriate challenge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

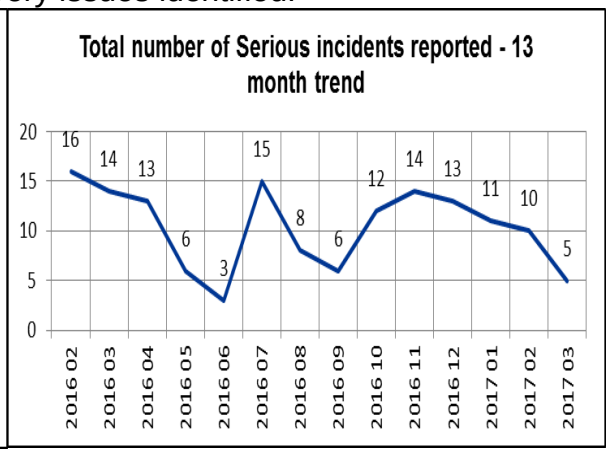
The Datix incident report form captures information to drive the quality and usefulness of safety information captured such as:

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

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

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





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

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

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

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

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

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

Duty of Candour

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

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

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

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

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

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

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

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

Friends and Family Test

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

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

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

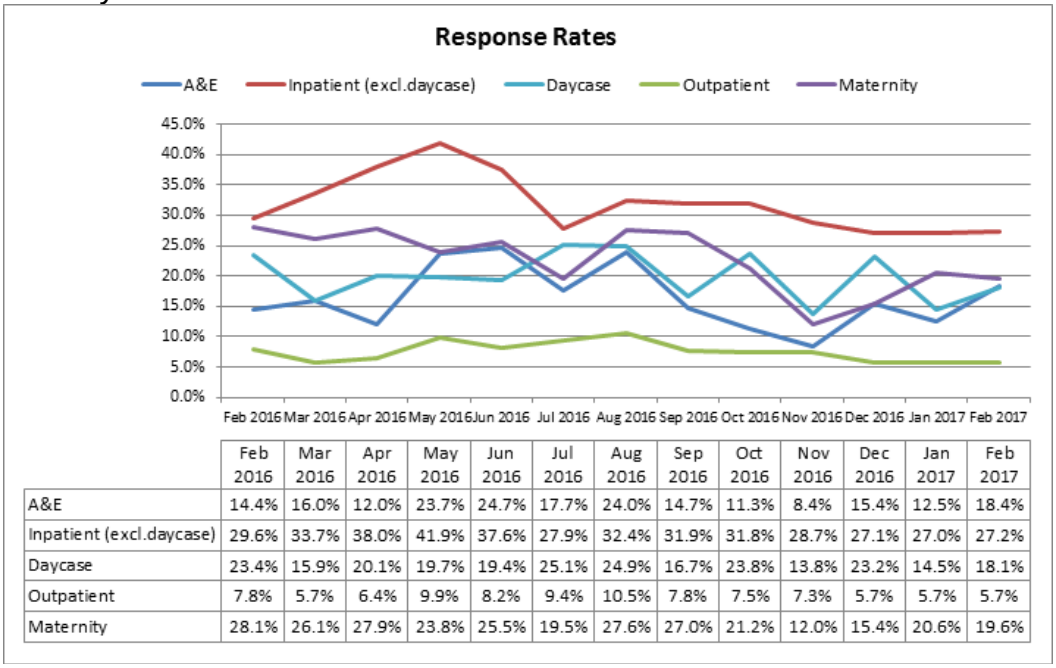
Internal standards for the Friends and Family Test Response Rates

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

Day Cases	20%

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

Monthly data for each CBU is reviewed at directorate level



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

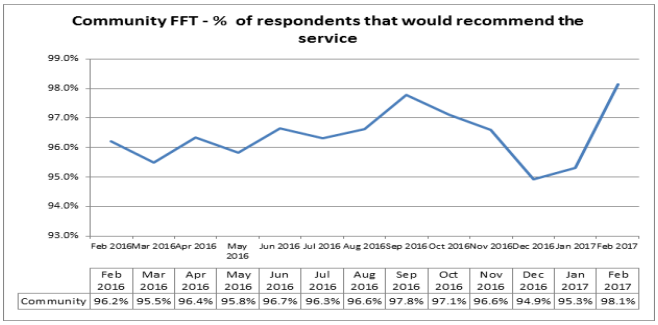
FFT results across the trust are monitored locally by Knowing How We're Doing (KHWD) methodology and results and actions are displayed publicly

Community Services FFT results February 2016

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

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

The recommendation rates are consistently good across services.



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

Improvement Actions

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

These include:

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

Staff Friends and Family Test (FFT)

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

PALS and Complaints

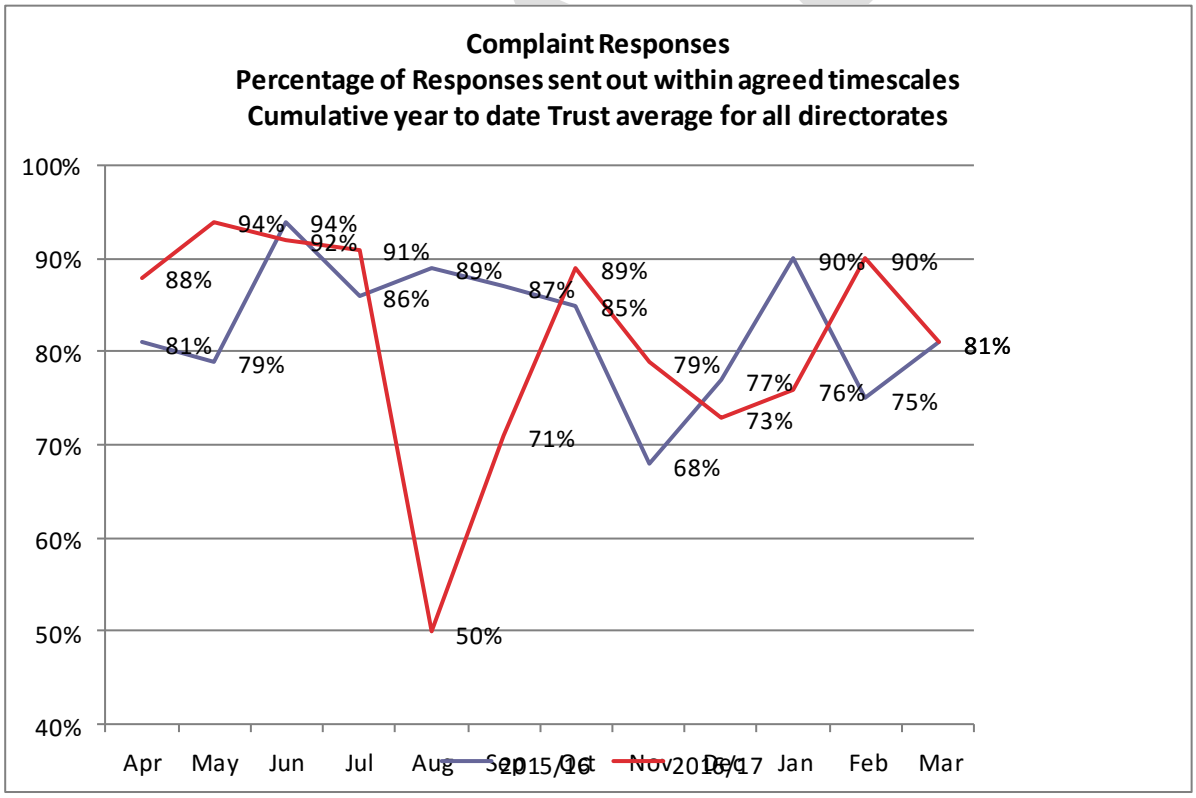
PALS

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

Complaints

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

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



Safe Staffing

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

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

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

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

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

Recruitment

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

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

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

**excluding Medical and Dental Staff*

E-roster

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

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

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

Volunteers

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

Staff Survey

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

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

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

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

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

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

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

Equality and Inclusion

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

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

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

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

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

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

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

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

Freedom to speak up Guardian

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

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

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

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

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

Emergency Department

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

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

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

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

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

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

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

Cancer Waits

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

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

New developments for Macmillan cancer team:

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

Listening into Action (LiA)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children’s services

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

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

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

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

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

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

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

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

International Nurses' Day

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

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

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

Chaplaincy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Iron deficiency anaemia (IDA)

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

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

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

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

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

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

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

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

Health Visiting Team for Older People Service

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

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

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

Croydon Stars

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

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

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

Statement from Croydon Clinical Commissioning Group

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

Statement from healthwatch Croydon

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

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

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

Statement from External Auditors

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

External Visits Summary Report for April 2016 – March 2017

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

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

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

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

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

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

KEY

Details of specific actions undertaken from the national clinical Audit

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

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

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

Local Clinical Audit

Specific actions being implemented from clinical audits

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

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