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Scrutiny Health & Social Care Sub-Committee Agenda

To: Councillors Sean Fitzsimons (Chair), Andy Stranack (Vice-Chair), Patsy Cummings, Clive Fraser, Andrew Pelling, Scott Roche and Gordon Kay (Healthwatch Croydon Co-optee)

Reserve Members: Jan Buttinger, Felicity Flynn, Toni Letts, Stephen Mann, Helen Redfern and Callton Young

A meeting of the **Scrutiny Health & Social Care Sub-Committee** which you are hereby summoned to attend, will be held on **Tuesday, 25 June 2019** at **6.30 pm** in the **Council Chamber - Town Hall.** A pre meet for Members only will take place in Room F4 at 6:00pm

Jacqueline Harris Baker
Council Solicitor & Monitoring Officer
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Simon Trevaskis
02087266000
simon.trevaskiss@croydon.gov.uk
www.croydon.gov.uk/meetings
Monday, 17 June 2019

Members of the public are welcome to attend this meeting.
If you require any assistance, please contact the person detailed above, on the righthand side.

N.B This meeting will be paperless. The agenda can be accessed online at www.croydon.gov.uk/meetings

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 10)

To approve the minutes of the meeting held on 13 May 2019 as an accurate record.

3. Disclosure of Interests

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality to the value of which exceeds £50 or multiple gifts and/or instances of hospitality with a cumulative value of £50 or more when received from a single donor within a rolling twelve month period. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Democratic Services representative at the start of the meeting. The Chair will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

4. Urgent Business (if any)

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

5. South London & Maudsley NHS Foundation Trust (Pages 11 - 74)

The Sub-Committee are presented with a copy of the Quality Report for the South London and Maudsley NHS Foundation Trust (SLaM) for noting.

An update on will also be provided on Slam's priorities for the forthcoming year.

6. Croydon Health Service NHS Trust (Pages 75 - 182)

The Sub-Committee are presented with a copy of the Quality Accounts for the Croydon Health Service NHS Trust for noting.

An update on will also be provided on their priorities for the forthcoming year.

7. Healthwatch Croydon - How Do I Register (Pages 183 - 218)

To receive a report from Healthwatch Croydon on their recent work on patient registration at GPs surgeries in Croydon.

8. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

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

PART B

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Scrutiny Health & Social Care Sub-Committee

Meeting held on Monday, 13 May 2019 at 6.30 pm in Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX

MINUTES

Present:	Councillor Sherwan Chowdhury (Chair), Councillor Andy Stranack (Vice-Chair), Pat Clouder, Andrew Pelling and Scott Roche
Also Present:	Councillors Jamie Audsley, Jane Avis, Sean Fitzsimons, Joy Prince Louisa Woodley
Apologies:	Councillor Toni Letts

PART A

9/19 **Minutes of the Previous Meeting**

The minutes of the meeting held on 26 March 2019 were agreed as an accurate record.

10/19 **Disclosure of Interests**

There were no disclosures of interest made at the meeting.

11/19 **Urgent Business (if any)**

There were no items of urgent business.

12/19 **Working together for a healthier Croydon - Update for Health & Social Care Sub-Committee**

The Sub-Committee received a presentation on the proposed changes at the Croydon Clinical Commissioning Group (CCG) and Croydon Health Service (CHS) as a result of the NHS Long Term Plan.

The Chair welcomed the following representatives who were in attendance at the meeting for the discussion of this item:

Attendees from the Clinical Commissioning Group

- Doctor Agnelo Fernandes – Clinical Chair
- Andrew Eyres – Accountable Officer
- Elaine Clancy – Joint Chief Nurse
- Martin Ellis – Director of Primary Care and out of Hospital

Attendees from Croydon Health Service

- Mike Bell – Chair

- Doctor Nnenna Osuji - Medical Director

Attendees from Croydon Borough Council

- Guy Van Dichele – Executive Director for Health, Wellbeing and Adults

Mike Bell & Doctor Agnelo Fernandez delivered the presentation to the Sub-Committee, during which the following was noted:-

- The NHS Long Term Plan was published in January 2019, a key part of which was an emphasis being placed on delivering integrated care systems. Arising from this the Government agreed to provide local health authorities with a guaranteed five year financial settlement on the proviso that they produced a ten year plan detailing how integration would be achieved.

- There would be a joint meeting of CHS and CCG on 14 May to present the ideas behind the plan to the public, which would include the publication of the strategic case for greater alignment of the two organisation.

- There was also a proposal for the Croydon CCG to become part of the wider South West London CCG. Should this happen, it was envisioned that 80-90% of decision making relating to care in the borough would still be taken at a local level.

- The alignment of the CCG and CHS was seen as a fundamental stepping stone, which would present a significant opportunity to take out costs from within the system from reducing duplication. From 1 April 2019 the two organisations had produced a joint budget, operational plan and a financial savings targets.

- To ensure joint decision making a number of joint management executive posts would be created, which would create savings that would be transferred to frontline services. Elaine Clancy was the first of the joint managerial appointments as Joint Chief Nurse.

- Work had begun on bringing the safeguarding teams together, which would deliver improved services and savings through a reduction in duplication.

- It was important that any changes made were focussed upon improving the quality of care and the long term health of residents in Croydon.

- The LIFE (Living Independently for Everyone) scheme had been successful. With over 1,000 referrals in the first year to either get patients home from hospital faster or avoid unnecessary hospital admission.

- The Integrated Care Networks (Huddles) had also been successful. This involved multi-disciplinary meetings to discuss the care of people with complex and escalating health needs. As a result of the Huddles there had been a 6% reduction in urgent and emergency admissions in over 65s. The Huddles were initially difficult to implement, but were now an embedded practice within the borough.

- The work of the One Croydon Alliance was gaining recognition outside of the borough and had resulted in the Alliance winning awards.

- It was acknowledged that there was a huge amount of change taking place as a result of the Plan and as such it was important that all staff were engaged throughout the process and given opportunities to input into the changes.

Following the presentation the Sub-Committee were given the opportunity to question the representatives on the Plan. The Chair highlighted that it would have aided the Sub-Committee's ability to scrutinise the Plan if a written report had also been provided setting out further information.

It was also questioned how the Sub-Committee would be able to scrutinise the changes as they progressed. It was advised that the partners welcomed the interchange with the Sub-Committee and were open to suggestions on how best to work together to improve the level of scrutiny going forward. It was agreed that it would be arranged for the leadership of the CHS and CCG to meet with the Chair and Vice-Chair of the Sub-Committee to plan a programme for the forthcoming year.

In response to a question about possible barriers to the plan, it was advised that Croydon was recognised as being ahead of other healthcare organisations in London in regard to the integration of services. The Healthy Care Partnership continued to be supportive and ensured that the maximum amount of resource was available.

Finance remained tight, but future progress was augmented by existing relationships developed through the One Croydon Alliance. These relationships had helped to ensure both health and social care was being planned jointly, enabling better services to be delivered for patients.

Given that it was proposed that the CCG would move to wider structure across South West London, it was questioned how Croydon would be able to ensure that its interests were represented, particularly when decisions were made on where to locate new services. It was advised that as part of the collaboration process across South West London it was envisioned that 80% of service decisions would still be made at a local level, with decisions relating to specialist services retained on a regional level as these were based on a number of factors including local need, geography and available workforce.

As Croydon was already implementing an integrated, place based leadership structure it would enable Croydon to have a strong voice in any discussion on future services, in comparison to other areas that were not as joined up. A

structure would be put in place to ensure that all partners had an input on decision making, which would include clinical representation from all the CCGs across South West London.

In response to a question about whether Croydon received its fair share of funding, it was highlighted that funding had previously been 10% under what was needed to deliver services. This had now been reduced to 4%, which was a more manageable level. As a follow up it was questioned whether there was a risk that the benefits of the savings targeted by Croydon CCG would be transferred to the South West London CCG. It was advised that the targeted 20% saving was from overall management costs within the CCG. It would be important to achieve the right balance in reducing governance to free up resources for transformational delivery.

A concern was raised about the feasibility of embedding joint working practices between CHS and CCG at the same time as the wider CCG restructure and as such it was questioned whether it would be possible to slow down this process until the CCG restructure had been completed. It was advised that slowing down the process would be likely to impact upon Croydon's voice in any discussion on services which was an integral part of the proposed collaboration.

In response to a question about the effect the changes would have on staff and their ability to feed into the change process, it was advised that the vast majority of staff would continue to do what they currently do. Work was ongoing to ensure staff were involved in the move towards an integrated structure, including regular communications and face to face meetings. There was also an event being organised in June that would give staff the opportunity to provide feedback on possible improvements. One potential benefit for staff was working as part of a larger organisation would provide greater opportunities for career progression.

It was questioned what the CCG and CHS were doing to ensure that the local community was aware of the proposed changes. It was confirmed that the organisations were working with the Council to mitigate some of these issues and it was important to ensure that people were able to engage in the process, should they want to. It was also important to continue to work with faith groups and community centres to disseminate information to the local community which would also help to ensure that they felt part of the change.

It was confirmed that the changes would not negatively affect patients having to travel either into or out of the borough for treatment. Where possible, services were planned around local pathways, but in certain instances such as emergencies, it was not always possible to do so.

In response to a question about how the new overarching South London CCG would be scrutinised, it was confirmed that work was currently underway on the governance structures, including scrutiny. Scrutiny was likely to be through either local authorities working together in a Joint Committee format or individually on a local level.

In response to a question about how the patient experience will be fed into the new structure, it was advised that the vision for locality care was being refreshed and to do so work was ongoing to engage with the population to design services for their needs. It was acknowledged that further work was needed to improve patient representation, but it was anticipated that there would be greater opportunities for the patient's voice to be fed into service design and experience.

It was questioned whether there was a risk that varying levels of service could be offered across the six boroughs in the proposed new structure. In response it was advised that devolution to local areas within the South West London CCG would allow local services to be designed to meet local need, but this would be informed by evidence and the use of data.

The Chair thanked the representatives from the CCG and CHS for their attendance at the meeting and the answers provided to the Sub-Committee's questions. An invitation was extended to return to future meetings with further updates as needed.

Conclusions:

Following the discussion of this item, the Sub-Committee reached the following conclusions:

1. The Sub-Committee recognised that the changes proposed as a result of the NHS Long Term Plan were significantly large in scale and agreed that further updates would be needed as the plans progressed.

2. The Sub-Committee welcomed both the CCG and CHS's openness to scrutiny and felt that this was to be commended. However there was disappointment about the level of detail provided in advance of the meeting.

3. The Sub-Committee was concerned about the 10%-20% decisions that were to be taken by the regional South West London CCG on specialist services and felt that further information on the new governance structure was needed to provide reassurance that Croydon had an equal voice in any such decision making.

4. The cost of the reorganisation was also a concern and it was agreed that the Sub-Committee would be provided with further information on the cost of implementing the changes once they were fully known.

5. The Sub-Committee agreed that it was essential that plans should continue to be discussed as far as possible with the Council to ensure that services could be aligned to reduce any unnecessary bureaucracy.

6. The Sub-Committee retained a concern that the unity created through the closer alignment of the CGG and CHS could be put at risk through the move of the CCG to a wider regional structure.

13/19 **Exclusion of the Press and Public**

This motion was not needed.

At the close of the meeting a motion was formally moved to extend a vote of thanks to the Chair in what was to be his last meeting in the role.

The meeting ended at 8.30 pm

Signed: .....

Date: .....

South London and Maudsley NHS Foundation Trust

Quality Report 2018/2019

Contents

Part 1: Statement on quality from our Chief Executive

It is my pleasure to introduce the 2018/19 Quality Report. The report is an important way for the Trust to communicate our commitment to improving the services we deliver to our service-users, their families, their carers and our local communities, and to report on progress with our Quality Priorities

As a large, diverse mental health trust providing local and national services, we aim to make a difference to lives by seeking excellence in all areas of mental health and wellbeing: prevention, care, recovery, education and research. This year we refreshed the Changing Lives strategy with five strategic aims; Quality, partnership, a great place to work, Innovation and Value to help achieve this aim. Our staff, service users and Governors helped us to select our Quality Priorities.

Each year we work with our commissioners, the CCGs, to agree funding available to provide mental health services in the boroughs we serve. The CCGs have worked with us to ensure that across Lambeth, Lewisham, Southwark and Croydon we have an increase this year that will enable us to invest in improving services and continue to work towards the quality and performance standards set out in the 5 year forward view, and more recently the Long Term Plan. This year the Trust has received a 6.6% uplift across all CCG contracts for 2019/20.

Our priority now is to work with services to ensure investments are made in the right place to have most impact for the people that use our services and for our staff. Of course, to make this new investment count we must continue to carefully manage our existing resources and to ensure that we deliver real value – better outcomes for every pound we have to spend – for the people we serve.

South London and Maudsley NHS Foundation Trust (SLaM) continued its leadership role in joint working at system-level, covering 3.6 million people, through the South London Mental Health and Community Partnership (SLP), alongside Oxleas and South West London and St George's. Particularly significant progress was made in improving Adult Forensic patients' experience and care outcomes; providing care locally for CAMHS Tier 4 patients previously placed outside south London; and developing skills and improving retention rates across the south London NHS mental health nursing workforce. The SLP's work continued to deliver millions of pounds of savings for reinvestment in local services through improved commissioning, new services and clinical pathways, and has been recognised for innovation and best practice in national awards and by NHSI, NHSE and CQC.

It is becoming clearer and clearer that we have a shared challenge within our local communities linked to mental health and emotional vulnerability which is approaching critical public health proportions. At the same time, we are on the cusp of being able to transform our understanding, identification and treatment of mental health issues in children and young people. A new partnership between SLaM, the Institute of Psychiatry, Psychology and Neuroscience (IoPPN), Kings Health Partners (KHP) and the Maudsley Charity is seeking to radically transform our understanding, identification and treatment of mental health problems in children and young people.

The project's vision is for an ambitious programme of research, clinical innovation and education across three key themes – mother and baby, brain development, and contemporary childhood. The programme will connect clinicians and researchers working across SLaM and the IoPPN in a range of localities. It will also support the creation of a brand-new centre at Denmark Hill. It will be supported in part by the Trust's first major fundraising campaign, which will launch in September 2019.

We are committed to working with our partners to commission and deliver integrated health and social care at a neighbourhood and community level and we have progressed the development of our two alliance contracts, the Lambeth Living Well Network Alliance and Partnership Southwark.

As part of the Lambeth Alliance we are formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council and Thames Reach. A key member of Partnership Southwark, we work alongside local GP federations and elements of Guy's and St Thomas' community services. We are continuing to work with partners to develop other population-scale contracts across both Lewisham and Croydon.

In 2018 we set Quality Priorities that are aspirational. This report is given at the end of year one. During the first year we have built the foundation from which to make change and as we go into the second year, in some areas, we are confident we are beginning to see positive change.

Finally, our workforce is our most valuable asset and it is imperative that all staff feel valued, supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high quality services by motivated and engaged staff and therefore the Trust Board has set the Organisation the challenge by Spring 2021 to improve the experience of our BME staff by setting some clear goals and objectives in this area, including improved representation of BME staff in senior positions and improved career opportunities. Although disappointed in the survey results, we see them as an invitation to redouble our efforts and lead positive change. We are confident in tour abilities in this regard.

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

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

Dr Matthew Patrick

Chief Executive Officer
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

Trust Vision

> Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all - locally, nationally and internationally.

Trust Strategy

During 2018 we refreshed our Trust Strategy which is named 'Changing Lives' because everything we do is to help people to improve their lives. The refreshed strategy was approved by the Board in September 2018 and launched in October 2018.

This strategy builds on the direction of travel set out in our previous strategy, with five strategic aims that include a strong focus on the quality of our services. These are:

Fig. 3: Trust strategic aims

2018/2019 quality priorities

The quality priorities set for 2018/2019 below incorporated the broader quality domains of patient safety, clinical effectiveness, and both patient and staff experience. Progress against these priorities are outlined later in this report. These areas continue to be priorities for 2019/2020.

Fig. 4: 2018/19 quality priorities

Care Quality Commission (CQC)

Below highlights the current Trust CQC rating; the overall rating is Good.

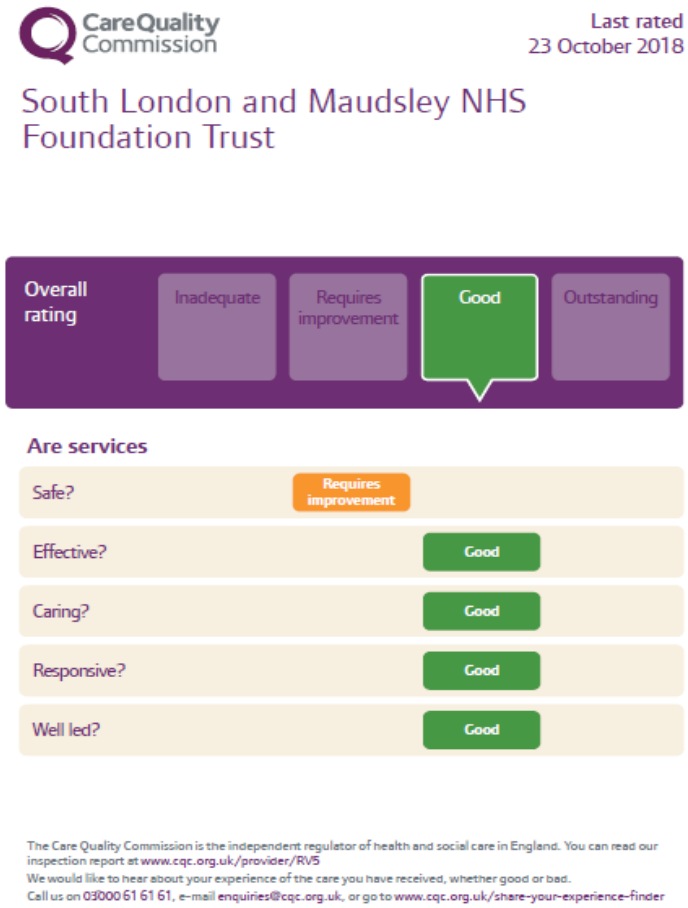


Fig. 5: Current trust CQC rating

Service user involvement

SLaM's Recovery College had 569 new students in the past year, with a total of 3,186 students participating since its launch with Maudsley Charity funding in 2014. Students consist of:

- People who use SLaM services
- Supporters (carers, family and friends) of SLaM's service users
- People who have been discharged from SLaM services within the last six months and their supporters
- Anyone working with SLaM as a volunteer or peer supporter or who is on the Involvement Register
- SLaM staff (not including students on clinical placement).

SLaMrecoverycollege
hope • control • opportunity

The workshops and courses aim to provide the tools for recovery through a learning approach that complements the existing services provided by the Trust. Every course and workshop are co-designed and co-run by trainers with lived experience working alongside trainers from the mental health profession.

The trust runs an Involvement Register as a way for the trust to advertise and allocate opportunities to people who want to use their experience of using our services to help us to develop and improve

them in the future. The trust's Peer Support scheme provides additional support to people leaving services from people with a lived experience.

There are currently 350 active volunteers across the Trust, of which approximately 47% have had lived experience. Volunteers make a valued contribution to many areas and services across the trust, including inpatient wards, administration and reception areas, phlebotomy, community group befriending, football group volunteers, IT support for service users, peer support befriending, Bethlem Community Café, Bethlem Museum of the Mind and Gallery, and gardening.

Part 2: Priorities for improvement and statements of assurances from the Board

Statements of assurance from the Board

During 2018/19, SLaM provided or subcontracted 233 NHS services including inpatient wards, outpatient and community services. As well as serving the communities of south London, we provide 53 specialist services for children and adults across the UK including perinatal services, eating disorders, psychosis and autism. We provide inpatient care for approximately 3,700 people each year and we treat more than 63,000 patients in the community in Lambeth, Southwark, Lewisham and Croydon, with a local population of 1.3 million with a rich diversity.

SLaM has reviewed all the data available to us on the quality of care in 233 of these NHS services.

- The income generated by the relevant health services reviewed in 2018/19represents 100 per cent of the total income generated from the provision of relevant health services by SLaM for 2018/19.

Audits

Participation in national quality improvement programmes

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

During 2018/19, nine national clinical audits and one national confidential enquiry covered NHS services that SLaM provides.

During that period SLaM participated in 100% of the national clinical audits it was eligible to participate in and 100% of national confidential enquiries.

The national clinical audits and national confidential enquiries that SLaM was eligible to participate in and did participate in during 2018/19 are as follows: [insert list].

- Four national Prescribing Observatory for Mental Health (POMH-UK) audits:
  - Valproate prescribing in bipolar illness
  - Use of antipsychotic long-acting injections for relapse prevention
  - Use of Clozapine
  - Rapid tranquilisation
- Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- National Audit of Care at the End of Life
- National Clinical Audit of Anxiety & Depression
- National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit
- National Clinical Audit of Psychosis
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquires that SLaM participated in, and for which data collection was completed during 2018/19 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.

- Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) (n=150; 100%)
- National Audit of Care at the End of Life (N/A – site level responses required)
- National Clinical Audit of Anxiety & Depression (n=200; 100%)
- National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit (n=200; 100%)
- National Clinical Audit of Psychosis (n=200; 100%)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (N/A – Trust required to report every suicide and homicide incident; 100% compliance).

The reports of two national clinical audits were reviewed by the provider in 2018/19 and SLaM intends to take the following actions to improve the quality of healthcare provided.

National Audit	Key actions
CQUIN Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)	Develop strategy to improve communication with GP mental health leads. Physical Health Improvement and Implementation Leads to review and develop pathways to ensure appropriate physical health interventions are offered/received.
National Audit of Care at the End of Life	Report not yet available
National Clinical Audit of Anxiety & Depression	Report not yet available
National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit	Report not yet available
National Clinical Audit of Psychosis	Please see Fig. 24 below

Fig. 23: Participation in national quality improvement programmes

National Clinical Audit of Psychosis (NCAP) 2018

In general performance was around the national average. Notable findings include:

- Monitoring of most physical health risk factors was above the national average.
- Prescribing practice was above average but provision of information to patients was below average in some respects.
- Availability of psychological therapies appeared to be above the national average.

Detailed recommendations are detailed in the table below, which Trust Leads will take forward.

Recommendation topic	Detailed recommendation	NICE Guidance
Physical health monitoring	Have at least an annual assessment of cardiovascular risk (using the current version of Q-Risk)	NICE CG181, 1.1.8
	Receive appropriate interventions informed by the results of the intervention	
	Have the results of this assessment and the details of the interventions offered recorded in their case record	
	Deploying sufficient numbers of trained staff who can deliver these interventions	

Psychological therapies and family interventions	Making sure that staff and clinical teams are aware of how and when to refer people for these treatments	NICE CG178, 1.4.4.1
Provision of written information	Are given written or online information about the anti-psychotic medication they are prescribed	NICE CG178, 1.3.5.1
	Are involved in the prescribing decision, including having a documented discussion about benefits and adverse effects of the medication.	
Employment and training opportunities	Ensure that all people with psychosis who are unable to attend mainstream education training or work are offered alternative educational activities according to their individual needs; and that interventions offered are documented in their care plan	NICE CG178, 1.5.8.1
Annual summary of care	An annual summary of care should be recorded for each patient in the digital care record. This should include information on medication history, therapies offered and PH monitoring/interventions; be updated annually; be shared with the patient and their primary care team.	N/A
Use of data in conjunction with NHS digital	NHS Digital, NWIS, Commissioners, Trusts and Health Boards should work together to put in place key indicators for which data can easily be collected, perhaps using an Annual summary of care (see rec 5). This work should be informed by the NCAP results and the experience of the NCAP team.	N/A

Fig. 24: NCAP recommendations 2018

POMH-UK audits

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

SLAM pharmacy has submitted data for the 2018-19 POMH-UK audits, as required. Below is a summary of the findings from those audits. SLAM is trust 022 and TNS is the total national sample.

Use of antipsychotic long-acting injections for relapse prevention

This survey assessed adherence with certain recommendations in the NICE guideline for the management of psychosis and schizophrenia in adults. SLAM submitted data for a random sample of community patients.

Overall, a higher proportion of patients in SLAM had evidence of the assessment of side effects of a depot, as shown below.

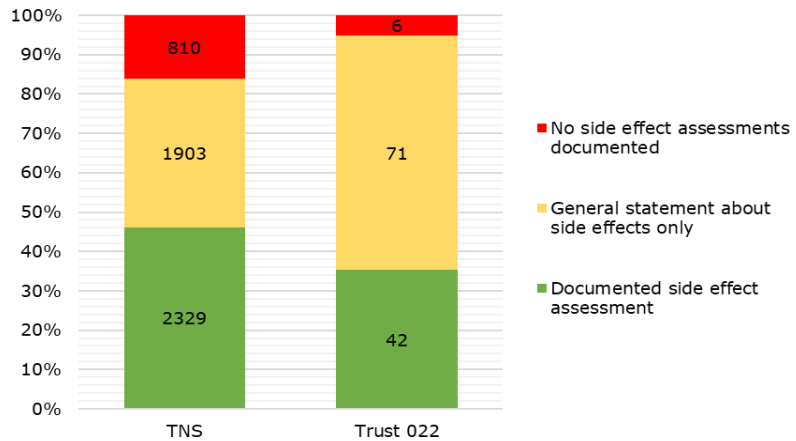


Fig. 25: POMH - Use of antipsychotic long-acting injections for relapse prevention

A similar proportion of patients in SLAM and the average national sample had received a medication review within the previous year and had a clinical plan documented in their notes for the management of non-adherence with a depot, as shown below.

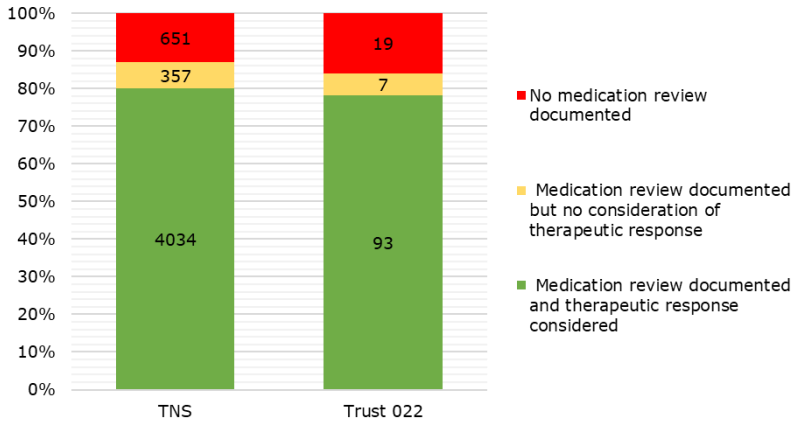


Fig. 26: POMH - Use of antipsychotic long-acting injections for relapse prevention

A similar proportion of patients in SLAM and the average national sample had a clinical plan documented in their notes for the management of non-adherence with a depot, as shown below.

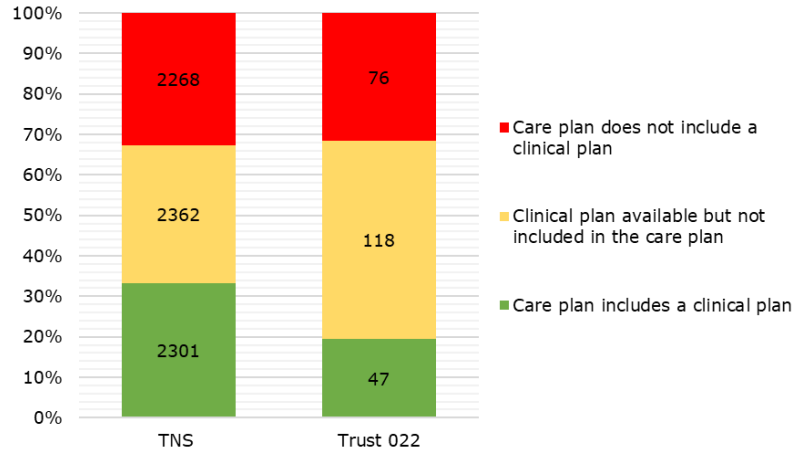


Fig. 27: POMH - Use of antipsychotic long-acting injections for relapse prevention

Actions: Clinicians have been informed of results and recommendations.

POMH – valproate prescribing in bipolar illness

Valproate should not routinely be prescribed for women of childbearing age. All patients prescribed valproate should have an annual physical health check. In 2017 the trust participated in the re-audit of valproate use in bipolar disorder. Results were reported in 2018.

Overall, more patients had evidence of physical health monitoring in SLAM compared with the average national sample, as shown below.

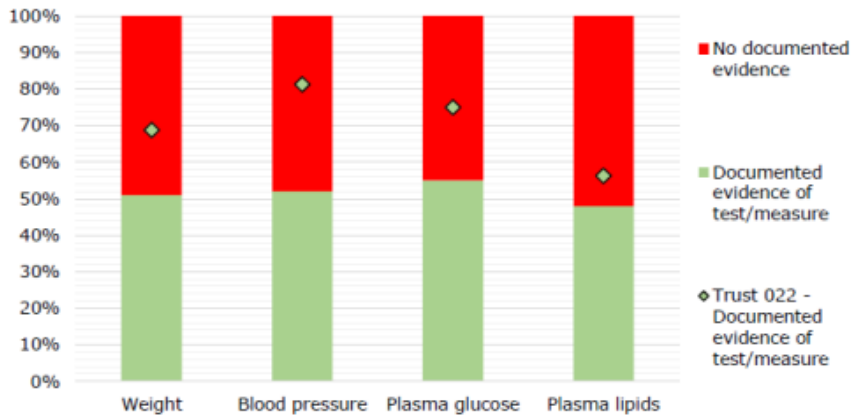


Fig. 28: POMH - valproate prescribing in bipolar illness

Fewer women of childbearing age were prescribed valproate in SLAM compared with the average national sample, as shown below.

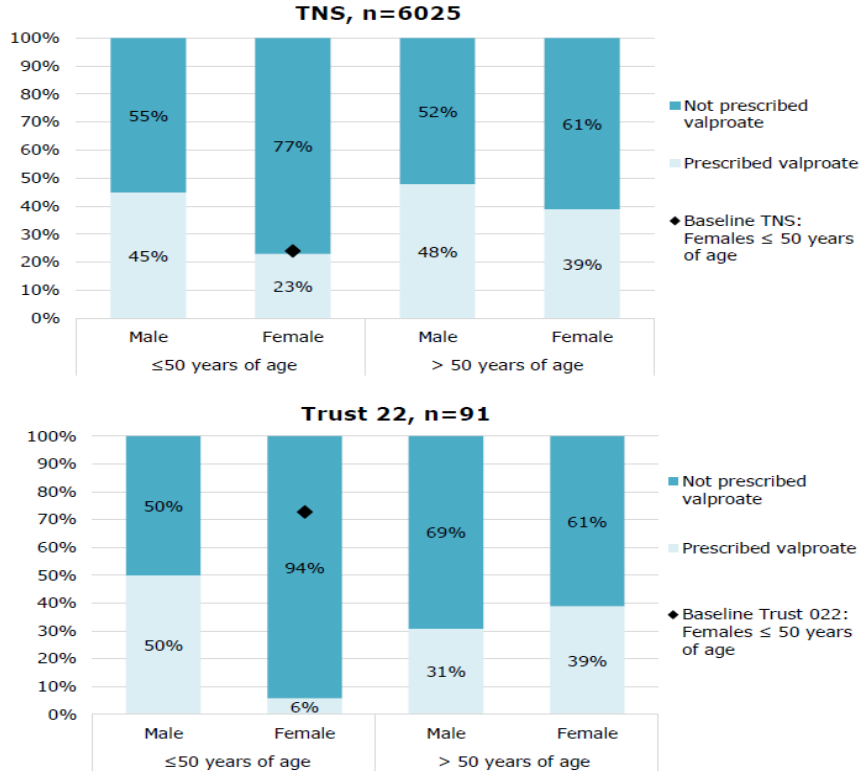


Fig. 29: POMH - valproate prescribing in bipolar illness

Actions: Clinicians have been informed of the results. In addition, clinicians have been informed of the MHRA requirements for valproate use in women of childbearing age. When supplying valproate to pharmacy checks that the women of childbearing age have been enrolled in the pregnancy prevention programme (PPP) and that they are given information about teratogenic potential of valproate. Prescribers are informed of any women who have not been enrolled in the PPP.

POMH – Rapid tranquilisation (RT)

Data were collected in March 2018.

Overall, no patients were administered IM haloperidol, which is in line with SLAM RT policy. Monitoring of physical and mental health after RT was evident for fewer patients in SLAM than in the average national sample (as shown below)

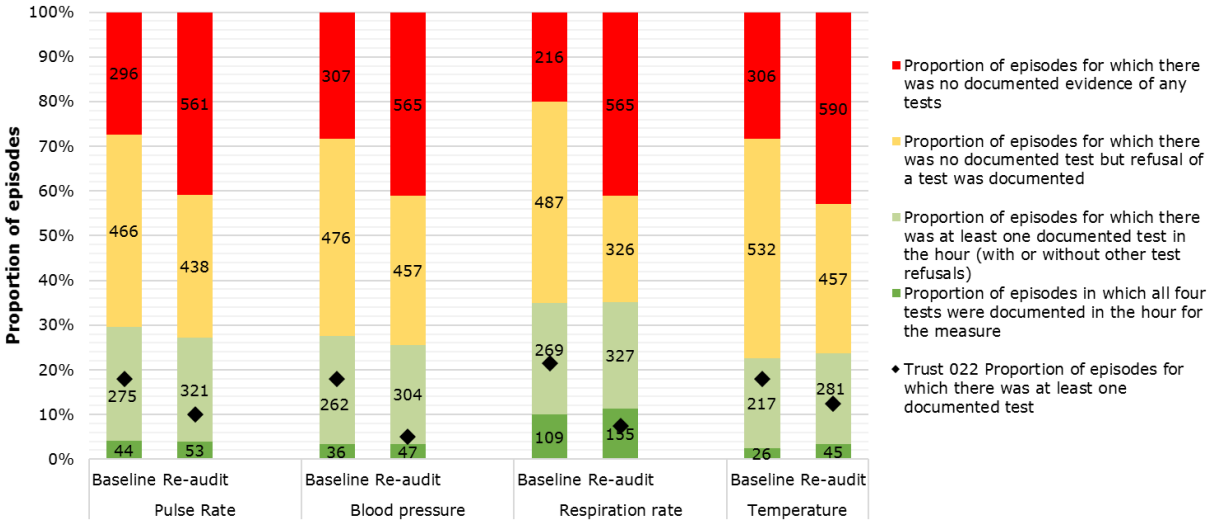


Fig. 30: POMH – Rapid Tranquilisation

Actions: The RT policy has been updated to include the updated physical health monitoring requirements after RT. The trust has provided training on physical health monitoring after RT. Individual incidents of RT are identified each week from prescription charts by pharmacy and followed up by the nursing team to ensure physical health monitoring was completed.

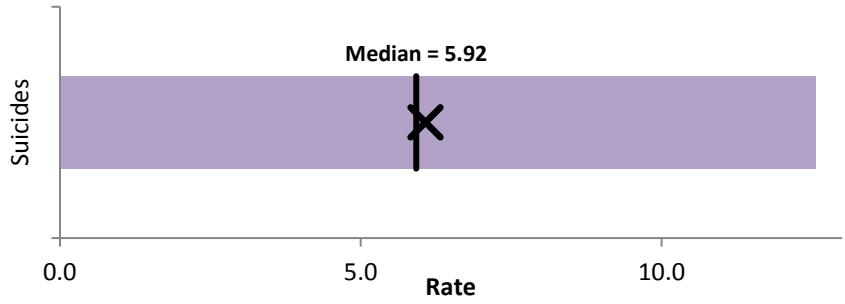
Use of clozapine

Data have been submitted and the Trust is awaiting the report.

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

The Trust participated in the NCISH which reviews data relating to people who have died by suicide or were convicted of homicide based on the most recent available figures (2014-2016).

The figure below gives the range of results for mental health providers across England, based on the most recent available figures for suicides (2014-16). 'X' marks the position of the Trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.



Suicide rate

The suicide rate was 6.08 (per 10,000 people under mental health care) between 2014-16.

Fig. 31: Suicide Rate (2014-2016)

The Trust is implementing a new suicide project group in May 2019 which will look at the implementation of the zero suicide strategy which will report into the mortality review group.

Trust Local Clinical Audit Programme

The reports of ten local clinical audits were reviewed by the provider in 2018/19 and SLaM intends to take the following actions to improve the quality of healthcare provided outlined in the table below.

Audit	Status	Summary	Key outcomes	Key actions
Care Plan and Risk Assessment - Inpatient and Community Monthly	Complete	To monitor ongoing care plan and risk assessment documentation.	There is good documentation of issues being identified in care plans, as well as support and intervention plans to address identified needs. Most care plans are written in ways which will be understood by service users and carers. There is good documentation with regards to risk domains being identified accurately.	Care Plan and Risk Assessments are reviewed monthly at Performance and Quality meetings. Service Directors will be supported to deliver improvements.
QuESTT – Inpatient Monthly	Complete	The Quality, Effectiveness and Safety Trigger Tool (QuESTT) is completed by inpatient wards on a monthly basis. It is a safety trigger tool developed so individual wards can anticipate where standards may start to deteriorate and therefore act to prevent care failures occurring.	Action plans for wards scoring Red, Blue and Amber have been formulated in a timely manner to address concerns highlighted in the relevant month's QuESTT tool. Services continue to experience unusual demand and high acuity on some of the units which is being monitored. Vacancies and supervision compliance also being monitored.	QuESTT scores are reviewed monthly at Performance and Quality meetings. Where wards score Red, Blue or Amber, action plans are recorded onto Datix for review and implementation. Immediate action is taken at the time of the audit with concerns/increasing risk and escalated.
Policy	Complete	The audit was undertaken to assess policy documentation across the Trust and identify and determine whether policies adhered to the Trust Policy for the Development and Management of Trust wide Policies. The audit followed	A summary was brought to the attention of the Operational SMT and Policy leads were made aware of any overdue policies.	An ongoing outcome is that the standard of policies is monitored and reviewed within the Clinical Policy Working Group according to the agreed checklist.

		changes in the clinical policy process carried out by the Clinical Policy Working Group (CPWG). All policies (179) publicised on the Trust intranet, from 25th October 2017 to 28th February 2018, were included within the audit.		
Duty of Candour	Complete	The audit was undertaken to assess ongoing compliance with the Being Open and Duty of Candour policy (2018) and to review the action plan from the 2017 audit. A sample of 80 serious incidents was randomly extracted from the Datix incident reporting system spread across a period of twenty months up to June 2018. The sample was split equally between Serious Incident Requiring Investigation (SIRI) and Serious Incidents (SIs).	The audit demonstrated high levels of compliance for SIRIs, but overall lower levels for C grade incidents which met the criteria for Duty of Candour. The recommendation from this audit was to continue to implement the comprehensive action plan that was derived following the 2017 audit.	The key action is that the comprehensive action plan derived following the 2017 audit will continue to be implemented and compliance monitored.
Engagement and Observation	Complete	The audit highlighted that while there was evidence of positive engagement with service users and observations were carried out correctly there still needed to be an improvement in documentation of these events. The audit involved four different approaches; incident analysis, service user questionnaire, daytime monitoring of interactions on the wards and night time monitoring too.	Compared to the 2015 audit, there is a significant improvement in observations of service users of the highest level of risk however overall compliance around record keeping for intermittent observations was generally low across most standards and require improvement. This includes documentation of decision making, risk assessments and care planning.	Audit results are informing the Engagement and Observations policy review currently underway.
Domestic Abuse	Complete	The audit aimed to assess awareness, knowledge and understanding of domestic violence among clinical staff. An electronic survey was emailed to all clinical staff and included questions regarding their attitudes and identification processes, and knowledge. A total of 167 responses were returned.	Staff reported that they feel confident in asking questions about domestic violence and documenting risks and history on EPJS. 20% increase in the number of staff reporting they knew who their borough MARAC representative is. Required improvements identified regarding staff awareness and in staff reporting they felt confident in conducting a safety assessment for children. A re-audit is planned for 2019.	Trust safeguarding Lead and safeguarding children advisors to look at the current training package to ensure that the current slides reflect domestic abuse and the impact on children. Trust Safeguarding adult lead will provide an update on guidance offered in the recent intercollegiate adult safeguarding document in relation to domestic abuse.

Safeguarding Children	Complete	The audit is designed to assess the current compliance with the Safeguarding Children Policy Principles and Procedures (2014). A random sample of 150 cases was selected where children were identified in the child risk screen in a minimum of 50 cases. The sample of 150 was distributed between 13 Safeguarding Children leads for data collection. Data was collected from 1st June 2018 to 20th July 2018.	Whilst compliance was generally high there were some standards which needed improving. Where dependent children were identified, not all sections of the child need risk screen were completed (35%). In a small number of cases (10%) current child need risk screens were not sufficient, and where no dependent children were identified the screens were inaccurate in 4% of cases. Where dependent children were identified, not all sections of the child need risk screen were completed (35%).	Recommendations in light of this audit include informing or reminding staff about timelines of completion and appropriate review of child need risk screens.
Supervision	Complete	The Supervision Audit assessed the current compliance with the Supervision Policy V5 (2018) standards for the Quality of Supervision. The Supervision Audit is a Trust-wide review of the quality of supervision as it has been experienced by all staff groups, not limited to clinical staff.	There was an increase of 3% in staff receiving supervision compared with the 2013 audit. There was high compliance relating to supervision enabling staff to do their jobs better, feeling valued and able to raise concerns, although the former two questions did decrease on 2013 results.	The audit is informing work to improve staff engagement, and a re-audit in 12 months is recommended.
Section 132 - Inpatient and Community Treatment Order	Complete	The audit assessed whether patients detained under the Mental Health Act (MHA) or subject to a Community Treatment Order (S17A/CTO) are informed of their statutory rights via the S132/132A and whether rights are repeated as required by policy.	The standards audited indicated that policy is being adhered to, however there is room for improvement.	Recommendations in light of this audit include the reissuing of a Blue Light Bulletin to emphasise the importance of improved compliance with S132, the issue of a Purple Light Bulletin, updates of the weekly MHA monitoring tables, continuation of a QI project to improve compliance at ward level and a re-audit in 12 months to check compliance.
Central Alerting System	Complete	The audit assessed compliance with reporting, actioning and maintaining evidence logs.	For reportable alerts, 100% compliance was confirmed for reporting, actioning and maintaining evidence logs. However, a lack of a formal system for logging drug alerts and non-reportable alerts was identified.	Formal logging systems for drug alerts and non-reportable alerts have been implemented and governance arrangements formalised with compliance reporting and annual reports. The policy has been updated.

Fig. 32: Trust clinical audit programme (2018/19)

Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by SLaM for the reporting period, 1 April 2018 – 31 March 2019, that were recruited during that period to participate in research approved by a research ethics committee was 3,578.

SLaM research is having an impact in many areas including:

- **Developing novel treatments:** e.g. Trials of Cannabidiol (CBD) for psychosis.
- **Influencing health policy:** e.g. Enhancing treatment guidelines for depression
- **Improving services based on our research evidence:** e.g. First episode service for eating disorders (FREED)

More information can be found here: https://www.kcl.ac.uk/ioppn/research/agenda.aspx

Payment by Results Clinical Coding

SLaM is not subject to a Payment by Results Clinical Coding audit as it has not provided acute hospital services during the 2018/2019 financial year. Mental health services have a different payment approach which includes mental health care clusters. Our clinical information system has built in alerts to remind clinicians that a mental health cluster has expired which promotes data capture.

We see high quality data as key to informing the provision of high-quality care, both at an individual patient level and in terms of commissioning services for our local populations.

Currently we recognise that, like many NHS organisations, we have challenges with both the consistency and accuracy of data across our systems, and ensuring this data is used in a meaningful way to drive improvements in our services.

Last year we started our data framework project to address these issues, specifically to develop an online automated Trust dashboard so that all staff can access data to make better data informed decisions. As part of this on-going project we have been addressing the issue of data quality through our weekly project meetings, looking at how, where and by whom data is entered, and how that data is integrated across our systems and subsequently presented back to staff in a way that is useful.

Our series of data summits 'Operation SOS: Solving our Systems' brought together our data system owners to collaboratively address these issues, and meanwhile work has continued to develop a new user interface for our electronic health record ePJS (launch April 2019) that will make accurate, timely and complete data entry easier for staff.

Over the course of the coming year we will continue to build on our data quality work, through development of our informatics strategy, system architecture and the establishment of the Trust's

new Quality Centre, which will see intelligent, high quality data use as central to improvements across our system for the benefit of all our patients, carers and staff.

Care Quality Commission (CQC); inspection July 2018 results and actions

The Trust is required to be registered with the CQC and its current registration status is registered, without condition. In 2018 SLaM participated in a Well Led review of the Trust as well as a CQC inspection of the following services outlined in the table below:

Pathway
Acute wards for adults of working age and Psychiatric intensive care units
Community-based mental health services for older people
Forensic Inpatient/Secure wards
Mental health crisis services and health-based paces of safety
Specialist Services - Eating Disorders
Specialist Services - Lishman Unit

Fig. 21: Services inspected by CQC in 2018.

Whilst the overall rating for the Trust remains the same at 'Good' the Trust received a regulation 29A (HSCA) Warning notice for the Acute and PICU pathway.

The Trust was asked to make improvements by the 1st April 2019 and ensured an appropriate action plan was brought in place which would build on the many actions that were already underway as a part of borough reorganisation. Following receipt of the Warning Improvement Notice the Trust Senior Management Team set about engaging with Trust Executives to develop a robust and achievable improvement plan.

These discussions resulted in the following priority areas for improvement:

(i) Fundamental standards of care
(ii) Governance
(iii) Leadership and culture
(iv) Clinical pathways including flow and discharge planning.

There was also a clear focus on ensuring that there is the right infrastructure in place (enablers) to support these improvements and a clear structure for engaging and communicating with staff (communication), service users and carers.

The CQC re-inspected the Trust in April 2019 and initial verbal feedback indicates there has been significant improvement. The warning notice has lapsed and the CQC has confirmed on the basis of improvement that there is no need for further regulatory action.

Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5% of SLaM income is conditional on achieving quality improvement and innovation goals agreed between SLaM and any person they entered into an agreement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The value of these payments for 2018/19 was £6.0m and at the time of writing the Trust is collating quarter four reports for submission to our commissioners.

Further details of the agreed goals for 2017-19 and for the following 12 month period (2019/20) are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ and https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Hospital Episode Statistics Data – HES

SLaM submitted records during 2018/19 to the Secondary Uses services (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data was:

	In-Patients – SUS data Apr -Dec 2018	Out-patients and Community – Mental Health Monthly Data Set (MHMDS) Nov 2018 (Final)
NHS No	98.1%	99.1%
GP Practice code	98.9%	98.3%

Fig. 33: Percentage of records relating to patient care which included the patient's NHS No and GP practice code.

Information Governance

Our submission for the NHS Digital Information Governance (IG) Toolkit 2017-18 demonstrated 90% compliance, which is satisfactory compliance. The submission was independently assessed by internal audit with a substantial assurance outcome. The Trust Digital Services are continuing to lead the digital transformation programme. The IG Operating Model has been implemented to further improvements around IG compliance with national standards and key legislation whilst implementing the trust's Digital Strategy.

The Trust undertook the General Data Protection Regulations (GDPR) preparedness programme overseen by the Information Security Committee (ISC). The ISC is also overseeing the Cyber Security Programme with close engagement and independent reviews by NHS Digital's careCERT and careCERT Assure Programmes. The trust has undertaken an extensive review of all data assets and data flows undertaking data protection impact assessments. All trust policies have been updated in line with the Data Protection Act 2018 and an updated Privacy Notice to notify service users and the public published. The Trust appointed a Data Protection Officer to oversee compliance and has set up the SE London DPO Forum to enable knowledge exchange and regional compliance between the DPOs.

SLaM refreshed NHS Digital's SCCI1596 Secure Email Standard conformance and @slam.nhs.uk continues to be accredited as a secure email system since 30 September 2017.

The Trust has worked with regional partners to sign up to a single, consistent, clear and unified data sharing framework across SE London. This has led to further expansion of the shared care record with the successful implementation of the Virtual Care Record (VCR).

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

Assurance around IG is presented to relevant committees chaired by the Caldicott Guardian, the CCIO and the Chief Information Officer (the Senior Information Risk Officer). The Trust Senior Management and the Board receives regular updates on levels of data assurance.

Patient safety incidents resulting in severe harm or death

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

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

The process of reporting trust data to the NRLS and NRLS publication of national data is retrospective by nature. For the latest benchmarked data, SLaM reported:

NRLS Data Q1-Q2 17/18	SLAM 17/18	Average for Mental Health Trusts	Highest Trust % or Score 17/18	Lowest Trust % or Score 17/18
Reported Incidents per 1000 bed days	=	51.5%	126.47 %	16%
Number of incidents resulting in severe harm	0.5%	0.3%	2.0%	0.0%
Number of incidents reported as deaths	0.2%	1.0%	3.8%	0.0%

NRLS Data Q1-Q2 18/19	SLAM 18/19	Average for Mental Health Trusts	Highest Trust % or Score 18/19	Lowest Trust % or Score 18/19
Reported Incidents per 1000 bed days	-	55.5	114.3	24.9
Percentage of incidents resulting in severe harm	0.2%	0.3%	2.1%	0.0%
Percentage of incidents reported as deaths	0.7%	0.9%	2.3%	0.1%

Fig. 39: NRLS (National Reporting and Learning Service) Data

SLaM will improve the route of reporting, by continuing to improve and develop our monthly Serious Incidents Review Group (SIRG) and continuing to drive an open culture focussed on learning and improving safety for patients and staff.

Learning from Deaths

During 2018/19, 511 SLaM patients died. This is a reduction from 565 deaths in 2017/18. This comprised the following number of deaths which occurred in each quarter of that reporting period: 120 in the first quarter; 133 in the second quarter; 134 in the third quarter; 124 in the fourth quarter.

144 case record reviews and 62 investigations have been carried out in relation to the 511 deaths. In 23 cases, a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Number of deaths where case record review or investigation was carried out	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
	29	36	47	94

Fig. 40: Number of deaths where case record review or investigation was carried out

Number of deaths reported in 2018/19 where case record review or investigations were carried out	Total
	CRR 144 SIRI 62

Fig. 41: Number of deaths reported in 2018/19 where the case record review or investigation was carried out in 2018/19

Our mortality reviews used adapted versions of two frameworks: the Mazars framework, and an adapted version of the grading system for case reviewers from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Reviewers assess and grade the care provided to a patient using the two systems to assess and identify learning or a requirement for further review.

We have identified a number of learning points from case record reviews and investigations conducted in relation to the deaths identified above:

- The quality of risk assessments and care plans in some cases has been variable.
- Where care plans and risk management plans were completed these were not always individualised or specific enough.
- In Psychological Medicine and Older Adults (PMOA) directorate there have been instances of referrals to the Memory Service that were either late, or the patient was too physically unwell.
- Mortality reviews have identified the need for improved physical health follow up in the community. This should include better links with primary care and better care planning.

A total of three cases in this reporting period were judged to be more than likely than not to have been due to problems in the care provided by the patient. This is 0.59% of all reported deaths.

Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
0 (0%)	0 (0%)	2 (11.11%)	1 (5.88%)

These figures were estimated using an adapted version of the grading system for case reviewers from the NCEPOD. Reviewers assess and grade the care provided to a patient using the two systems to assess and identify learning or a requirement for further review. The deaths considered in this section are those assessed using the NCEPOD Classification as Several aspects of clinical and/or organisational care that were well below satisfactory requires reporting as Serious Incident or SI.

Actions taken

The Trust has taken the following actions during 2018/19:

- In PMOA there is work underway with GPs to redesign the referral process and referral form.
- Older Adult have worked with CRISS to develop a tool to monitor antipsychotic monitoring for patient with dementia.
- Quality improvement projects to improve the waiting times for patients with a diagnosis of dementia have been ongoing; including increasing memory service capacity in Croydon.
- Up to date Information on community Speech and Language Therapy (SALT) services has been circulated to community teams.
- The inpatient nutrition screening tool is being redeveloped and that will include feeding / swallowing issues.

The Trust continues to assess the impact of the actions highlighted in mortality reviews.

In 2019/20 we will be implementing the Royal College of Psychiatrists' standardised care review tool for mental health services. The new care review tool will replace the existing mortality review tool in Datix. All deaths will be subject to completion of Section 1 of the review tool. Comprehensive mortality reviews (Section 2) will be triggered by Red Flags identified, or by random allocation of cases to be reviewed. The Red Flags included are:

- Family, carers or staff have raised concerns about the care provided.
- Diagnosis of psychosis or eating disorders during the last episode of care.
- Psychiatric inpatient at time of death or discharged from inpatient care within the last month.
- Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.
- Other locally determined criteria for review.

Directorates will be expected to randomly allocate 5% of all reported deaths for a mortality review. We are currently in the process of ratifying our mortality review policy and making changes to Datix. Directorates might decide on locally determined red flag criteria, and this will be presented and recorded in the Mortality Review Group meetings.

Duty of Candour 2018/2019

A number of actions have been taken during this year, including:

- A Duty of Candour information poster was produced April 2018.
- The Policy was revised in June 2018 including guidance for staff, template letters and external website reference.
- The Maud intranet site was updated regarding Duty of Candour in August 2018.
- The Serious Incident Review Group has continued to increase the scrutiny and oversight of Duty of Candour for serious incident investigations.

Further work that will be taking place in 2019/2020, including:

- Datix fields will be updated to help to improve Datix reporting.
- A QI project will be undertaken during 2019 to improve Datix reporting

Governance and Assurance

The Trust has robust operational and quality governance systems and processes in place to monitor the quality of care provided.

The Trust Board receives assurance from the Quality Committee (QC) chaired by a Non-Executive Director. The purpose is to:

- Provide assurance to the Board of Directors on the delivery of the Trust's Quality Strategy.
- Examine where there have been failures in service or clinical quality and monitor progress against action plans to address them.
- Ensure that there are processes in place to monitor quality effectively.
  - Identify risks related to service and clinical quality and provide assurance to the Board that the principal risks threatening quality are being managed appropriately at all levels within the Trust.
  - Consider issues escalated by the committees accountable to the Quality Sub-Committee.

Managing clinical risk

Managing clinical risk is central to all the work that we do, to manage risk all clinical staff receive clinical risk management training commensurate with their grade and experience.

National indicators 2018/2019

SLaM is required to report performance against the following indicators:

- Care Programme Approach (CPA) 7-day follow-up
- Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)

- Re-admission to hospital within 28 days of discharge

National indicators 2019/2020

SLaM is required to report performance against the following indicators:

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

Care Programme Approach (CPA) seven-day follow-up

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

National Target	SLaM 2015/16	SLaM 2016/17	SLaM 2017/18	SLaM 2018/19	National Average 2017/18	Highest Trust % or Score 2017/18	Lowest Trust % Score 2017/18
Not specified (formerly 95%)	96.99%	**97.1%**	**97.5%**	**96%**	95.4% (Q3)	100%	69.2%

Fig. 34: CPA, seven day follow up

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2017/18 published at the time of writing the Quality Report available at www.england.nhs.uk/statistics

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

The Trust performance continues to be comparable with previous years. SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ongoing monitoring through the I-Care programme as part of the trust's quality improvement programme.

Access to Crisis Resolution Home Treatment (Home Treatment Team)

Home Treatment Teams provide intensive support for people in mental health crisis, in their own home. Home Treatment is designed to prevent hospital admissions and give support to families and carers. The indicator here is the percentage of admissions to the Trust's acute wards that were assessed by the crisis resolution home treatment teams prior to admission.

	National Target	SLaM 2015/16	SLaM 2016/17	SLaM 2017/18	SLaM 2018/19	National Average 2017/18	Highest Trust % or Score 2017/18	Lowest Trust % Score 2017/18
Number of admissions to acute wards that were gate kept by the CRHT teams	95%	95.9%	**96.5%**	99.9%	**96.1%**	98.5 (Q3)	100%	84.3%

Fig. 35: Access to crisis resolution

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

Note: that Psychiatric Liaison Nurse assessments of patients in Emergency Departments are included in the gatekeeping performance figures for previous years. Following the creation of the Assessment and Referral Centre (ARC) in 2016 with embedded Home Treatment the ARC now acts as the single point of access for the adult care pathway. PLN's now refer to ARC who do the HTT assessment as part of the admission/diversion process.

SLaM considers that this data is as described for the following reasons: The Acute Referral Centre (ARC) is fully operational and all patients are triaged through this system.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ongoing monitoring of the Adult mental health pathways, a redesign of our community provision and the implementation of QI initiatives.

Readmissions to hospital within 30 days of discharge for patients 0 – 15 years and 16+ years

Readmission within 30 days Standard measure is 30 days	SLaM 2018/19
Patients readmitted to hospital within 30 days of being discharged (0 – 15 years)	10.9%
Patients readmitted to hospital within 30 days of being discharged (16 years or over)	5.9%

Fig. 35: Readmissions to hospital for within 30 days by age group

SLaM considers that this data is as described for the following reasons: The routine monitoring indicator for readmissions for mental health contracts and Clinical Commissioning Groups (CCG) is readmissions within 30 days. The Benchmarking Network for Adult Mental Health report 2016/17 reports that the Trust had a 4% emergency readmission rate in comparison to a national mean of 9% for emergency readmissions within 30 days.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ongoing monitoring of the Adult mental health pathways, a redesign of our community provision and the implementation of QI initiatives.

Core indicators

The following indicators form part of appendices 1 and 3 of the Single Oversight Framework (SOF) published by NHS Improvement.

Indicator	SLaM 2018/19	National Target	National Target Met
1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	76%	50%	✓

2. Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50.1%*	50%	✓
3. Improving access to psychological therapies (IAPT): patients seen within 6 weeks of referral	90.8%	75%	✓
4. Improving access to psychological therapies (IAPT): patients seen within 18 weeks of referral	99.3%	95%	✓
5. Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	96.1%	Not specified (formerly 95%)	✓
6. Admissions to adult facilities of patients under 16 years old	0	Not specified	✓
7. Inappropriate out-of-area placements for adult mental health services ***(This is a new requirement for 2017/2018 and reporting begins in Q4/18 which is broken monthly in the data presented.)***	Apr-18 – Feb-19 13,439 OBDs	Not specified	✓
8. Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: **a) inpatient wards** **b) early intervention in psychosis services** **c) community mental health services (people on care programme approach)**	96% inpatient and 75% community	90% inpatient and 75% community	✓

Fig. 36: Core indicators

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

*The yearly average for indicator 2 for 2017/18 was 48 per cent although by the end of the financial year the Trust had achieved a recovery rate of 52 per cent

Indicators two, three and four are based on collated monthly internal Trust reporting, NHS Digital will publish full year performance later in 2019/20.

The indicator percentage of CPA patients with a review in 12 months is not specified within the Single Oversight Framework.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services: these indicators will continue to be monitored via monthly performance and quality meetings.

Service Users Experience of Health and Social Care Staff Service Users Experience of Health and Social Care Staff

	SLaM 2017	SLaM 2018	Highest Trust Score 2018	Lowest Trust Score 2018
Service users experience of Health and Social Care Staff *Scores out of 10*	7.5	7.2	7.7	5.9

Fig. 37: Service users experience of health and social care staff

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

The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2018, overall SLaM scores for this section were about the same as other mental health Trusts. The average Health and Social Care Worker section score for SLaM patients was 7.2 with other Trusts performing in a range of 5.9 to 7.7. The score for Q4 decreased by 0.2 points and Q5 increased by 0.1 points, although these changes are not categorised as significant shifts (changes of 5 points).

		SLaM 2018	Lowest trust score	Highest trust score	SLaM (n)	SLaM 2017	SLaM 2016	SLaM 2015	SLaM 2014
Health and social care workers									
S1	Section score	7.2	5.9	7.7		7.6			
Q4	Were you given enough time to discuss your needs and treatment?	7.3	6.2	8.0	176	7.5	7.3	7.6	8.0
Q5	Did the person or people you saw understand how your mental health needs affect other areas of your life?	7.1	5.7	7.5	168	7.0	7.1	7.1	7.8

Fig. 38: National survey of people who use community mental health services 2018

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services: The trust continues to prioritise service user and carer involvement. Feedback regarding this is collected in a systematic way across the Trust, including through the local experience survey programme, PEDIC. This work is taken forward as part of the Patient and Public Involvement strategy and directorate improvement plans.

Part 3: Other information

Review of quality performance 2018/2019

Review of progress made against last year's priorities

Our 2018/2019 quality priorities were selected after consultations with stakeholders and staff from our services and are highlighted below:

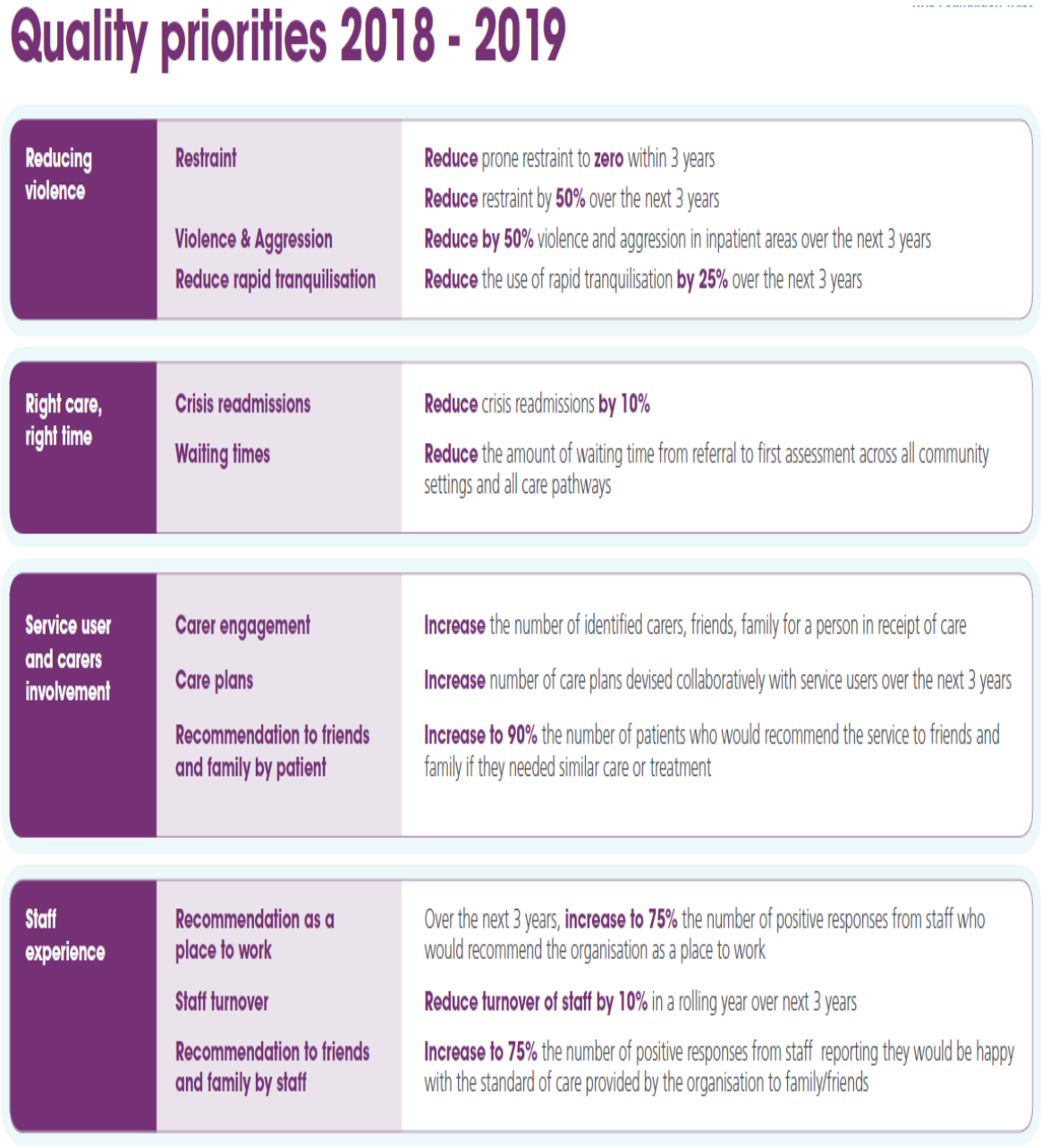


Fig. 6: Quality priorities 2018/19

The following summarises progress made against each priority over the year. The priorities set for 2018/19 were three-year targets to allow for systems to embed and afford real sustained improvement. Therefore, whilst targets have not been achieved fully in 2018/19, good systems have been embedded and progress has been made, such as around care plans. The wording of three

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Reducing violence by 50% over 3 years								
Reducing violence by 50% over 3 years	4158	4372	659	1198	665	661	812	377
Reduction in restraint by 50% in over 3 years	1716	1789	357	386	257	275	396	118
Reduction in prone restraint – zero by 3 years	708	549	40	92	80	134	188	15
Reduction in the use of rapid tranquilisation by 25% in 3 years	840	772	25	143	140	173	224	47

indicators (two staffing and one carer) have been clarified. The metric indicators to measure performance in the key priorities are outlined below:

Patient safety

How did we do?

The number of reported incidents of violence and aggression appears to be on an increasing trajectory. With a focus on restrictive practice and violence reduction it is expected that the quality of the data will improve and thus is likely to increase before reducing again. At present, Trust wide data do not show any overall indicators of change, however, there have been local areas of improvement, for example, an area of particularly good performance is the reduction in use of prone restraint in the Lambeth directorate. We are proud of this change driven by our clinical staff.

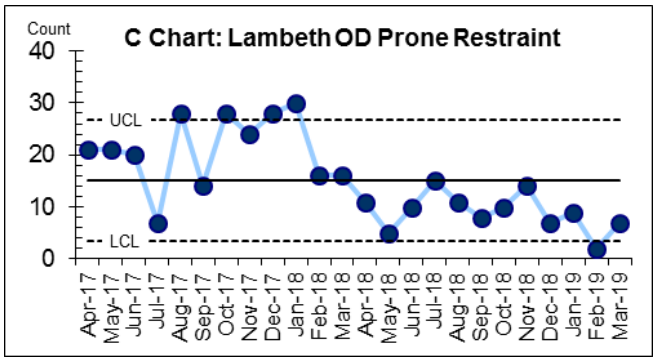


Fig. 8: Lambeth OD Prone Restraint

The main focus with the work around Rapid Tranquillisation has been to ensure that where it is being used in the Trust it is done so safely and with appropriate physical health monitoring. An area of good performance is in Lewisham directorate, which may be seeing a downward shift in the rates of rapid tranquillisation usage, including a seven-week period in the male PICU where no rapid tranquillisations were used at all.

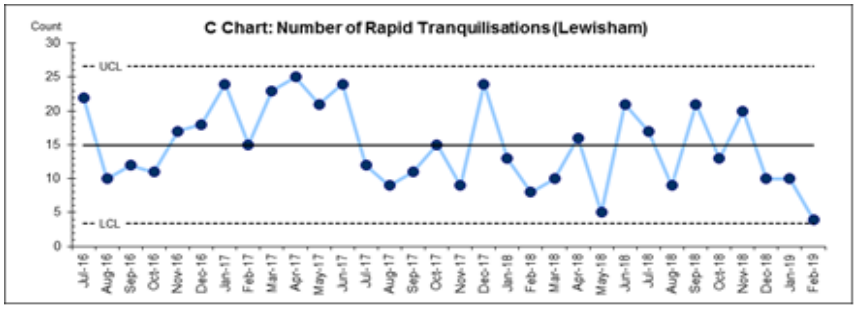
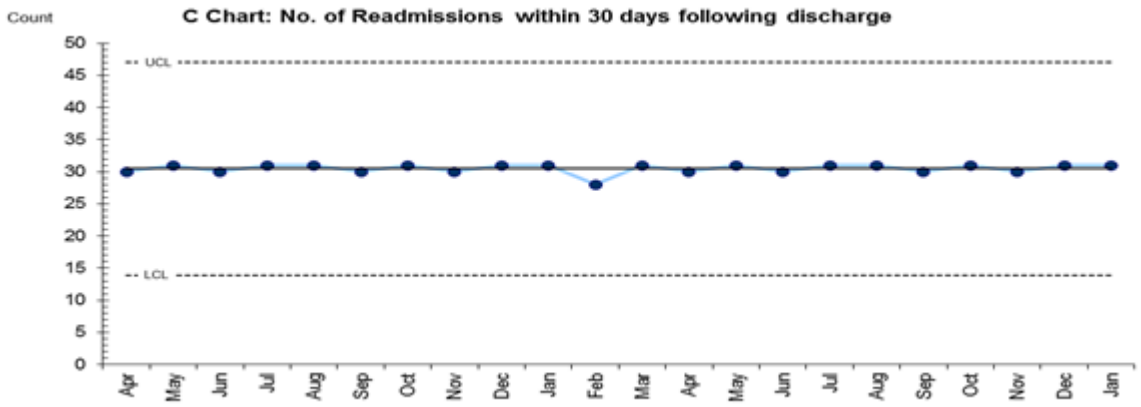


Fig. 10: Lewisham OD Rapid Tranquilisation

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Right care, right time in appropriate setting								
Reduction in the amount of time waiting from referral to first assessment. (Days)	45	47.8	88.62	71.72	20.78	21.90	16.78	64.56
Reduction in crisis readmissions by 10%	311	295	19	80	56	55	71	14

Right care, Right time

How did we do?



ICare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). There are three work streams:

1. Patient safety
2. Standardised ways of working
3. Patient flow and capacity

Inpatient operational care process model

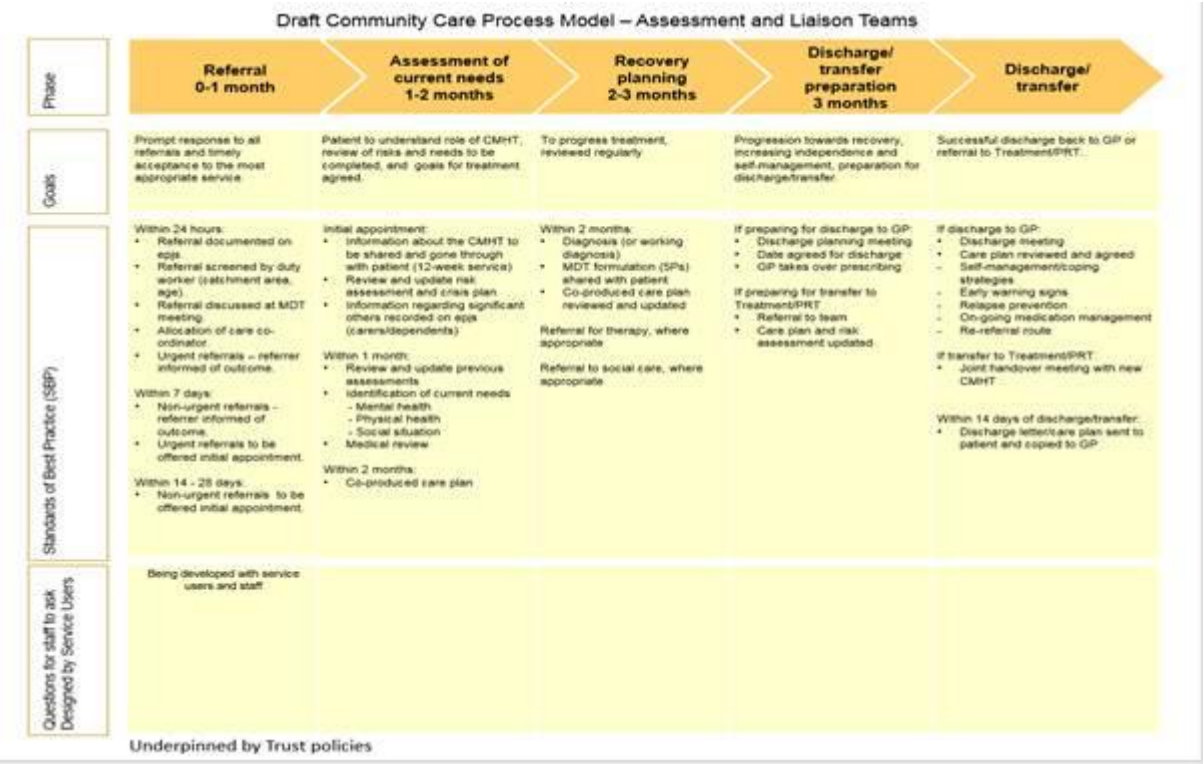
Inpatient Care Process Model (CPM) and expectations of community in the adult acute inpatient care pathway

Inpatient CPM

The inpatient Care Process Model (CPM) has taken ten months to develop and is being tested in Lewisham, prior to being scaled up and spread across the Trust. The first phase is collecting baseline data with staff and service users and carers to identify which standards of best practice are being demonstrated and the focus for priorities for improvements. Initial tests will focus on the admission and discharge elements of the process in order to prioritise the improvement in flow.

Community CPM (see visual below)

Several very positive engagement events were held throughout 2018 with staff, service users and carers, and partner organisations to inform the development of the Community Care Process Model. Feedback from these events, along with data, have formed the basis of the community care process model (CPM) that is being drafted with clinicians, service users and carers from Southwark community teams, where the model will initially be tested.



CPM Model- Draft Community Care Process Model- Treatment/Promoting Recovery Teams

Fig. 7: Progress against quality priorities 2018/19

Service user and carer involvement

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	19/20						
Service User and carer involvement								
Increase the proportion of service users under the care of SLAM services who have at least one carer, partner, relative or friend identified, with their contact details recorded on the Core Info section of EPJ.	50.3%	51.1%	64.3%	42.5%	63.6%	65.5%	58.2%	51%
Increase in the number of care plans over the next three years that have been co-produced with the service user and the contents shared with them. Target: 100%	54.3%	78%	85%	77%	58%	60%	75%	64%
Increase the number of positive responses to 90% over the next three years regarding patients recommending the service to friends and family if they needed similar care or treatment		85.36%	85.55%	81.42% (Croydon) 82.13% (BDP)	80.02%	81.03%	78.81% (Southwark) 93.93% (Addictions)	92.65%

How did we do?

Carer Engagement- Increase in identified carers

This year work was completed with Business Intelligence to establish a reporting mechanism to broaden the terminology for identifying carers to include Carer, Family member, Children's Guardian, Nearest relative, Next of kin, Resident and Non-resident parent, and Friend, recognising that not everyone identifies with the word carer.

There has been communication with the Service Directors/Clinical directors and the Carers leads in each directorate in preparation for the Performance and Quality meetings to discuss ways to increase the number of identified carers.

Work streams to help with improvement in this area, included:

- Work with communications to raise awareness for "Think Carer" month
- Directorates to remind staff / do a drive for the month to complete field on EPJ re contact information – role and relationship (provided guidance/rationale).
- If directorates have carers leads/ champions on wards for example, consider doing a snapshot audit of completion of contact form completion for identified carer or family – identify gaps and complete as appropriate, feedback on ideas to improve.
- Work ongoing in the directorates to engage and work with families and carers and examples of this could be promoted.

Co-produced Care plans

This year has seen a continued effort by clinical services to improve the numbers of care plans being co-produced with service users. Ongoing monitoring of this by monthly audits has seen an increase during the year and was identified as an improvement in the recent 2019 CQC inspection. The percentage of co-produced care plans has seen a very positive change. We will build on this further to ensure our patients' needs are accurately documented and understood.

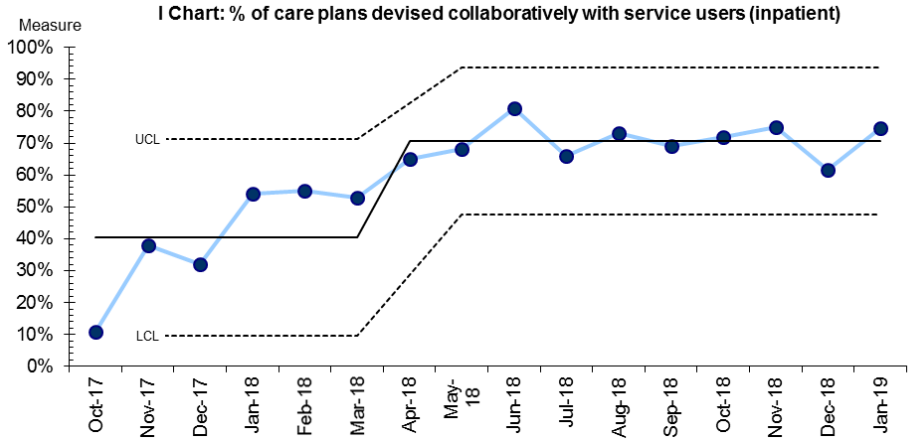
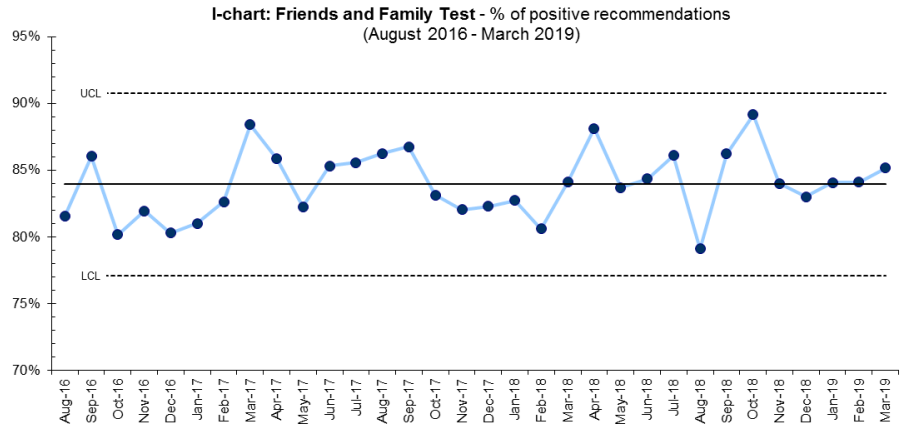


Fig. 11: Percentage of care plans co-produced with service users (Trust wide – inpatient)

Friends and Family Test (FFT)

The trust collects approximately 12,000 Friends and Family Test (FFT) responses annually. It is available in several formats to aid collection of opinions from different patient groups, such as easy-read for Learning Disabilities and child- and adolescent-friendly formats. The trust's FFT score sees peaks twice a year when the Addictions directorate complete their bi-annual push for responses. The trough in August 2018 was due to a temporary issue with the freepost address which paper surveys are returned to. The FFT score has been maintaining or exceeding the median line for the past two quarters. The trust has several projects in development to improve FFT performance, which includes the co-production of a dementia-friendly survey, launching in the Place of Safety, development of a trust PEDIC dashboard in Power BI, and a project to validate some new core PEDIC questions. These new questions have been developed with staff, service users and the IoPPN to ensure the questions are consistently interpreted across patient groups, valid and reliable, which will make it easier for people to give us feedback. The trust has also been part of the national working group for the review of the FFT with NHS England.



	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Staff experience								
Achieving buy-in across the organisation for the need for a large-scale programme of work to enable staff to experience improved satisfaction and joy at work, as measured by reducing turnover rate by 10% in a rolling year over the next three years using the current baseline of 19%. [Quality Priority]	18.6%	18.9%	26.76%	19.69%	17.8%	13.17%	14.06%	17.99%
Increase to 65% of staff who recommend SLaM as a place to work from its current level at 59% by Spring 2020. [Quality Priority]	60%	58.9%	N/A	N/A	N/A	N/A	N/A	N/A
Increase the number of positive responses to 75% over the next three years of the number of staff who, if a friend or relative needed treatment, would be happy with the standard of care provided by the organisation.	61%	58.6%	N/A	N/A	N/A	N/A	N/A	N/A

Safer staffing and staff experience

How did we do?

The newly designed Operations Directorate leadership teams are recruited to and have gained traction. The teams clearly know their wards and teams well and are sighted on the quality issues of which staffing is a part. Recruitment activity continues in earnest and through the General Managers, the Matrons and the Heads of Nursing we are ensuring that ward teams have the support they need to recognise and deliver the expected standards of care.

Actions to improve staff experience are detailed in the Trust's Staff Survey Action Plan and include the following:

- Executive visibility walkabouts
- Changing Lives Roadshows
- Staff fora
- Flexible working policy and HR oversight of requests
- E-Rostering
- ICare
- Wellbeing strategy
- Schwartz rounds
- BME and Lived experience networks
- Transparency in acting up and secondments
- Four Steps to Safety
- Various local QI projects
- Reinforcing the bullying and harassment policy with a personal message from the CEO
- Promoting FTSU

In addition, we have added a local question to the Friends and Family Test (FFT) about perceptions of career progression and promotion based on ethnicity. This is one of the three key aspirations of the Workforce Race Equality Standard (WRES) action plan. It is recognised that this question is only asked once per year so in order to gain more regular feedback it has been included in the quarterly FFT survey.

National patient survey of people who use community mental health services 2018

SLaM scored 'about the same' as most other trusts that took part in the 2018 National Community Mental Health Survey. One survey section scored 'better' than most other trusts, related to changes in who people see (7.3/10). A total of five questions increased on 2017 scores (two significant shifts; a shift of 5 or more), 20 decreased (ten significant shifts) and for three there was no change. One individual question scored 'better' than most other trusts in relation to changes in who people see having a positive impact upon care (8.2/10) and was also one of the two questions with a significant shift upwards. A total of two questions scored 'worse' than most other trusts in 2018 (care organisation and involvement in agreeing what care will be received; 7.4/10 and 6.6/10 respectively). The scores for the top two rankings on the overall experience question stayed the same as last year (16% 10/10 and 11% 9/10). When comparing SLaM scores against other London-region trusts only, SLaM scored within the highest 20% for two survey sections (health and social care workers and changes in who people see) and within the lowest 20% for six sections.

Section	Significant shift upwards	Score 2017	Score 2018
Support and wellbeing	Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	6.2/10	6.7/10
Changes in who people see	What impact has this had on the care you receive?	7.6/10	8.2/10

Fig. 12: National community mental health survey – questions with significant shift upwards

Section	Top five performing questions	Score
Organising care	Do you know how to contact this person if you have a concern about your care?	9.4/10
Changes in who people see	What impact has this had on the care you receive?	8.2/10
Organising care	Have you been told who is in charge of organising your care and services?	7.8/10
Overall views of care and services	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	7.8/10
Treatments	Were these NHS therapies explained to you in a way you could understand?	7.6/10

Fig. 13: National community mental health survey – top five performing questions

Section	Bottom five performing questions	Score
Support and wellbeing	In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?	5.3/10
	In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity?	4.7/10
	In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	4.1/10
	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	3.7/10
	Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?	3.6/10

Fig. 14: National community mental health survey – bottom five performing questions

The survey free-text comment themes largely reflect the trust's other experience feedback. The theme care and treatment received the most free-text comments (35.71%), of which the largest sub theme was that people had a general positive experience of their treatment (n=17) and excellent care (n=17). The largest number of negative comments related to wanting more support from staff (n=10) or more sessions (n=9). There were also many comments about staff, of which most were positive (n=28) with some negative comments regarding staff turnover and staffing levels (n=5). The theme with the largest

number of negative comments was appointments and access, with 17 comments regarding long waiting times.

Overall, when comparing the national survey results with local trust feedback, including the trust-wide survey programme (PEDIC), it seems that respondents to the 2018 national survey generally reported a more negative experience. This apparent discrepancy could be due to several reasons such as small sample size and differences in sample population, methodology and timeframe. As such, services should consider these results in conjunction with other feedback mechanisms and in light of any actions that have taken place in the time following the data collection period. This will enable the findings to be incorporated into local improvement initiatives. To further improve experience of services, the Trust continues to implement the Patient and Public Involvement (PPI) strategy and report to the Service User Involvement and Family and Carers Committees, which in turn report to the Quality Committee.

National Staff Survey 2018

In 2018, 1939 staff across the Trust took part in this survey. The response rate was 43% which is below the average for mental health/learning disability trusts in England (54%) and compares with a response rate of 44% last year.

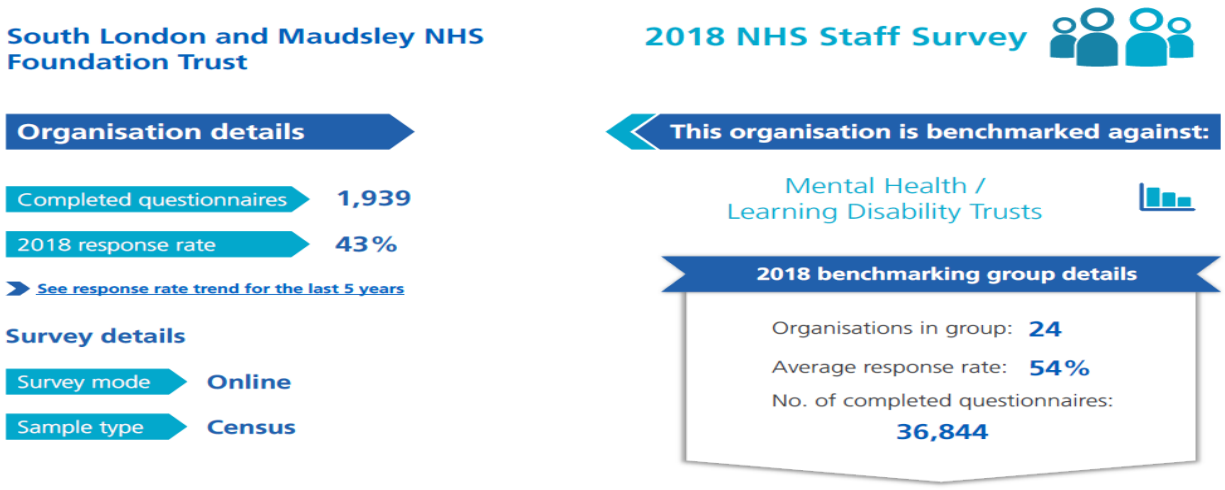


Fig. 15: 2018 NHS Staff survey details

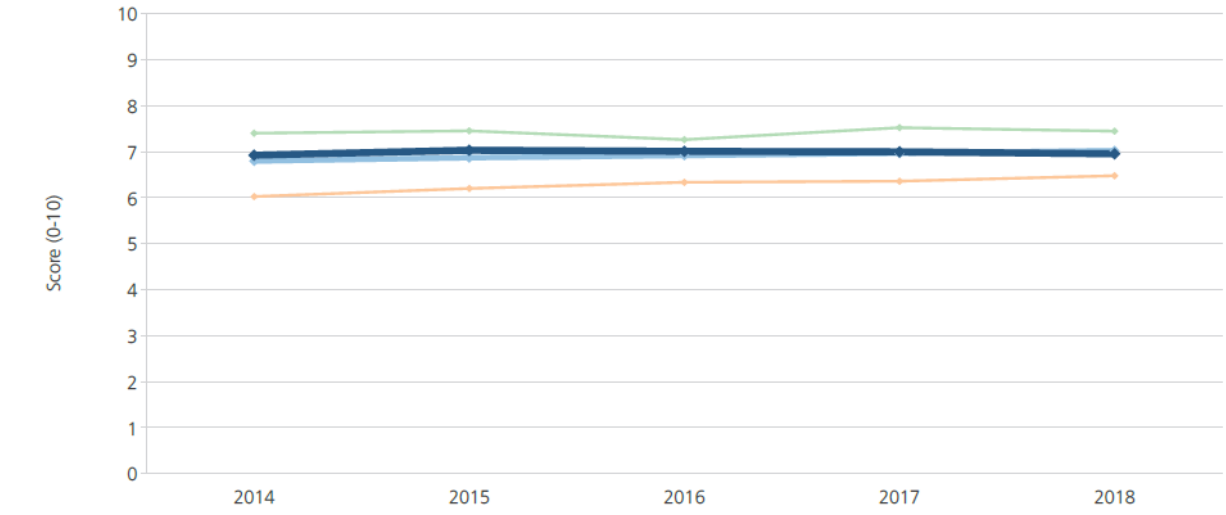
Overall Staff engagement

The graph below highlights Trust performance with staff engagement overall. SLaM performed alongside the average score of 7.0 and the same as 2017.

Survey Coordination Centre

2018 NHS Staff Survey Results > Theme results > Trends > Staff engagement

NHS England



	2014	2015	2016	2017	2018
Best	7.4	7.5	7.3	7.5	7.4
Your org	6.9	7.0	7.0	7.0	7.0
Average	6.8	6.9	6.9	7.0	7.0
Worst	6.0	6.2	6.3	6.4	6.5
No. responses	1,752	1,689	1,814	1,872	1,919

Fig. 16: 2018 NHS Staff survey results – staff engagement

Survey Coordination Centre

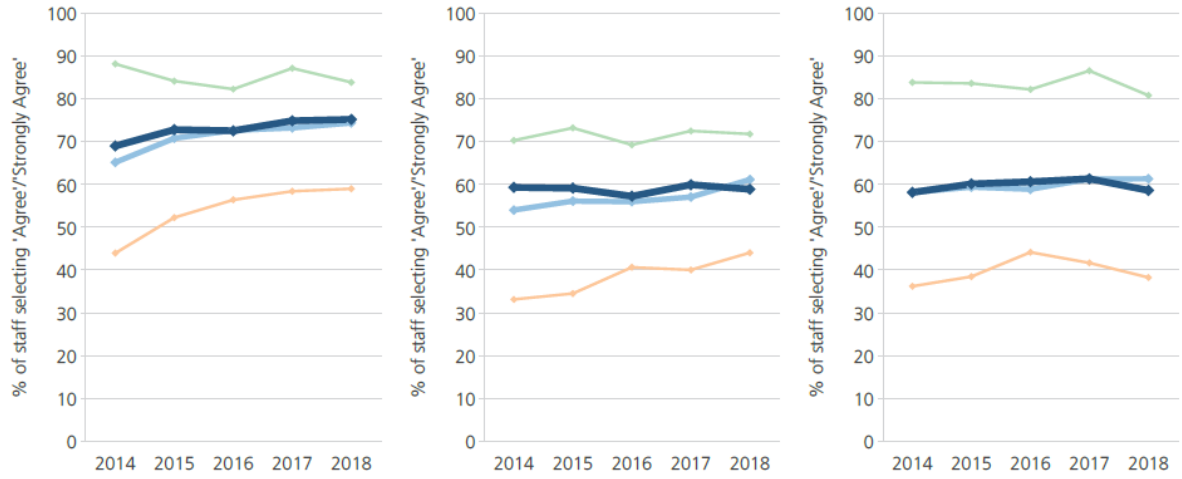
2018 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Recommendation of the organisation as a place to work/receive treatment

NHS England

Q21a
Care of patients / service users is my organisation's top priority

Q21c
I would recommend my organisation as a place to work

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2014	2015	2016	2017	2018
Best	88.1%	84.2%	82.3%	87.1%	83.9%
Your org	69.0%	72.8%	72.5%	74.9%	75.2%
Average	65.1%	70.8%	72.6%	73.2%	74.3%
Worst	43.9%	52.2%	56.4%	58.4%	59.0%

	2014	2015	2016	2017	2018
Best	70.3%	73.2%	69.2%	72.5%	71.8%
Your org	59.3%	59.1%	57.2%	59.9%	58.9%
Average	54.0%	56.1%	55.9%	57.0%	61.1%
Worst	33.1%	34.5%	40.6%	40.0%	44.0%

	2014	2015	2016	2017	2018
Best	83.8%	83.6%	82.2%	86.5%	80.8%
Your org	58.1%	60.1%	60.6%	61.3%	58.6%
Average	58.1%	59.4%	58.9%	61.2%	61.3%
Worst	36.2%	38.4%	44.1%	41.6%	38.2%

Fig. 17: 2018 NHS Staff survey results – detailed staff engagement theme

Key Findings – Overall Trust

Theme	2017 score	2017 respondents	2018 score	2018 respondents
Equality, diversity & inclusion	**8.6**	1786	**8.3**	1853
Health & wellbeing	**6.0**	1825	**5.7**	1875
Immediate managers	**7.1**	1824	**7.1**	1886
Morale		0	**5.9**	1843
Quality of appraisals	**5.7**	1653	**5.5**	1717
Quality of care	**7.3**	1603	**7.3**	1625
Safe environment - Bullying & harassment	**7.8**	1758	**7.7**	1831
Safe environment - Violence	**9.0**	1753	**9.1**	1818
Safety culture	**6.7**	1801	**6.6**	1862
Staff engagement	**7.0**	1872	**7.0**	1919

Fig. 18: 2018 NHS Staff survey results – key findings

There are some similarities between the Trust's overall results and the national picture. Nationally there are disappointing scores in relation to health and well-being, bullying and harassment, increases in the areas of stress and musculo-skeletal problems, and worsening perceptions of fairness of opportunity or career progression. Similarly, there are improvements nationally in the fairness of treatment of staff involved in incidents.

Next steps

Much of the work the Trust embarked upon over the past year to improve staff experience needs to be sustained over the long term to make a difference. The Trust-wide action plan is largely therefore a reinforcement of actions that are already in train, though renewed energy is needed to ensure they start delivering tangible results.

Now that the new borough-based clinical operational structure is well-established, the new directorates are being asked to develop and implement targeted local action plans to complement and reinforce this Trust-wide plan. We are confident that local leadership will make a difference to our staff.

Workforce Race Equality Standard (WRES)

Below outlines the percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

White	Trust score 2017: 23%	Trust score 2018: 25%

BME	Trust Score 2017: 26%	Trust Score 2018: 31.6%

Fig. 19: Percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

Our workforce is our most valuable asset and it is imperative that all staff feel valued, supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high-quality services by motivated and engaged staff.

The WRES Implementation Plan Year 1 and Year 2 are aimed at continuing to develop the foundations for change for equality and inclusion within the Trust, especially for BME staff where their reported experience is less favourable than white staff. This report identifies the difference in experience between white and BME staff and applicants through the 9 different WRES standards including Board composition and the proportional ethnicity of staff across the different pay scales and bandings. Four standards are taken from the Annual Staff Survey.

The first 9 months of Year 1 of the WRES Implementation Plan has provided useful learning with a range of degrees of progress. The Snowy White Peaks Group's reflection is that the components of the plan largely remain valid however there is a need in Year 2 to become much more focused in ensuring full implementation in all parts of the Trust and in obtaining detailed monitoring and more contemporaneous data that will enable Operational Directorates and Corporate Directorates to spot issues as they arise and adjust their plans and behaviours accordingly.

To remind ourselves, the Board's 3 Aspirations approved at its May 2017 meeting are that there will be proportionate numbers of BME staff:

• Across all senior grades

• Within disciplinary processes

• Accessing career development opportunities.

We are continuing to implement the Action Plan which will include a further phase of the inclusive leadership organisational intervention, the development and implementation of a mentoring programme, ongoing monitoring of recruitment success and referral to formal disciplinary process and additional training of Diversity in Recruitment Champions to participate in recruitment to senior roles within the Trust. We are beginning to see more BME staff represented at Band 7 and anove – it is too soon to report a sustained change.

Freedom to Speak Up Guardian (FTSU)

2018/19 has been a busy year for Freedom to Speak Up (FTSU) in the Trust. As the statistics show in the Board reports, we have seen an increasing number of cases being raised and a growing recognition of the function across the Trust.

The National Guardian's Office (NGO) declared October 2018 to be a national Freedom to Speak Up month and the Trust fully participated. Many activities were carried out across the Trust to increase staff awareness of the function. This was reported in detail at a presentation to the Board at the end

of October. As a result of the activity three new Advocates came forward to join the FTSU Network and cases jumped from nine in Q2 to 19 in Q3.

The CQC in August 2018 scrutinised the FTSU function as part of the Well Led Inspection. They identified tree "should do's" about the need to continue to promote the function so that every member of staff is aware of it; to ensure there is clear open recruitment to the role of Advocate; and to continue to train and develop the Advocates. A report to the Delivery Board in February 2019 has demonstrated satisfactory progress on all three fronts.

Preparation is underway for the Board to undertake a self-review against the Guidance for Boards on Freedom to Speak Up in NHS Foundation Trusts. The response to the Guidance was reported to the Board by the Chief Executive in October 2018 and the Self-Review exercise will take place in May 2019.

The second Annual Report of the Freedom to Speak Up Guardian (FTSUG) will be presented to the Board in April 2019 with quarterly reports to the Board from the FTSUG for the rest of the year. This report will analyse the cases for 2018/19, reported quarterly to the NGO, identifying themes and barriers to speaking up as well as learning and improvement opportunities.

Equality information and objectives

The Trust has a longstanding commitment to demonstrating accountability for its performance on promoting equality within its workforce and service provision. The Trust publishes a suite of annual equality information to demonstrate how it complies with its equality obligations. This includes the following:

- 2018 Workforce equality information: This provides equality data for staff with different protected characteristics on a range of workforce metrics.
- 2018 Trust-wide equality information: This provides information on the demographic profile of the Trust's service users and the experience of service users from all protected characteristics during the previous three years
- 2018 ethnicity reports for Croydon, Lambeth, Lewisham and Southwark: These provide ethnicity access and experience ethnicity data on key services in each borough. This year's report also includes outcome data for Improving
- Workforce Race Equality Standard (WRES) information
- Annual gender pay gap report.

The Trust's equality objectives are set out in our Integrated Equalities Action Plan 2018-21. It aligns the Trust's approach to promoting equality for its workforce and for service users, carers, families and communities and reflects the strategic priorities of the Trust's 'Changing Lives Strategy'. It captures existing commitments, legal requirements, prioritised areas for improvement and sets out measures of success over the next three years.

From this year the Board will receive an integrated annual report on action plan delivery, equality information and a refreshed Equality Delivery System (EDS 2) assessment in June. This alignment will

provide the Board with an efficient and effective view of implementation and outcomes of all work streams in the Integrated Equalities Action Plan. It will also enable the Trust to be more focussed and responsive to the equality information it publishes each year.

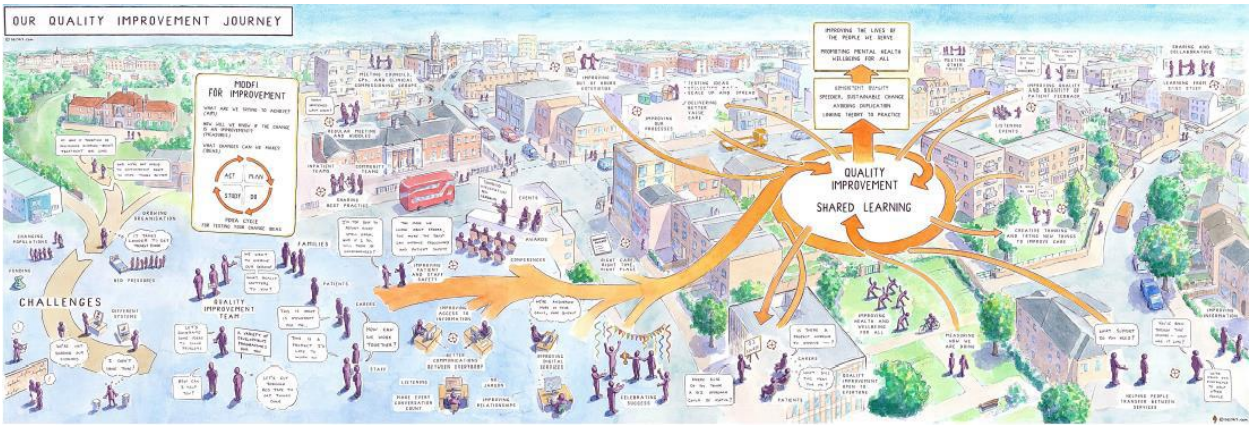
Our priorities for improvement for 2019/2020

The priorities for 2019/2020 have rolled over from 2018/2019 and remain arranged under the four areas outlined below which incorporate the broader domains of patient safety, clinical effectiveness, patient experience and staff experience. It was agreed to set the priorities over a three year stretch target to enable Quality Improvement (QI) programme and relevant work streams to embed and sustain real improvement. Wording for three indicators has been clarified for 2019/20. Achievement relating to these priorities will be reported in next year's Quality Report.

- We will reduce violence by 50% over three years with the aim of reducing all types of restrictive practices
- All patients will have access to the right care at the right time in the appropriate setting
- Within three years we will routinely involve service users and carers in: service design, improvement, governance and the planning and delivery of their loved one's care.
- Over the next three years we will enable staff to experience improved satisfaction and joy at work

Fig. 20: Percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

Quality Improvement (QI)



Instrumental in achieving the Trust Quality priorities is the QI methodology underpinning the many improvement work streams within the Trust. The main Trust-wide streams are outlined below:

Improving Care and Outcomes (ICare) with general adult mental health inpatient and community services

ICare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). It was set up in May 2017 with support from the Institute for Health Care Improvement (IHI), in response to problems that were highlighted with inconsistency in the quality of care and outcomes for people who use SLaM services. Whilst there were some areas of excellent practice, others required improvement. Too many patients are admitted outside of their local borough, significant variation in hospital length of stay was highlighted, with significant delays in some areas, and teams were not always working at their best across boundaries with teams in other directorates and with primary and social care.

The IHI quality improvement collaborative methodology was adopted as an approach. This provides an opportunity for the four boroughs to work together to develop and improve a consistent approach to care (access, safety, experience) and outcomes.

Seven key principles, developed collaboratively underpin the approach, namely that ICare improvement work would:

1. Have clear sponsorship and leadership from senior clinicians and managers
2. Be co designed or co-produced with patients being at the centre and involve carers, staff and external stakeholders
3. Make systematic use of data to inform and test and change ideas for improvement
4. Ensure service users and staff feel physically and psychologically safe to use and work in services
5. Provide opportunities for people to develop their knowledge and skills in QI methodology to enable them to test changes, share learning and scale up and spread successes.
6. Be supported by the Quality improvement and SLaM Partners (QISP) team, who have expertise in QI methodology (methods, tools, measurement, value) and psychological approaches to organisational development
7. Governed through weekly Icare meetings

Patient Safety

There are a range of initiatives being tested to improve the safety of our inpatient units. ICare has focussed on Four Steps to Safety and latterly the testing of behaviour support plans.

Four Steps to Safety

Four Steps to Safety was initially launched in January 2016 and involved an extensive suite of interventions to reduce violence and aggression. This is a trust-wide initiative and for adult mental health this work has been incorporated into ICare. Between January – April 2018, the QI Team facilitated a review of the work across each directorate, identifying the challenges and what had worked well. The findings were presented at an Inpatient Safety Learning event in May 2018. As a result, the initiative was relaunched with fewer interventions:

- DASA: A risk assessment tool used to identify and communicate the likelihood of violence and aggression over a very short period of time, prompting staff to provide support earlier to prevent incidents from escalating.
- Report-out board: A visual tool used to update the team of specific tasks and who in the team is responsible for which task, to help ensure people's needs are being met.
- Proactive engagement: 'Checking-in' conversations with patients during each shift to identify and act on their needs promptly.

- Mutual agreement: A document coproduced with patients and staff around the values and shared expectations of how people will behave towards each other.
- SBARD (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, **D**ecision): A communication tool used for clinical handovers to ensure the concise communication of pertinent information.

Successes and challenges

The QI Team have worked alongside the Matrons in adult mental health to support the acute wards to implement the Four Steps to Safety. There are pockets of success where wards have fully implemented the interventions and are demonstrating improvements. Although we have not yet reached the target of a reduction by 50% there are a number of teams that have demonstrated positive and sustained change.

Standardised ways of working

We want to ensure that the people who access our services experience the same standards of care no matter which borough they live in or which service they are under. Both the inpatient and community operational care process models (CPM) are being developed with service users, carers and staff so that people know the fundamental standards of care, namely standards of best practice (SBP), they can expect to receive in every ward and community team. The theory is that SBPs will reduce variation in practice and have a positive impact on patients receiving timely assessments and treatment thereby reducing need for admission, improving experience and achieving outcomes that matter to them. The operational standards for the SBP in the models below have been developed in the context of Royal College of Psychiatrists' Standards and learning from other mental health Trusts, Trust policies for good practice and national guidance. Furthermore, it has been informed and developed using Trust data and the outputs of the detailed care process maps produced with clinicians, service users and carers.

The aim therefore is:

For inpatient CPM that:

The patient experience and recovery journey is structured, purposeful, collaborative, safe and compassionate, taking into account complex needs and harm minimisation.

For the community CPM that:

Together with partners provide the community with easy access to the right mental health services, of the right quality, for the right length of time that meets their needs

We will measure whether the inpatient and community CPMs contribute to making a difference to outcomes using the agreed set of outcome and process measures for ICare, including length of stay, number of admissions, readmissions with 30 days, adherence to SBP, patient experience and staff engagement and cost. Local and more specific ward/community improvement measures will be used in addition and will be determined based on the needs of local teams.

Annex 1

NHS Croydon CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG Joint Statement on South London and Maudsley NHS Foundation Trust's Quality Report 2018/19

The Clinical Commissioning Groups contracting with the South London and Maudsley NHS Foundation Trust have welcomed the opportunity to review your Quality Account for 2018–2019. We are able to confirm that it complies with the requirements as set out by NHS England. The Quality Account provides an open and transparent declaration of the status of the quality of the services the Trust provides which is well written and generally easy to navigate. It appears to be at a fairly final draft stage at the point of review.

We have been grateful to the Trust for the way that colleagues have worked openly with us – supporting our assurance processes – taking our concerns seriously and responding to questions helpfully and in a timely way. We are grateful and supportive of the move taken by the Trust during 2018/19 to listen to our concerns and suggestions for improvement in its internal serious incident processes in order to provide us with greater levels of information.

We also note the Trust's engagement and commitment to working in partnership and their open and honest approach to quality. There is widespread appreciation across the four commissioners of SLaM's senior commitment and regular attendance at CQRGs, enabling transparent productive discussions.
Commissioners recognise that the Trust is committed to providing the very best quality care to patients.
We support the Trust's quality priorities for 2019/20 and beyond, noting that that there are fewer priorities than in some previous years and that delivery of these priorities is planned over three years (2018-19 being the second of three years). This makes the achievement of the ambitious targets the Trust has set itself more likely, as a consequence of the clearer prioritisation and the ability to plan over longer timeframes this approach will afford.

We are disappointed that progress against the quality priorities has been slow but are looking forward to an increase in the pace of change. There is recognition amongst commissioners that the Trust has set challenging targets, and look forward to more tangible improvements in 2019/20. The enhanced Quality and Performance report now includes the quality priorities, giving them more profile and the ability to be tracked. This is welcomed by all four commissioners.

We wish to publicly acknowledge the significant amount of work undertaken and sheer focus and application across all grades of staff in response to the CQC inspection. This was demonstrated most clearly by the quick response to the issues raised by CQC in the 2018 core services inspection and the lifting of the improvement notice just into 2019/20. We see this as evidence that SLaM staff are able to make rapid and effective improvement when fully supported to do so.

We are pleased to see feedback about the work of the Freedom to Speak up Guardian and a clear plan for how the Trust intends to learn from this.

The CCGs are looking forward to continuing to work collaboratively with the Trust over the coming year in new partnerships and alliances as we implement wider system changes in support of quality improvement for the benefit of service users in Croydon, Lambeth, Lewisham and Southwark.

Council of Governors' reply to South London and Maudsley NHS Foundation Trust (SLaM) Quality Report 2018/19

The SLaM Governors are drawn from a membership which covers the very wide area of south London served by the Trust. We have aimed over the past year to play a robust and meaningful part in the governance of the Trust, and the Governors value this opportunity to comment on the current year's Quality Accounts. The Governors' Quality Working Group meets four times a year and sends an observer to meetings of both the Quality Committee and the Trust-wide Mental Health Law Committee, who reports the proceedings back to the group.

We have followed closely the effect of the CQC warning notice following the 2018 inspection, and have been aware of the very real efforts made by the Board, the NEDs and the staff as a whole to bring about a more qualitatively even level of service across all pathways of care. We congratulate them on their success, whilst acknowledging the further improvement that can still be made.

We have followed the development of the QI programme at Board meetings and have seen some impressive ideas and outcomes, particularly on the management areas of the Trust's work. Whilst we recognise that this ultimately, of course, has a positive effect on patient experience, and are aware that the key QI initiatives are co-produced with service users, we are looking forward, in future, to hearing examples of service user initiation in QI initiatives.

Stakeholders were surveyed on their general awareness and understanding of the Trust's Quality Priorities and it made interested reading, showing that not all staff are as aware as they might be of them and how they might/should affect their work. However, this confirms, we feel, the good sense in the decision made to keep the same priorities for three years in order to give them a chance to embed as fully as possible throughout this very large organisation.

Review of the Quality Performance for 2018/19

Patient safety

We accept that the apparent increase in reported incidents of violence and aggression is a recognised effect of increased observation and recording of these events, and are pleased to note that, while no statistically important changes have been signalled in the Trust-wide data graphs, there are significant examples of reduction in prone restraint in Lambeth, and there has been decreased use of Rapid Tranquillisation in Lewisham. We will be eager to see if the data continues to show reduction as this important Quality Priority continues into another year.

Patient experience

We are pleased to see the increase in the number of care plans being co-produced, and the involvement of carers in this process, and hope that this performance will continue to increase in the year ahead.

We are pleased to see that the Trust scores highly in many areas in the *2018 National Community Mental Health Survey*. We note, with particular approval, the "significant shift upwards" in scores in answers to questions about support and wellbeing in relation to carer involvement.

We hope that the disappointing results of the bottom five questions are being noted, and while we understand that there is excellent work being done in some areas in the Trust, we hope that this good practice will extend throughout all the boroughs, so that all service users will eventually get the advice and help that they need, particularly on practicalities such as advice on benefits and job advice.

Safer staffing and staff experience

The wellbeing of staff is crucial for the success of the Trust's work, and is a major concern of the Governors. As the clinical operational structure of SLaM has changed to borough-based directorate, and more focus is placed on community services, we recognise that recruitment and retention of good staff is of prime importance if this change is to have the success that everyone is looking for. Equality and diversity issues have to be fully and successfully addressed. We know that the Board is fully aware of this issue, and that they are committed to finding ways of improving staff experience so that they feel valued, supported and engaged. Many new initiatives have been introduced, but sustained and sympathetic action is needed to ensure their success.

The Freedom to Speak Up Guardian plays a vital role in this work, and we are pleased to see this function making some significant progress.

Priorities for improvement 2019/2020

Staff at all levels of the Trust approached the CQC inspection in July 2018 with their usual energy and are to be congratulated on the overall 'good' rating. The warning notice given for the Acute and PICU pathway for, in the main, inconsistency in quality of care was tackled with similar energy and determination. A new method of reporting and monitoring activity at team level – involving reporting concerns and issues from 'floor' up to the Board – was implemented, huddles happened, changes were wrought and, as a result, the warning notice expired in April 2019. The Governors are fully aware of how much focused effort and hard work went into this undertaking, and know how deserved was the result. We have every hope that the changes will become firmly embedded – and improvements made permanent.

Participation in national quality improvement programmes - Audit

The Governors are interested to see that SLaM has taken part in national audit programmes, thus ensuring that our services are constantly being improved and kept up to the highest national standards.

The Trust has undergone an operational structure change from Clinical Academic Groups to borough-based directorates; we hope that community services – also the focus of a redesign process - will be subject to the same rigorous audits. We are encouraged, therefore, to see that the *National indicators for 2018/2019* and the *National indicators for 2019/2020* require SLaM to report performance against indicators in three areas of community care:

1) Care Programme Approach 7-day follow up;

2) Home Treatment Team Gatekeeping; and

3) Re-admission to hospital within 28 days of discharge.

As these are all significant indicators of the quality of community care (and in (1) contributing to reducing the suicide rate) we are hopeful that good oversight will be kept on these future developments throughout the Trust.

Information Governance

The Trust is to be congratulated on its work to improve its digital competence. In signing up to a unified data-sharing framework across South East London, it has further supported the expansion of the shared care record in this part of London – the Virtual Care Record.

We are aware that SLaM, like NHS organisations throughout the country, has challenges with the consistency and reliability of its digital systems. However, we are also cognisant of the work being done to improve data provision for all its staff, and therefore to contribute to the ultimate improvement in care for its service users. Governors welcome improvements to data quality, and anticipate effective and regular training to make the most of digital tools available to staff.

We might mention here the work being done to develop the Trust's informatics strategy, and to establish the Quality Centre which will provide the basis of Trust-wide data which will prove central to the provision of excellent care for all its service users and staff.

Local Healthwatch organisations' reply to South London and Maudsley NHS Foundation Trust (SLaM) Quality Report 2018/19

No response received

Annex 2

Statement of Directors' Responsibilities in Respect of the Quality Report

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to 21 May 2019, including
  - Papers relating to Quality reported to the Board over the period April 2018 to 21 May 2019;
  - Feedback from commissioners dated May 2019
  - Feedback from Governors dated May 2019
  - Feedback from local Healthwatch organisations May 2019
  - The Trusts complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Quarters 1, 2, 3 and 4 2018/2019
  - 2018 national patient survey results dated November 2018
  - 2018 national staff survey results dated November 2018
  - The Head of internal audit's annual audit opinion over the Trust's control environment dated 20 May 2018
  - CQC quality and risk profiles published throughout the year

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

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

By order of the Board

Signed

June Mulroy
Chair
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

Signed

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

Annex 3

Glossary

Approved Mental Health Professionals (AMHP)	AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating assessment and admission to hospitals.
Care Programme Approach (CPA)	The Care Programme Approach (CPA) is a type of support that a person might receive or be offered if they have mental health problems or complex needs. The Care Programme Approach is inclusive of an assessment of needs, a care plan, regular review of your needs and the care plan and a Care Co-ordinator.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) is a health and adult social care regulator in England. The CQC inspects services based on five Key Lines of Enquiry, these are: safety, effectiveness, caring, responsiveness and well-led.
Chief Clinical Information Officer (CCIO)	Deputy Medical Director for Information
Clinical Commissioning Groups (CCG) / Commissioner	A Clinical Commissioning Groups (CCG) (also known as Commissioners) "are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area." (*About CCGs, NHS Clinical Commissioners*). SLaM is commissioned by Croydon, Lambeth, Lewisham and Southwark CCG.
Control Objectives for Information and Related Technologies (CoBIT)	IT governance and management framework which covers risk management, assurance and audit, data security, governance and governance
Commissioning for Quality and Innovation (CQUIN)	Commissioning for Quality and Innovation (CQUIN) is a payment framework whereby quality improvement goals are linked to financial reward.
Datix	Datix is the incident reporting system which SLaM uses for the recording of incidents and complaints.
Electronic Observation Solution (eOBs)	Electronic Observations Solution is the digitalisation of patient observations (vital signs) also known as early warning signs (MEWS) as opposed to the use of paper MEWS Charts.
Electronic Patient Journey System (ePJS)	ePJS is the electronic system that SLaM uses to document patient notes.
Health Service Journal (HSJ)	The Health Service Journal (HSJ) is a website and serial publication which covers topics relating to the National Health Service and Healthcare.
Hospital Episode Statistics (HES)	Hospital Episode Statistics is a data repository held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which stores information on hospital episodes i.e. admissions for all NHS trusts in England.
Local Care Record (LCR)	A secure integrated portal between SLaM, GSTT, KCH and 90+ GP practices in Southwark and Lambeth electronic health records, which provides instant real-time access to health records to care professionals during direct care.
Mental Health Minimum Data Set (MHMDS)	Mental Health Minimum Data Set (MHMDS) is a regular return of data from providers of NHS funded adult secondary mental health services, produced during in the course of delivering services to patients.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	NCISH is a National Confidential Inquiry into Suicide and Homicide by People with Mental Illness which collected suicide data in the UK from 2003-2013 (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester). It is commissioned by the Healthcare Quality Improvement Partnership (see Healthcare Quality Improvement Partnership entry).
National Health Service England (NHSE)	National Health Service England (NHSE) is a body of the Department of Health (see Department of Health entry) which leads and commissions NHS services in England.

National Reporting and Learning Service (NRLS)	The National Reporting and Learning Service (NRLS) is a system which enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.
Operations Directorates (OD)	In 2018/19, the services SLaM provides were reorganised into Operations Directorates. These directorates are largely organised by borough. This means that the trust can work in close partnership with local organisations and health and social care agencies across all mental health conditions to provide care closer to home. In some instances, our services are provided for national patients or are specialist for specific groups of our local population. In these instances, the care is best managed on a trust-wide basis so that we can concentrate expertise around smaller numbers of patients. Therefore, the new management model brings together Operations Directorates and previous research-focussed Clinical Academic Groups (CAGs) to ensure we have the expertise to offer patients the very best care and treatment, based upon reliable research evidence. The new Operations Directorates are: • Child and Adolescent Mental Health Services • Croydon and Forensics • Lambeth • Lewisham • Psychological Medicine and Older Adults • Southwark and Addictions.
Prescribing Observatory for Mental Health -UK (POMH-UK Audits)	The Prescribing Observatory for Mental Health UK audits are National Clinical Audits (see National Clinical Audit entry) which assess the practice of prescribing medications within mental health services in the United Kingdom.

Fig. 40: Glossary

Fig. 28: POMH - valproate prescribing in bipolar illness

Fewer women of childbearing age were prescribed valproate in SLAM compared with the average national sample, as shown below.

Actions taken

The Trust has taken the following actions during 2018/19:

- In PMOA there is work underway with GPs to redesign the referral process and referral form.
- Older Adult have worked with CRISS to develop a tool to monitor antipsychotic monitoring for patient with dementia.
- Quality improvement projects to improve the waiting times for patients with a diagnosis of dementia have been ongoing; including increasing memory service capacity in Croydon.
- Up to date Information on community Speech and Language Therapy (SALT) services has been circulated to community teams.
- The inpatient nutrition screening tool is being redeveloped and that will include feeding / swallowing issues.

The Trust continues to assess the impact of the actions highlighted in mortality reviews.

In 2019/20 we will be implementing the Royal College of Psychiatrists' standardised care review tool for

Independent Practitioners Limited Assurance Report to the Council of Governors of South London and Maudsley NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of South London and Maudsley NHS Foundation Trust to perform an independent limited assurance engagement in respect of South London and Maudsley NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

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

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to May 2019;
- feedback from commissioners dated May 2019;
- feedback from governors dated May 2019;
- the Trust's internal complaints reports over the period April 2018 to January 2019
- the 2018 national patient survey;
- the 2018 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 20/05/2019; and
- the Care Quality Commission's inspection report dated 23rd October 2018;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.
The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of South London and Maudsley NHS Foundation Trust as a body, to assist the Council of Governors in reporting South London and Maudsley NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and South London and Maudsley NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing

and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by South London and Maudsley NHS Foundation Trust.

Our audit work on the financial statements of South London and Maudsley NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as South London and Maudsley NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to South London and Maudsley NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006.

Our audit work is undertaken so that we might state to South London and Maudsley NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of South London and Maudsley NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than South London and Maudsley NHS Foundation Trust and South London and Maudsley NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK
LLP Chartered
Accountants
110 Bishopsgate, London, EC2N 4AY

29th May 2019

Croydon Health Services NHS Trust

Croydon Health Services NHS Trust

Quality Account

2018 – 2019

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Contents

PART 1

Information about the Quality Account

Introduction

Croydon Health Services NHS Trust (CHS) had a remarkable year that included opening our major new Emergency Department and reshaping our local partnerships - creating new opportunities for seamless high-quality care across the borough.

Our Emergency Department is already providing more urgent care than before, to an even higher standard of comfort and clinical efficiency. Huge credit is due to our clinical teams who invested so much thought into its design – including a new Urgent Treatment Centre, two mental health liaison rooms and dementia-friendly features.

Croydon Health Services NHS Trust is very well positioned to fulfil the new NHS Long Term Plan. We had already been making great progress with partner care organisations, who share our vision of helping people in Croydon lead longer and healthier lives.

In April 2017 we established an alliance called 'One Croydon' with Croydon Council and Age UK Croydon. In a very short space of time it has made services more seamless and created services like Living Independently for Everyone (LIFE), which helped 847 people avoid possible hospital admissions in its first year and helped many more to get home earlier after treatment. Other systems within One Croydon, such as our Integrated Care networks, are similarly successful. These successes were recognised when One Croydon won the Local Government Chronicle's prestigious annual Health & Social Care award in March this year.

Our partnership with Croydon Clinical Commissioning Group (CCG) is also about to become even stronger. Together we are already seeing considerable benefits from the shared roles and functions of, for example, our Joint Chief Pharmacist and our Integrated Safeguarding Team.

To further strengthen this CCG partnership, in May 2018 we started discussions with them about how we could work more closely together. I am very pleased to say that, by April 2019, we have already announced our first shared appointment at executive level – Elaine Clancy, who will work for both organisations as Joint Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals.

Through closer alignment, we will be able to improve the health of local people by providing better quality, more joined-up care and working more efficiently by reducing duplication.

The CQC held a routine inspection of our services in the community and at Croydon University Hospital, rating us 'good' for caring. When combined with the results of the Trust's previous inspection in 2017/18, this latest report shows seven out of the nine core

services inspected at Croydon University Hospital (CUH) are now rated as 'good'. We do however have much more to do as the Trust overall is rated as 'requires improvement' and we are committed to improving this going forward.

A survey by the Care Quality Commission (CQC) also rated our multi-award-winning maternity services the best in London for treating mothers with dignity and respect during labour and the birth of their babies.

The Trust is continuing on its improvement journey and we have made real progress to act on the findings of the CQC – but there are many other areas where more work is required – one example being our response to the findings of the NHS staff survey. To improve our services for the people we care for, we must improve our support for staff.

Like the majority of NHS trusts, we face the challenges of increasing demand and rising expectations. An area where this is particularly obvious is in our Emergency Department (ED). Our four hour performance in ED has been below the national target of 95%. This has begun to improve as a result of the decisive targeted actions we are taking and the hard work of our teams in the ED and across our acute and community services. We are also working closely with our health and social care partners right across Croydon.

Additionally, some of our teams are below their full permanent staffing complement and, whilst we ensure safe staffing levels through the use of our Bank staff, recruitment is an ongoing priority.

To help with this, we have set very clear objectives for the year alongside our longer term goals as well as our vision and values to ensure our progress continues at pace throughout the year ahead. All Trust projects will now be aligned to four objectives:

- High quality care
- Supporting our staff
- Sustainable finances
- Improving health for all

Beyond the partnerships mentioned above, we continue to perform well in many other areas. Some examples are:

- Throughout the year, our Trust was also better than the national average for our consultants seeing patients with 18 weeks.
- We have consistently performed within the capital's top five trusts for short waiting times to diagnose and treat patients with cancer.
- The annual national Inpatient Survey revealed a continuation of our positive trend, rating us as improved in the vast majority of areas.
- We have successfully delivered against the incomplete national performance target for referring patients to treatment (RTT) during 2018/19. Performance has continued to improve on an upward trend since April 2018, ending the year on 92.22%. The

Trust's performance has consistently been positioned around 11th out of the 24 London Trusts since November 2018.

- We were rated top in South West London for cleanliness and maintenance of buildings in the annual Patient-Led Assessments of the Care Environment (PLACE).
- Out Infection Control Team met the national C.Difficile target for the third year running, again reflecting the premium we put on cleanliness.
- No other acute Trust in England matches our percentage increase in participation in clinical trials, and we are bringing the latest treatment, techniques and thinking to benefit people in our community first in Croydon.

The developments in our Trust and the deepening of our partnerships mean we can focus more time, energy and expertise on transforming our services, and fulfilling our twin ambitions of excellent care for all and better public health in future.

Mike Bell
Chair

Matthew Kershaw
Interim 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 11) we describe our main priorities for 2019/20. We are required to include specific data from 2018/19 that we have provided to National Bodies such as the Care Quality Commission and the Health and Social Care Informatics Centre.

In section 3 (page 42) of this report we describe our achievements against the quality priorities we set in 2018/19. 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 a hugely diverse borough with a growing population and we play an important role in keeping our community well and healthy.

Croydon Health Services employs more than 3,800 staff and provides integrated NHS services to care for people at home, in schools, and health clinics across the borough, as well as at Croydon University Hospital and Purley War Memorial Hospital.

Croydon University Hospital, in the north of the borough, provides more than 100 specialist services and performs 350,000 outpatient appointments every year. We also perform more than 25,000 procedures annually. The hospital is also home to the borough's only Emergency Department, supported by three GP hubs, as well as 24/7 maternity services; including a labour ward, midwifery-led birth centre and the Crocus home birthing team.

Purley War Memorial Hospital (PWMH), in the south of the borough, offers outpatient care, including diagnostic services, physiotherapy and ophthalmology services run by Moorfields Eye Hospital, alongside an onsite GP surgery.

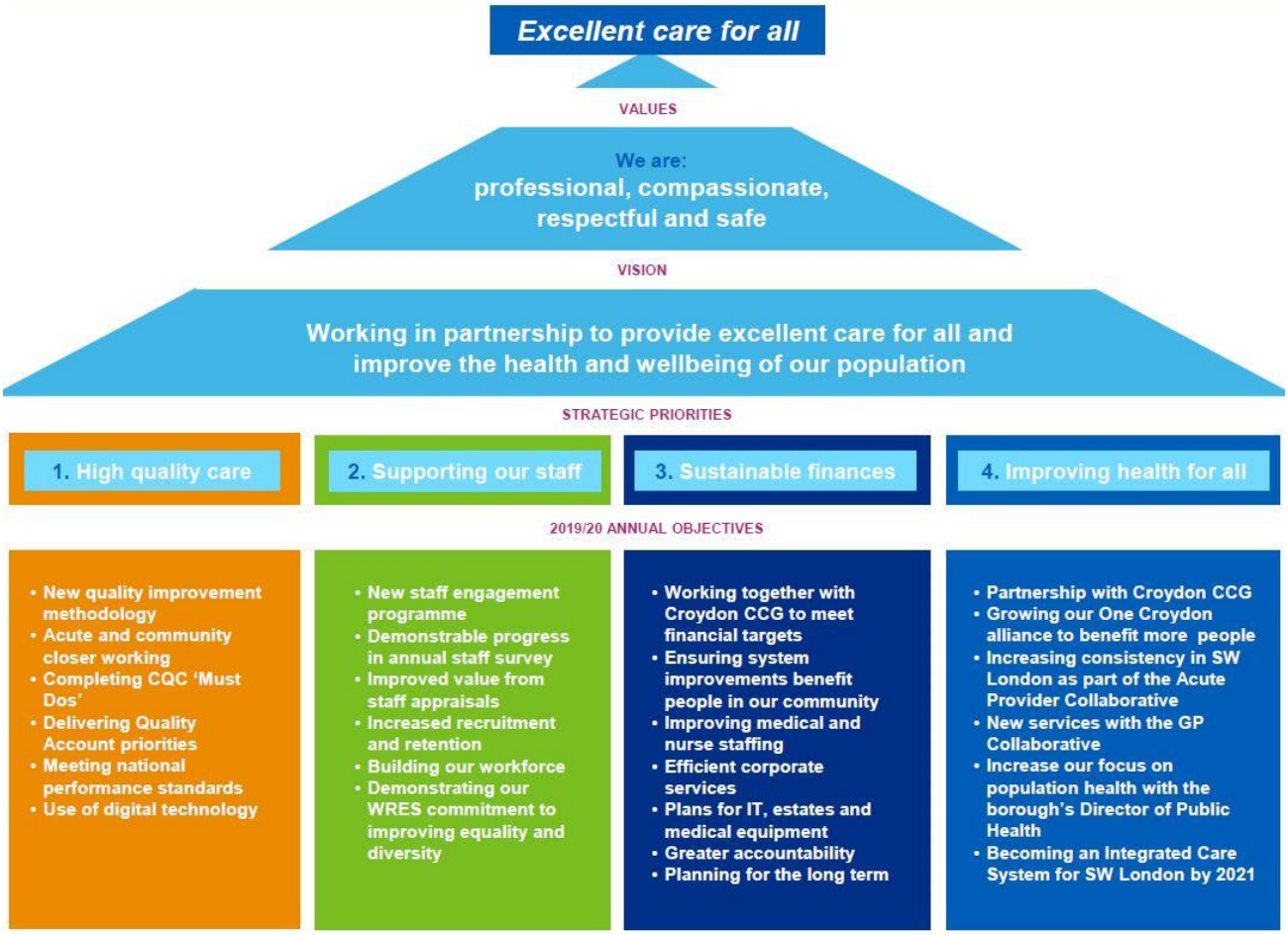
Our experienced district nursing teams, Allied Health Professionals and community matrons look after people of all ages across Croydon, and our Children's Hospital at Home cares for children with long-term conditions without them having to come to hospital.

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.

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

Trust Objectives

Well led organisations have, among other attributes, a clear set of objectives that explain the priorities for the organisation to its staff, partners and other key stakeholders. Our objectives, detailed in the table below, are the result engagement with our workforce and ongoing planning with partner organisations.



Vision and values

"Working in partnership to provide excellent care for all and improve the health and well-being of our population"

This is our renewed vision for the Trust.

Rooted in our community through our hospitals and clinics across the borough, we always strive to provide excellent care for all.

Croydon is a great place to live and work but some people in our borough face the challenges of poverty, housing or other environmental factors that can contribute towards poorer health and shorter lives.

Our local population is also growing rapidly in size. We have the youngest population of any London borough, with almost a third of our residents aged under 25 and, at the same time, people are living longer.

This means we have to do much more to prevent ill-health and help people in Croydon to stay well. We must do this at the same time as providing rapid access to diagnostic services and medical expertise when and where it is needed.

Collaboration is the key. Only by working well together with our partners in the borough, can we connect the services available to give people more coordinated and person-centred care which will deliver real benefits for our patients and service users in the years to come.

Our values

We want local people to feel confident in our care, and for our staff to feel proud to work here. Our values shape everything we do, every single day. They determine our behaviour and the experience of those we look after.

We will always be professional, compassionate, respectful and safe.

Professional:

- Set ourselves very high standards and share best practice
- Keep our uniforms smart, and be professional and consistent in our approach
- Work in partnership to best support our community's needs
- Use resources wisely without compromising quality or safety

Compassionate:

• Treat everyone as we would want to be treated ourselves

• Demonstrate kindness, dignity, empathy and compassion

• Make time for the people we are caring for, to understand their needs and wants

• Organise our services to give people the best possible experience of care

Respectful:

• Be courteous and welcoming, and introduce ourselves

• Value the diversity and needs of everyone

• Always involve people in decisions about their care, listening to and respecting their wishes

• Appreciate the contribution that staff from all backgrounds bring to our services

Safe:

• Be open and honest in everything we do, sharing what we do well and admitting our mistakes, to constantly improve our care

• Protect the confidentiality of those in our care and show sensitivity to people around us

• Feel free to raise concerns so we are always learning

• Make time for training and development and support research so people always receive the highest standards of care

PART 2

Priorities for improvement and statement of assurance from the Trust Board

Priorities for Improvement 2019 - 2020

The quality of the care that we provide and the safety of our patients are both very important priorities for the Trust. Our vision is to deliver continuous improvements in the quality of care and 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.

As a Trust we have developed our Integrated Quality and Performance Report (IQPR) which includes a wide range of qualitative and quantitative information to monitor our performance. It also supports the identification of themes and areas of both best practice and areas for improvement. The IQPR is produced each month and is presented to the Executive Management Board, the Quality Committee, the Finance and Performance Committee and the Trust Board. A Directorate level IQPR is also produced and presented to the monthly Directorate Quality Boards. The IQPR provides 'ward to board' openness and transparency and is a key tool to improve quality and performance throughout the Trust.

A key challenge for the Trust continues to be 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 post inspection recommendations) from the Royal Colleges, NICE and CQUINs. 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 themes emerged.

Our priorities for 2019/20 were developed in discussion with our Clinical Directorates, Patient Safety and Mortality Committee, and our Quality Committee. We held a public survey on our priorities which was open to staff, patients, stakeholders and members of the public, along with our Commissioners, Croydon CCG (Croydon Clinical Commissioning Group), and Healthwatch.

We have kept those priorities from 2018/19 which remain key, or where we consider further improvement is required, for example creating a safety culture and listening to our patients. This will allow us to continue to make sustained improvement and build on the good work that we have achieved in the previous year.

The delivery of this year's quality priorities will be monitored through our Integrated Quality and Performance Report.

Our quality priorities for this coming year are set out below and each makes reference to the key related CQC domain and our specific objectives for these.

1. **To continue to embed a culture of patient safety and shared learning (CQC safe domain)**

    - Medication management – ensuring patients are discharged with the correct medication first time and reducing the number of inpatient omitted doses from 5% to 3%.

    - Continue to improve reporting of incidents and sharing learning throughout the Trust by an increase in reported incidents and a reduction in the percentage which have resulted in harm.

    - Reduce laboratory confirmed catheter associated e-coli blood stream infections by 5%.

2. **To improve accessibility to our services (CQC effective domain)**

    - Continue to roll out the NHS electronic Referral Service (eRS) Advice and Guidance provision – currently 75% of services providing 48 hour response to GPs – to 100% of services.

    - Improve the signposting and provision of information in preferred languages.

    - Be compliant with the Accessible Information Standards.

    - Continue to improve the access & flow from ED to discharge in order to meet national targets.

    - Continue to improve our support and care of people with mental health conditions, learning disabilities, autism and dementia who access our services by an improved position against 'Treat as one' and an increase in the number of these patients with a personalised care plan.

3. **To continue to listen to our patients and service users (CQC responsive domain)**

    - Involve patients and service users in the co-design of services through the establishment of a Patient/Public Engagement Strategy and Forum.

    - Review and respond constructively to patient feedback through a thematic review of the Friends and Family Test (FFT) free text responses to develop an improvement action plan and 'You said, we did' campaign.

- Respond to 95% of complaints within agreed timescales and reduce number of re-opened complaints.

- Review and improve upon our public engagement through the establishment of a Patient/Public Engagement Strategy and Forum.

4. **To embed the Trust's vision and values throughout the Trust – "Excellent care for all and helping people in Croydon live healthier lives" by being professional, compassionate, respectful and safe (CQC well led domain)**

    - Continue to strengthen our governance systems and processes through a programme of improvement supported by review and internal audit

    - Develop and embed quality improvement methodology by launching the Croydon Quality Improvement Programme in association with the CCG

    - Delivering the Trust's Quality Improvement Strategy

    - Delivering the Trust's Staff Engagement plan

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
Mike Bell

By order of the Board Chair
Date xxxx

Statement of assurance from the Board of Directors

Review of Services

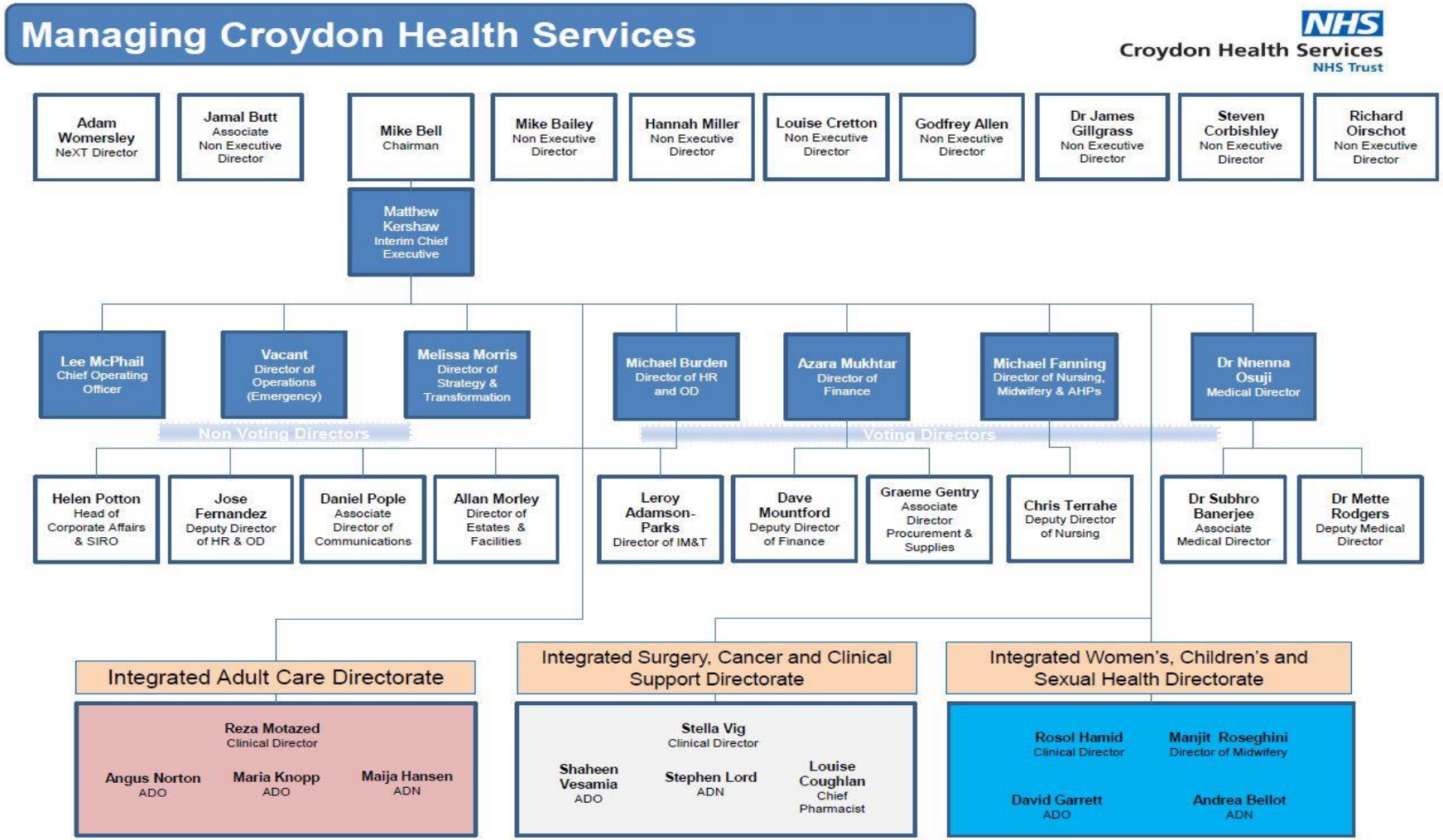
Throughout 2018-19 we have been privileged to continue to provide services to the people of Croydon whether in their own home, at one of our community facilities or at one of our hospitals.

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 Committee, monthly Quality Boards and Clinical Governance meetings.

The Trust reviews quality indicators using an integrated quality & performance 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 2018-19 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 2018-19 represents 100% of the total income generated from the provision of NHS services by Croydon Health Services NHS Trust for 2018-19.

Activity for 2018/19	Q1	Q2	Q3	Q4	TOTAL
Planned Care - Outpatient Appointments	97,923	96,876	99,603	98,587	**392,989**
Planned Care - Inpatients	598	606	694	588	**2,486**
Planned Care - Day cases	6,715	6,090	6,776	6,411	**25,992**
Maternity -Deliveries	894	916	842	807	**3459**
Maternity -Babies Born	900	930	861	808	**3499**
Maternity - Home Births	23	23	17	18	**81**
Emergency Attendances - Main ED & UTC	32,546	31,260	33,211	34,916	**131,933**
Emergency Attendances - GP hubs	19,559	18,331	21,278	23,354	**82,522**
Emergency Admissions	7,369	7,778	8,127	7,119	**30,393**
Ambulance Arrivals	8,226	8,130	9,081	9,373	**34,810**
Occupied Bed days (General & Acute)	43,172	41,360	41,086	42,732	**168,350**
Beds Open	43,474	41,717	41,361	42,914	**169,466**
Bed Occupancy	99.31%	99.14%	99.34%	99.58%	**99.34%**


Managing Croydon Health Services
NHS
Croydon Health Services
NHS Trust
Adam Womersley
NeXT Director
Jamal Butt
Associate Non Executive Director
Mike Bell
Chairman
Mike Bailey
Non Executive Director
Hannah Miller
Non Executive Director
Louise Cretton
Non Executive Director
Godfrey Allen
Non Executive Director
Dr James Gillgrass
Non Executive Director
Steven Corbishley
Non Executive Director
Richard Oirschot
Non Executive Director
Matthew Kershaw
Interim Chief Executive
Lee McPhail
Chief Operating Officer
Vacant
Director of Operations (Emergency)
Melissa Morris
Director of Strategy & Transformation
Michael Burden
Director of HR and OD
Azara Mukhtar
Director of Finance
Michael Fanning
Director of Nursing, Midwifery & AHPs
Dr Nnenna Osuji
Medical Director
Non Voting Directors
Voting Directors
Helen Potton
Head of Corporate Affairs & SIRO
Jose Fernandez
Deputy Director of HR & OD
Daniel Pople
Associate Director of Communications
Allan Morley
Director of Estates & Facilities
Leroy Adamson-Parks
Director of IM&T
Dave Mountford
Deputy Director of Finance
Graeme Gentry
Associate Director Procurement & Supplies
Chris Terrahe
Deputy Director of Nursing
Dr Subhro Banerjee
Associate Medical Director
Dr Mette Rodgers
Deputy Medical Director
Integrated Adult Care Directorate
Reza Motazed
Clinical Director
Angus Norton
ADO
Maria Knopp
ADO
Maija Hansen
ADN
Integrated Surgery, Cancer and Clinical Support Directorate
Stella Vig
Clinical Director
Shaheen Vesamia
ADO
Stephen Lord
ADN
Louise Coughlan
Chief Pharmacist
Integrated Women's, Children's and Sexual Health Directorate
Rosol Hamid
Clinical Director
Manjit Roseghini
Director of Midwifery
David Garrett
ADO
Andrea Bellot
ADN

Integrated Surgery, Cancer and Clinical Support Directorate

Inpatient Pathways	• General Surgery • Trauma & Orthopaedics • Urology • Upper GI • Vascular • Breast • Surgical wards
Ambulatory Pathways	• Outpatients • Head & Neck • Dentistry • Clinical Haematology • Dermatology • Pathology • Palliative Care
Theatres & Anaesthetics	• Main Theatres & Recovery • Day Surgery & Recovery • Pre-assessment – Coulsdon 1 • Critical Care (ITU and HDU) • Surgical wards – Fairfield 1, Queens 1, Queens 2, Queens 3
Diagnostics & Clinical Support Services	• Diagnostic Imaging • Pharmacy • Neurophysiology
Cancer, Access & Performance	• Cancer • RTT • Access • Macmillan Nursing • Medical Records

Integrated Women's, Children's and Sexual Health Services Directorate

Obstetrics and Gynaecology	• Maternity Services – Labour ward, ante and post-natal wards (Hope and Mary) • Birthing Unit • SCBU • Community Midwifery Services • Crocus Homebirth Team • Gynae Outpatients • Colposcopy • Hysteroscopy Services • Endometriosis Services • Early Pregnancy Unit • Gynae Diagnostics • Fertility Services • IVF Unit • Continence Services

	• FGM Service
Public Health	• Sexual Health Services & Genitourinary Medicine • Contraception Services • Domiciliary Contraception Service • Sexual Health Outreach Service • HIV Team • Homeless Health Team • Health Visiting • School Nursing • Family Nurse Partnership • Breast Feeding Service • Sexual Health Advisers • Smoking Cessation Team • Enuresis Team • Immunisation Team
Children's Services	• Paediatric Emergency Department • Paediatric Urgent Care • Rupert Bear & Dolphin Wards • Paediatric Inpatients Paediatric Outpatients Service • Paediatric Surgery Paediatric Pre-assessment • Children's Community Nursing Service • Paediatric Asthma Nurse Specialist Service • Children's Therapies – Physio, Speech & Language Therapy, Occupational Therapy • Audiology • Community Paediatricians • Special School Services

Integrated Adult Care Directorate

Emergency Care	• Emergency Department
	• Urgent Care Centre
	• Edgecombe Unit:
	  ○ Rapid Assessment Medical Unit (RAMU)
	  ○ Acute Care of the Elderly Unit (ACE)
	  ○ Ambulatory Emergency Care Unit (AECU)
	• Acute Medical Unit (AMU)
	• CUCA – Out of Hours GP

Acute Specialist Medicine: Endoscopy, Gastroenterology, Diabetes & Renal Medicine	• Inpatient & Outpatient Services • Purley wards • Specialist Nurses
Acute Specialist Medicine: Cardiac & Respiratory Medicine	• Inpatient & Outpatient Services • Cardiac Cath Lab • Coronary Care Unit • Duppas wards • Specialist Nurses
Community & Therapies, Rheumatology & Musculosketal Services	• District Nursing • CICs • Community Matrons

	• Community Cardiac Nurse Specialists • CITMS • BHF Heart Failure • Health Visiting for the Elderly • Long Term Conditions
Learning Disability Team	• Learning Disability
Elderly Care, Neurology & Stroke	• Inpatient & Outpatient Services • Heathfield 1 • Wandle Wards • Specialist Nurses
Adult Therapy Services	• Podiatry • Dietetics • Community Pulmonary Rehabilitation Service • Adult Speech & Language Therapy (SALT)
Rehabilitative & Independent Living Services	• A&E Liaison Team • Community Neuro-rehabilitation • Neuro-psychology Service • Rehab Consultant • Community Stroke Team

Service and quality accreditations

The Trust has achieved, or is working towards, a variety of external accreditations and also hosts external peer reviews. Some of those completed this year include:

- BSGE Endometriosis Centre for 2019 (British Society of Gynaecological Endoscopy) accreditation.
- British Society of Urogynaecology (5 year accreditation from May 2017).
- Sterile services department 93/42/EEC on medical devices and ISO 13485: 2016.
- JAG accreditation (valid until May 2021).
- Human Tissue Authority (HTA) in September 2018.
- ICNARC peer review of Critical Care.

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 2018-19, the Trust participated in 60 national clinical audits and 3 National Confidential Enquiries. Out of the 60 national audits, 55 were in the NHS England Quality Account listed audits that the Trust was eligible to participate in, so representing 100% participation.

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

The Trust also completed 29 local clinical audits in 2018/19. Examples of some of those completed are included at Appendix 1.

The national clinical audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2018/19, 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 2018/19.

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.

National Audits participation

National Clinical Audit for inclusion in quality report	Data collection completed in 2018/2019	Number of cases submitted	% submitted
Adult Community Acquired Pneumonia	√	57	100%
Breast and Cosmetic Implant Registry (BCIR)	Continuous data collection	In Progress	Continuous data collection
Cardiac Rhythm Management (CRM)		In Progress	In Progress
Case Mix Programme (CMP)	√	725	Continuous data collection
Elective Surgery (National PROMs Programme)	Continuous data collection	Stopped Participation	Stopped Participation

National Clinical Audit for inclusion in quality report	Data collection completed in 2018/2019	Number of cases submitted	% submitted
Endocrine and Thyroid National Audit	Continuous data collection 1 Jan to 31 Dec	In Progress	In Progress
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison service Database	Continuous data collection	226	100%
Falls and Fragility Fractures Audit programme (FFFAP) Inpatient Falls	Continuous data collection	In Progress	In Progress
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	Continuous data collection	247	100%
Feverish Children (care in emergency departments)	√	51	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	Continuous data collection	In Progress	In Progress
Learning Disability Mortality Review Programme (LeDeR)	√	16	100%
Major Trauma Audit	Continuous data collection	251	
Myocardial Ischaemia National Audit Project (MINAP)	Continuous data collection	In Progress	In Progress
National Audit of Breast Cancer in Older People (NABCOP)	Continuous data collection	Audit collecting data from existing data sources	100%
National Audit of Cardiac Rehabilitation	Continuous data collection	525	Continuous data collection
National Audit of Care at the End of Life (NACEL)	√	53	
National Audit of Dementia (in General Hospitals)	√	50	
National Audit of Intermediate Care (NAIC)	√	80 – Home Based Service 50 – Bed based Service	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Continuous data collection	In Progress	In Progress
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Continuous data collection	71reg cases	Continuous data collection
National Bowel Cancer (NBOCA)	√	128	95%
National Cardiac Arrest Audit (NCAA)	√	79	100%

National Clinical Audit for inclusion in quality report	Data collection completed in 2018/2019	Number of cases submitted	% submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme Pulmonary Rehabilitation	Continuous data collection	In Progress	Continuous data collection
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme Secondary Care	√	130	Continuous data collection
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Continuous data collection	192	In Progress
National Comparative Audit of Blood Transfusion programme Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Awaiting feedback from National Audit Lead	In Progress	In Progress
National Comparative Audit of Blood Transfusion programme 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	√	14	Awaiting feedback from National Audit Lead
National Comparative Audit of Blood Transfusion programme Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	Awaiting feedback from National Audit Lead	In Progress	In Progress
National Comparative Audit of Blood Transfusion programme Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	√	1	Awaiting feedback from National Audit Lead
National Comparative Audit of Blood Transfusion programme Management of massive haemorrhage	√	10	
National Diabetes Foot Care Audit - Adults	√	58	100%
National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	Not running 2018/19	Not running 2018/19	Not running 2018/19
National Core Diabetes - Adults	√	916	100%
National Pregnancy in Diabetes Audit - Adults	√	16	100%
National Emergency Laparotomy Audit (NELA)	√	119	Continuous data collection
National Heart Failure Audit	Continuous data collection	In Progress	Continuous data collection

National Clinical Audit for inclusion in quality report	Data collection completed in 2018/2019	Number of cases submitted	% submitted
National Joint Registry (NJR)	In Progress	In progress	In Progress
National Lung Cancer Audit (NLCA)	√	In Progress	In Progress
National Maternity and Perinatal Audit (NMPA)	Continuous data collection	In Progress	In Progress
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Continuous data collection	465	Continuous data collection
National Oesophago-gastric Cancer (NAOGC)	√	76	
National Paediatric Diabetes Audit (NPDA)	Continuous data collection	142	In Progress
National Prostate Cancer Audit	√	248	100%
National Vascular Registry	Continuous data collection	In Progress	In Progress
Non-Invasive Ventilation - Adults	In Progress	In Progress	In Progress
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	In Progress	In Progress	In Progress
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	In Progress	In Progress	In Progress
Sentinel Stroke National Audit programme (SSNAP)	Continuous data collection	In Progress	In Progress
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Continuous data collection 1 Jan to 31 Dec.	In Progress	In Progress
Seven Day Hospital Services Self-Assessment Survey	In Progress	In Progress	In Progress
Surgical Site Infection Surveillance Service	In Progress	In Progress	In Progress
Vital Signs in Adults (care in emergency departments)	√	132	100%
VTE risk in lower limb immobilisation (care in emergency departments)	√	42	100%

Clinical Outcome Review

(Previously the National Confidential Enquiries and Centre for Maternal and Child Death Enquiries)

National Clinical Audit for inclusion in Quality Report	Data completion completed in 2018/19	% Submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme • Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • National surveillance of perinatal deaths	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • Confidential enquiry into serious maternal morbidity	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • National surveillance and confidential enquiries into maternal deaths	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • Perinatal Mortality Surveillance	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Continual data reporting cycle	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme • Maternal mortality surveillance	Continual data reporting cycle	100%

NCEPOD Study	Data completion completed in 2017/18	Number of Clinical Q Included	Number of Clinical Q Submitted	Number of Case notes Q submitted	Number of Organisational Q Submitted
Cancer In Children, Teens and Young Adults	√	0	0	0	1
Perioperative Diabetes	√	3	3	3	1
Pulmonary Embolism	In Progress	5	5	5	1

Research 2018 – 2019

In order to improve patient outcomes and transform health services, research has to be at its core. The organisation will greatly benefit from the outcomes of research when compared to organisations that do not, leading to better quality care and improved use of resources. 'Clinical research' refers to studies that have received a favourable opinion from a Research Ethics Committee.

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 stay abreast of the latest possible treatment availabilities, and active participation in research can lead to successful patient outcomes.

All patients receiving NHS services, provided or sub-contracted by Croydon Health Services NHS Trust in Apr 2018 – Mar 2019, may be approached for research. Of those eligible, 2,015 patients were recruited to participate in Research Ethics Committee approved studies. This figure is based on the Clinical Research Network (CRN) registered file. Compared to last financial year, this is a fall in recruitment of 22%. This drop in recruitment is in large part due to closure of one study that recruited a large number of patients during the 2017/18 year.

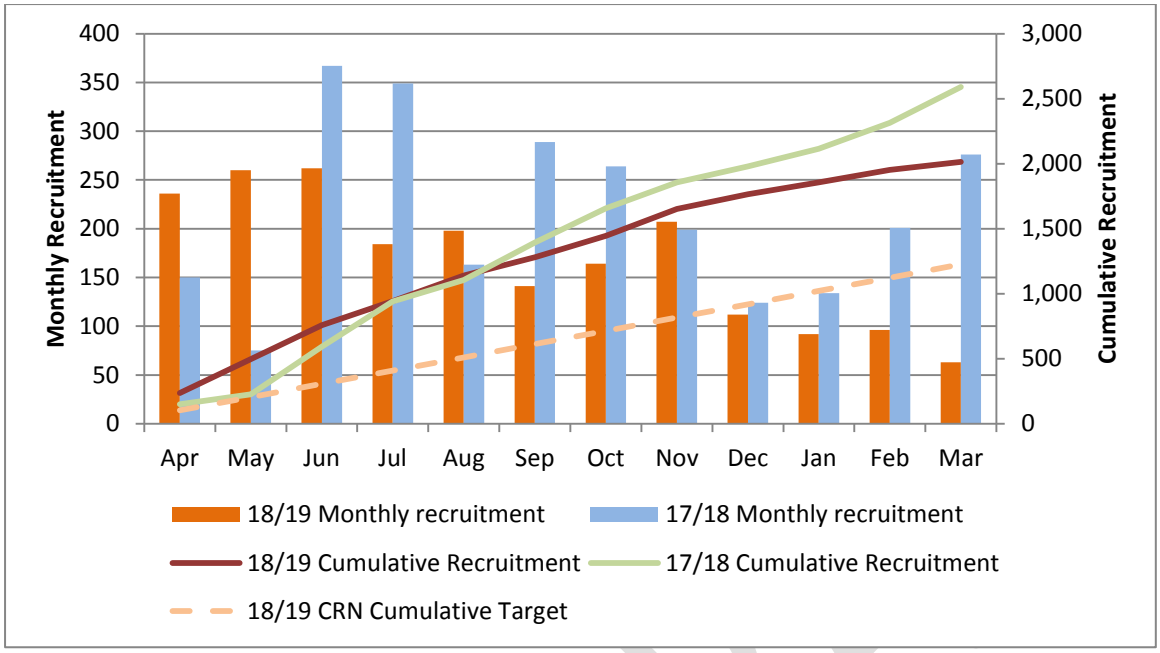


Figure: A comparison of recruitment over the 2018/19 financial year against that of 2017/18

The Trust continued to recruit over 2,000 patients into our research trials this financial year, following the last. This was due in part to several studies that were open at Croydon.

The first study is the NICE FIT trial, which examines for the presence of blood in patient stool samples and comparing these results to colonoscopy results. This is with the view of having a non-invasive test for cancer. The study recruited 705 patients over the 2018/19 year. With Croydon acting as the sponsor for this study we oversaw 12,522 patients recruited into the study from over 50 trusts across the UK. The study finished in March 2019, but there are 2 sub-studies that have extended their recruitment till December 2019.

The second was the OPTIMAL study that closed in June 2018. The study investigated a computer system working with discharge advocates following up patients after discharge. It aimed to streamline their discharge process and reduce readmission into hospital before the 30 day window. The study could have the potential to save the Trust money by reducing penalties incurred when patients are readmitted within 30 days, as well as improving quality of patient care. From the preliminary analysis, the project only achieved a 2-3% reduction to readmissions, not the 5% that was aimed for. This lower than expected reduction could be due to a fall in the number of readmissions compared to the previous year. The Trust also introduced a scheme with the aim to reduce the readmissions, this worked in parallel to the study. There were aims to create a further study that would have expanded it to further trusts across the UK. However, due to the competitive environment, the grants submitted did not unfortunately score high enough to get the funding.

The Obstetrics Department also contributed to the high recruitment number, through all the trials combined, recruiting 433 patients from 11 studies. This is testament to how close the research team works with clinicians to deliver recruitment to time and target.

In 2018-2019, 55 clinical research studies were being conducted in the Trust; 51 of which were funded by the CRN. Of these 12 studies concluded by March 2019 of which 83% were completed as designed within the agreed time and to the agreed recruitment target.

In 2018-19 Croydon approved 14 studies of which 12 were supported by the CRN. 40% of eligible studies were approved within the 30 day time frame. The predominant reason for delays to the approvals has been due to contracting issues with sponsors and staffing issues.

There were 86 clinical staff members participating in research approved by research ethics committee at Croydon Health Services during 2018 – 2019. 41% of these were Research Passport Personnel supporting the research studies. These staff participated in research covering 20 specialities.

An EU funded project called AEGLE completed its fourth year and finished in November 2018. This is a big data analytics programme that analysed anonymised patient data to try to improve the treatment of diabetes. We have diabetes data from Croydon and Epsom and St Helier, plus data from Northern Ireland. Analysis and testing of the software was carried out to visualise the data and create predictive models. From the models, we were able to make predictions on potential outcomes for patients suffering from diabetes. At present we have been approached by commercial companies to take this further forward.

In the last three years, 30 publications have resulted from our involvement in Research. Of these 30 publications, 19 were directly from National Institute for Health Research (NIHR) studies.

With the success so far generated, Croydon has now achieved the minimum status to have a devolved budget from CRN. However, given current headwinds, we have continued to stay within the ‘smaller Trusts’ and work with a negotiated budget: in this regard we have seen an uplift to the CRN budget – the next three years budget has been set at almost £320,000 - 30% increase compared to previous years.

Furthermore, we are looking to the future – two Horizon 2020 grant proposals have now been submitted in April, as well as one NIHR grant proposal. There is also ongoing dialogue with our collaborators at Kingston University, South West London (SWL) Smaller Trusts and with Exus into developing more ideas for projects looking at telehealth medicine and long term conditions.

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

Health Commissioners hold a budget for the Croydon population to spend on health care services in both the hospital and community setting, e.g. services provided by Croydon Health Services NHS Trust. A proportion of this budget each year is reliant on the Trust meeting annual improvement goals set by Croydon Clinical Commissioning Group and NHS England. This system is called the Commissioning for Quality and Innovation (CQUIN) payment framework. The aim of the CQUIN goals is to achieve improvements in quality and innovation which will support health gains for patients and staff.

For 2018/19 the Trust achieved 94.8% (Q3 figures) of our CQUIN income from the NHS England and Croydon Clinical Commissioning Group (CCG) and 100% (Q3 figures) of the specialist CQUINs from NHS England.

The National CQUINS covered the 2 year period 2017/19 and were as follows:

- Improving the health and wellbeing of NHS Staff
- Health 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

The NHS England CQUINS were:

- Dental dashboard
- Medicines optimisation
- Cancer dose banding

Clinical standards for seven day hospital services

Since 2014, the Trust has been working with the clinical directorates to look at how to best implement a 7 Day Service (7DS). As part of the team job planning process, each clinical speciality had to review compliance with 7 day working and identify resource gaps. In 2015 the Trust developed internal standards for clinical teams to ensure compliance with some of the 7 day working clinical standards.

Whilst compliance to date has been supported in part through financial investment, a key challenge is the ability to progress compliance with 7DS in a financially constrained context.

The Trust's strategy remains focussed on:

1. Improving clinical documentation and coding to ensure understanding of true compliance with early consultant review.

2. Deployment of internal professional standards and agreed clinical pathways, to facilitate early consultant review, and embed consultant-directed requesting for diagnostic interventions.

3. Service portfolio optimisation/clinical service redesign review identifying and quantifying areas where investment is required to allow clinically safe provision of 24/7 care.

4. Collaborate with other SWL providers to formulate network solutions where appropriate and possible.

NHS England accepted that significant changes and considerable improvements had not always been reflected in the survey results due to the quality of source data and validation issues. The survey also places a significant administrative burden on providers as it involves reviewing many patient case notes. At the Trust we reviewed a total of 179 patient records (a sample selected from emergency admissions over a 7 day period in May 2018).

As a result of the above, the survey tool has been replaced by a board assurance framework for measuring 7DS delivery; this was introduced at the end of November 2018 with a trial submission taking place in February 2019. Feedback from the trial submission is expected in June 2019. This trial submission was based on previous submission data (reported in last year's Quality Account). Full implementation will be introduced with the next submission covering the period March to June 2019.

The process of 7DS board assurance emphasises provider boards giving evidence-based assurance of their organisation's delivery of 7DS, rather than relying on a national recording tool and will continue to be measured to existing timescales, i.e. provider boards must self-assess performance twice a year, once in spring and once in autumn.

The new system consists of a standard template that all trusts will complete with self-assessments of their performance against the 7DS clinical standards, supported by local evidence.

This self-assessment will then be formally assured by the Trust board. Boards can decide appropriate processes and details to include, based on local systems, governance structures and timetables.

As well as measuring progress against the four priority 7DS standards, the measurement template asks providers of acute services to summarise progress against the six standards collectively known as the 7DS standards for continuous improvement.

Statements from the Care Quality Commission (CQC)

Overall rating	Requires Improvement

The Care Quality Commission (CQC) is the independent regulator for health and social care services in England. The CQC's duty is to ensure that hospitals meet government standards of safe, effective, caring, responsive and well led care.

The Trust is required to register with the CQC and comply with their fundamental standards of quality care. Our current registration status is "registered without conditions" which means that CHS is not subject to any CQC enforcement actions.

The CQC monitors the fundamental standards of care through inspections, patient feedback and other external sources of information. They inspect Trusts at a core service level and publish reports giving each service a rating which is then amalgamated into a Trust wide rating.

The current CQC ratings for all core services:

Core service	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & emergency services	RI	Good	Good	Good	Good	**Good**
Medical care	RI	Good	Good	RI	RI	**RI**
Surgery	RI	Good	Good	Good	Good	**Good**
Critical care	RI	RI	RI	RI	Inadequate	**RI**
Maternity	RI	Good	Good	Good	Good	**Good**
Gynae	RI	Good	Good	Good	Good	**Good**
Services for CYP	RI	Good	Good	Good	Good	**Good**
End of life care	Good	RI	Good	Good	Good	**Good**
OPD & diagnostics	Good	n/a	Good	Good	RI	**Good**
Community adults	RI	Good	Good	RI	RI	**RI**
Community CYP	RI	RI	Good	RI	RI	**RI**
Overall	RI	**RI**	**Good**	**RI**	**RI**	**RI**

The CQC inspection schedule to date:

Core service	2015 All core services inspected	2017 Surgery, Critical Care, End of Life Care & Outpatients	2018 Community Adults, Children & Young People and Medical Care
Urgent & emergency services	Good	Good	Good
Medical care	RI	RI	RI
Surgery	RI	Good	Good
Critical care	RI	RI	RI
Maternity	Good	Good	Good
Gynae	Good	Good	Good
Services for CYP	Good	Good	Good
End of life care	RI	Good	Good
OPD & diagnostics	RI	Good	Good
Community adults	RI	RI	RI
Community CYP	RI	RI	RI
Overall	**RI**	**RI**	**RI**

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'.

In October/November 2017 the CQC re-inspected the following core services: surgery, critical care, end of life care and outpatients. Of these, all but critical care improved to a rating of 'Good'. Critical care remained as 'Requires improvement'.

The CQC also looked for the first time at mental health provision in an acute setting and carried out a separate in-depth review of the well led domain in conjunction with NHS Improvement.

In 2018 the CQC inspected our community services (adult and children & young people) along with the medical care core service. Of the Trust's nine acute core service, seven are now rated as 'Good'. The Trust has retained a 'Good' rating for the Caring domain, with the remaining domains of Safe, Effective, Responsive and Well Led given the rating of 'Requires Improvement'.

Following this inspection the Trust was given nine 'must do' actions to complete, with a further ten 'should do' recommendations. A comprehensive action plan has been drawn up to address these areas of improvement and is being monitored and reported on by the Trust's Quality Improvement Programme (QIP).

The Trust continues to work towards achieving a "Good" or "Outstanding" rating throughout the CQC inspection process to build on our previous achievements.

In August the CQC also inspected Croydon's reablement services, including one of our new services run in partnership in the borough. Publishing the results on 5 October, CQC inspectors rated the Croydon community reablement service as 'good' for all aspects of the service, including its safety, responsiveness and how well it was led.

The service is part of LIFE (Living Independently For Everyone) service. This was created by the One Croydon alliance in 2017, bringing together teams from health and social care as well as the voluntary sector. It provides coordinated short-term support to people and enable them to retain or regain their independence and continue living in their own home. It was set up to look after mainly over-65s with long-term conditions by tailoring their care to reduce the need for hospital stays.

Health and Safety Executive

There were no health and safety incidents investigated by the Health and Safety Executive during 2018/19.

There were thirteen (13) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents during the financial year.

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.

In April 2018 Croydon Health Services was been rated top in South West London for the condition, appearance and maintenance of its buildings and second for cleanliness.

The annual Patient-Led Assessments of the Care Environment (PLACE) looks at cleanliness, food, privacy, dignity, general building maintenance and how well the hospital environment is able to support the care of those with dementia or disabilities.

In 2018 assessments, published by NHS Digital on 16 August 2018, CHS achieved a score of 98.83 percent for cleanliness and 94.83 percent for the condition,

appearance and maintenance of its buildings – the highest scores among South West London acute hospitals.

Against the measure of how well the Trust meets the needs of people with dementia, CHS scored 85.15 percent which was the highest in the South West London region. The Trust also scored an impressive 94.83 percent for how well equipped it is to meet the needs of people with a disability which was the highest score among London's 18 acute hospital trusts.

The assessments also showed areas where the Trust can improve further. On food, the Trust achieved 89.85 percent which was just below the national average of 90.2 percent. On privacy, dignity and wellbeing, CHS was rated at 80.44 percent which was below the average for England of 84.2 percent.

With a lot of older buildings it was an excellent result to have achieved the best scores in South West London for how well we maintain our estate and for the cleanliness of our hospital environment.

There is always room for improvement and so we will look closely at how we can enhance our scores on food, privacy, dignity and wellbeing in next year's assessments."

Data Quality

(SP –waiting for a response from NHS Digital (10.6.19)

The Trust submitted records during 2018/19 to the Secondary Users Service (SUS) which is the single, comprehensive repository for healthcare data in England. In 18/19 the national average was 96.7% and the London average was 96.8% (Based on provisional April 2018 to February 2019 SUS + Data at the Month 11 Inclusion Date).

The Trust achieved an average of 98.5% which was higher than both the national and London average. The Trust is ranked 4th out of the 31 Acute NHS Trusts in London.

	NHS number		Postcode		GP Practice Code	
	Trust %	National %	Trust %	National %	Trust %	National %
Percentage for inpatient care	99.2	99.4	99.8	99.9	100	99.9
Percentage for outpatient care	99.5	99.6	99.6	99.9	100	99.8
Percentage for A&E care	96.7	97.6	99.7	99.8	100	99.3

Information Governance

Information Governance (IG) encompasses a number of different elements such as data quality, records management, legislative compliance, technical information security and organisational information security. The objective of IG is to ensure the confidentiality, integrity and availability of information.

The Data Security and Protection Toolkit (DSPT) is a mandatory self-assessment performance tool that enables health organisations to measure their performance against data security and information governance requirements. This is the first year organisations have completed the DSPT, which replaces the former IG toolkit. The Trust submitted mandatory evidence for the DSPT confirming compliance with the majority of requirements. The Trust took advantage of the opportunity to submit an action plan to further improve compliance against a small number of outstanding requirements. The Trust expects to reach a status of 'Standards Met' by autumn 2019.

All organisations with access to NHS patient information are expected to complete the DSPT and attain 'Standards Met'. The purpose of the assessment is to enable the Trust to measure compliance against the law and central guidance, and to ascertain whether information is handled correctly and protected from unauthorised access, loss, damage and destruction. Compliance demonstrates that the Trust can competently maintain the confidentiality and security of personal and corporate information which, in turn, increases public confidence in the NHS and its partners.

Two information security breaches were reported to the Information Governance Information Commissioner's Office. Both incidents resulted in no further action from the ICO. The Trust continues to incorporate any advice or lessons learned from breaches to minimise and remove the risk of similar incidents.

Code	Description	No.
A	**Corruption or inability to recover electronic data**	**0**
B	**Disclosed in Error**	**0**
C	**Lost in Transit**	**0**
D	**Lost or stolen hardware**	**2**
E	**Lost or stolen paperwork**	**0**
F	**Non-secure Disposal – hardware**	**0**
G	**Non-secure Disposal – paperwork**	**0**
H	**Uploaded to website in error**	**0**
I	**Technical security failing (including hacking)**	**0**
J	**Unauthorised access/disclosure**	**0**
K	**Other**	**0**

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	2016/17	2017/18	2018/19	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.	0.8913 Band 2 (as expected)	0.8759 Band 3 (lower than expected)	0.97 Band 2 (as expected)	0.97	Oct '17 - Sept '18 NHS Digital	0.6917	1.2681	1.003	Data according to the most recent publication in Mar 19 for the period Oct 17 to Sept 18
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.	34.71%	34.5%	43.29%	43.29%	Oct '17 - Sept '18 NHS Digital	14.35%	59.5%	33.8%	Data according to the most recent publication in Mar 18 for the period Oct 16 to Sept 17
Helping people recover form episodes of ill health following injury	Patient reported outcome measure score for groin hernia surgery	21.6%	TBC	Data not available	NHS Digital	N/A	N/A	N/A		NHS Digital are not expected to provide this data until after this report
	Patient reported outcome measure score for varicose vein surgery	55.7%	TBC	Data not available	NHS Digital	N/A	N/A	N/A		NHS Digital are not expected to provide this data until after this report
	Patient reported outcome measure score for knee replacement surgery	The Trust did not submit data for this PROMS	SWLEOC provide this service for CHS patients	SWLEOC provide this service for CHS patients	NHS Digital	N/A	N/A	N/A		SWLEOC: South West London Elective Orthopaedic Centre

Domain	Indicator	2016/17	2017/18	2018/19	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	% of patients aged 0-15 re admitted to hospital within 28 days of being discharged from hospital	HSCIC	HSCIC	NHS Digital?	N/A	N/A	N/A	N/A	N/A	Waiting for email response from qualityaccounts@dhsc.gov.uk
Enhancing quality of life for people with long term conditions	% of patients aged 16 or over readmitted to hospital within 28 days of being discharged from hospital	N/A	N/A	NHS Digital?	N/A	N/A	N/A	N/A	N/A	Waiting for email response from qualityaccounts@dhsc.gov.uk
Ensuring people have a positive experience of care– Friends & Family Test (FFT)	The Trust's responsiveness to the personal needs of its patients	60%	62.8%	Not available	62.8%	2017/18	85%	60.5%	68.6%	2018/19 data due August 2019
	% of staff employed who would recommend the Trust as a provider of care to their friends and family	69.83%	71%	71%	71%	Q2 2018/19	94%	31%	65%	
	FFT - % of inpatients who would recommend the trust as a provider of care to their friends and family	93.47%	91.67%	83%	83%	Feb 2019	100%	76%	96%	

Domain	Indicator	2016/17	2017/18	2018/19	Most Recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National Average	Comments
Ensuring people have a positive experience of care – Friends & Family Test (FFT)	FFT - % of patients discharged from A & E (type 1 and 2) who would recommend the trust as a provider of care to their friend and family	93.78%	90.38%	76%	76%	Feb 2019	100%	57%	86%	
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism	96.85%	96.1%	95.89%	95.51%	Q4 (18/19)	N/A	N/A	N/A	National target is 95%
Treating and caring for people in a safe environment and protecting them from avoidable harm	The rate per 100,000 bed days of C difficile infection amongst patients aged 2 or over.	7.91	7.20	7.72	7.72	Q4 (18/19)	N/A	N/A	N/A	2018/2019 figure based on 13/168350* 100000. March 2019 data not available on PHE website
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	7,515	21,341	20,465	20,465	2018/19	15,228	1,133	5,226	Data from NRLS

Domain	Indicator	2016/17	2017/18	2018/19	Most Recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National Average	Comments
Treating and caring for people in a safe environment and protecting them from avoidable harm	The rate of patient safety incidents reported per 1,000 bed days	29.71 (per 1000 bed days)	111.7 (per 1000 bed days)	120.40 (per 1000 bed days)	121.49 (per 1000 bed days)	2018/19	111.7	23.47	42.80	Data from NRLS
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.	0.64%	0.13%	0.95%	0.95%	2018/19	0.00%	2.00%	0.37%	Data from NRLS (195/20,465)*100=0.95%

Part 3

Review of Quality Performance 2018-19

Review of Quality priorities 2018-19

This section demonstrates the Trust's achievements throughout 2018-19 in the areas of patient safety, clinical effectiveness and patient experience. Performance against the priorities in our 2018-19 Quality Account is included in each section.

The Trust: overview of the year 2018-19

April 2018

- **Croydon Stars staff awards**
- **Listening into Action**
- **Awards and recognition for CHS**
- **Ending PJ paralysis**

The Croydon Stars

We held our annual Croydon Stars Awards Ceremony on 25 April at Selhurst Park, to recognise the great work of our staff and volunteers. Crystal Palace footballing legend Mark Bright joined our Chief Executive John Goulston and Trust Chair Mike Bell to present the awards to the following winners:

- Amazing Achievement - Mortuary Team
- Tremendous teamwork - Living Independently for Everyone (LIFE) team
- Incredible customer service - Sharan Gray, Wandle 1 ward
- Landmark leadership - Dr Chris Bell
- Listening into Action individual champion - Celsa Soares
- Volunteer of the year - Breastfeeding Peer Support team

Listening into Action - 2018 Pass it on Event

Our LiA Pass It On event showed just how dedicated and passionate our staff are about improving CHS. At the event on 25 April, the second cohort of LiA Ambassadors all picked different creative ways to showcase their achievements, including a quality street market place, video and presentations. The directorates also provided updates on their longer term improvement plans. Shagufta Ali from Pharmacy, Dianne Wilson from Estates & Facilities and Maria Johnson & Tara Terry from Cardiology won the prizes for best improvement showcases.

Awards and recognition for CHS

Vascular surgeon and one of the Trust's Clinical Directors, Stella Vig, won the national *'Silver Scalpel'* award at The Association of Surgeons in Training (ASiT) awards on 7 April. The award was given in recognition of her fantastic leadership and support when training England's future surgeons and Stella was nominated by her surgical trainees.

Emmie Stewart-Parker who trained under Stella at Croydon in 2013/14, won the new *'Silver Suture'* award in recognition of the training courses she established which are now part of the annual induction programme for all new London surgical trainees.

Yvonne Battie, our Senior Emergency Services Clerk in the Emergency Department, won an ISTV (Information Sharing to Tackle Violence) Excellence award coordinated by the Mayor's Office for Policing and Crime (MOPAC). The two-year ISTV programme seeks to develop more effective data sharing between Community Safety Partnerships, health and other partners, using a new approach to collating and analysing anonymised Emergency Department data.

Our Macmillan Cancer Information and Support Service Manager, Benny Millier, also won a Volunteering Quality Standard award for her excellent work at the Macmillan Cancer Information and Support Centre at Croydon University Hospital.

The Trust was also shortlisted for the Quality of Care Award at the CHKS Top Hospitals Awards 2018. These awards are assessed entirely on public statistics about what hospitals have achieved including data such as lengths of stay, discharge rates, admissions and mortality.

Ending PJ paralysis

The Trust signed up in April to the national End PJ Paralysis campaign 70 day challenge aimed at boosting people's recovery. All of our adult wards signed up to the initiative that encourages, where possible, our patients to get up, dressed in their own clothes and moving before midday.

Evidence shows that for patients over 80, staying in bed for a week can create 10 years of muscle ageing, which can lead to a loss of independence. Helping patients to stay mobile while in hospital can reduce length of stay and risk of falling, while also improving their independence.

May 2018

- Working together for a healthier Croydon
- Celebrating the achievements of our midwives and nurses
- Farewell to our lead chaplain Hilary Fife
- New CT scanner for CUH

Working together for a healthier Croydon

On 23 May 2018, our board met with Croydon CCG to discuss how we could work more closely together to improve the health of people in the borough. We have a strong history of collaboration in Croydon, with partnerships already in place to improve our care and services for people aged over 65 years and children under five. Looking forward, we want to build on this to offer more coordinated care for people of all ages in the borough.

The two Boards discussed the priorities for the One Croydon alliance, including:

- How to build a proactive and preventative health and care system for people of all ages;
- Maintaining momentum the improvements already made to frail and elderly services; and
- Identifying new priorities to improve the health and mental wellbeing across all ages and communities in the borough.

We also discussed our quality improvements in many areas at CHS, including cancer waiting times that are consistently among the best in London. Further joint meetings have taken place throughout the year to look at opportunities for even closer working.

Celebrating the achievements of our nurses and midwives

As part of this year's celebration of International Nurses Day, we held a special awards ceremony on 11 May to recognise the care, compassion and professionalism of our nursing and midwifery colleagues across the Trust.

Nakita Martin won Healthcare Assistant of the Year**,** Linda Litchfield was Nurse of the Year and Yvonne Tapping was Midwife of the Year. Their awards were presented by NHS England's National Head of Safeguarding, Dr Kenny Gibson.

Retirement of our Chaplain Hilary Fife

On Wednesday 30 May, a service was held to mark the retirement of Hilary Fife. The service was led by the Bishop of Southwark and multi-faith leaders from across the borough who all spoke of Hilary's dedication, commitment and achievements during her career.

She was employed by the trust for 22 years but worked for five years prior to this as a volunteer chaplain. During this time the chaplaincy team increased its services to include Bereavement Support Services and she raised money to refurbish the chapel at CUH. She also provided support for many thousands of patients, their families and our staff. Her legacy is a chaplaincy team which is leading in its field and an example of how such departments should be developed and provided in other NHS hospitals.

New CT Scanner in our Diagnostic Centre is fastest type in the NHS

Olympic gold medallist Tessa Sanderson came to the Trust on 24 May to open our new Aquilion ONE™ GENESIS Edition CT scanner which is part of our Diagnostic Centre upgrade this year.

It is the fastest type of CT scanner in the NHS and can produce high-resolution, accurate images of a heart in only 135 milliseconds – faster than a heartbeat. In particular it will help us manage NICE's requirement to do many more CT scans for people with Coronary Artery Disease (to reduce invasive coronary angiography.

June 2018

- New pay deal for NHS staff
- Research and Development at CHS

New pay deal for NHS staff

Following the Trade Union consultation, it was announced that the on 27 June 2018 the NHS Staff Council had accepted and ratified a proposed new pay deal for Agenda for Change staff. Pay was backdated pay from 1 April 2018.

Research and Development at CHS

On 20 June the Trust held its Annual Research and Development Day. The 56 clinical research projects showed how staff at CHS are working to improve healthcare and are enabling local people to access innovative new treatments. Awards were given across a range of categories including research, clinical service/service improvement, and audits.

Also this month, the National Institute for Health Research (NIHR) published new figures covering April 2017 to March 2018 that showed the number of research participants at CHS jumped 191% to 2,544 from 873 the previous year. This was the largest percentage increase of any acute trust across England and meant that more patients at Croydon had the opportunity to take part in research.

Inpatients said we continued to get better - although we had more to do

The annual national 2017 Inpatient Survey results, published on 13 June by the Care Quality Commission, revealed that care in our Trust continued to improve.

Our two areas of 'significant improvement' were in giving patients enough privacy when discussing conditions or treatments and also providing enough help for patients when they are eating meals. We also gradually improved across the vast majority of other areas, continuing a trend. Inpatients gave better scores in 80% (39 of 49) of the same questions now compared to 2013. By comparison, only 8% were lower - and only marginally. Overall, 78% of patients responding rated our care as seven or more out of 10 – an improvement from 69% in 2013.

However, we were below most trusts and the survey showed we were not improving as quickly as them. Relevant factors could be our especially large and diverse local population (considering the size of our Trust) and the fact that 83% of our 331 respondents were from A&E – a service where we were stretched and, at that time, in a temporary location.

A number of changes were introduced to help improve our patients' experience of care going forward, including work to improve discharges home, twice-monthly quality meetings, new electronic quality rounds, daily environmental checks and comfort packs for inpatients.

July 2018

- NHS 70
- Trust's own pop up shop opened in Croydon
- CQC visit to community services
- Praise for ENT team

NHS 70

On July 5, the NHS turned 70 and there were a whole range of activities across the Trust, in our hospitals and community clinics to mark the occasion.

Tea and cake were provided in the Post Graduate Medical Centre (PGMC) at Croydon University Hospital as well as cakes and strawberries out in the community, thanks to the generosity of our catering team, estates suppliers, Unison and charitable funds. Michael Fanning went to Lennard Road for the cake cutting, where staff had also organised their own cake sale and dressed up in their nursing uniforms from many years ago. Radiology created a fascinating photo exhibition and teams in Nightingale House came together for a celebratory lunch.

Members of our senior team also joined colleagues from Croydon CCG, Croydon Council, HealthWatch Croydon, Croydon Voluntary Action and South London and Maudsley NHS Foundation Trust (SLAM) for a 70th birthday celebration at our pop up shop in the Whitgift Centre.

Pop up shop

Our first ever CHS pop up shop opened during July in the Whitgift Centre in central Croydon. We opened for three days a week for three weeks to showcase the services that we provide for the people across the borough.

Our recruitment team offered on the spot assessments and interviews to job applicants for a range of opportunities across the Trust. Our Patient Experience, Volunteering, Communications and Maternity teams were also regularly in the shop speaking with local people as were Croydon Works job brokerage team and SLAM. Our falls team even got out and about to give advice to people using walking aids in the shopping centre.

CQC visit to community services

During July the CQC held an unannounced inspection of our community services for children and young people and for adults. They also inspected core medical services at Croydon University Hospital.

In their report, which was published in September, inspectors awarded our medical care and community services overall ratings of 'requires improvement'. All our services were rated as 'good' on caring and both medical services (including older people's care) and community health services for adults were also judged 'good' on being effective.

In total, combining the results of our previous inspection last year, this latest report meant seven out of the nine of the core services inspected at Croydon University Hospital were rated as 'good'. The Trust, however, remained on 'requires improvement' overall.

The inspectors said Trust staff treated people with dignity, respect and kindness, and patients spoke positively about the care they had received. They also highlighted

areas of outstanding practice including new research initiatives by our Speech and Language Therapy staff and community teams and the work of the Rainbow Health Centre which looks after homeless people and asylum seekers in the borough.

The CQC also set out a range of actions needed to address the issues raised and build upon work already underway. These included discharging patients earlier in the day when they are medically ready and not moving people late at night in the hospital because of capacity issues. They also highlighted how, like many trusts, we face challenges to recruit more clinical staff at a time when there is increased demand and limited supply.

Rupert Bear ward

As part of renovation work Rupert Bear ward at CUH moved to a new temporary home on the first floor of the Orange zone. This allowed renovations to take place and created a more welcoming environment for our young patients. The ward was also lucky enough to receive a £1,000 donation from friends of our multi-faith chaplaincy, a Non-Governmental Organisation (NGO) called the Al Khair Foundation.

ENT praised for 'getting it right first time'

We were visited by NHS England's 'Getting It Right First Time' (GIRFT) team in June. The initiative looked at Hospital Episode Statistics to compare each of 122 Ear Nose Throat (ENT) departments across England. They called our service "stellar" and their ENT lead for GIRFT (an ENT surgeon from Nottingham) commending our team highly. We ranked in the top 10 per cent in almost every aspect, both for raw numbers and when adjusted for population and size of department.

Croydon NHS spearheads change in England's surgery teams

It was announced that clinicians who work alongside surgeons during operations could join the distinguished Royal College of Surgeons (RCS) as 'Associate Members'. The first ever person to join under this new arrangement was Matthew Smith who is Surgical First Assistant in the operating theatre for trauma and orthopaedic cases at Croydon University Hospital.

Launch of FFT by text

From 20 July the Trust launched a new initiative as part of the Friends and Family Test (FFT) so patients and service users could share their views by mobile. Patients in our Emergency Department were the first to get this option which it was hoped would enable more people to give us vital feedback in a convenient way.

August 2018

- **Reablement service rated good**
- **Trust rated top in SW London on cleanliness and maintenance**
- **Trust among the best in London on waiting times for treatment and suspected cancer**

Reablement service rated good by the CQC

In August the CQC inspected Croydon's reablement services, including one of our new services run in partnership in the borough. Publishing the results on 5 October, CQC inspectors rated the Croydon community reablement service as 'good' for all aspects of the service, including its safety, responsiveness and how well it was led. Feedback to CQC inspectors during the visit included comments from a service user's relative, who said: "The service is very good, I'd rate it outstanding."

The service is part of LIFE (Living Independently For Everyone) service. This was created by the One Croydon alliance in 2017, bringing together teams from health and social care as well as the voluntary sector. It provides coordinated short-term support to people and enable them to retain or regain their independence and continue living in their own home. It was set up to look after mainly over-65s with long-term conditions by tailoring their care to reduce the need for hospital stays.

Trust rated top in SW London for cleanliness and maintenance of buildings

In the annual Patient-Led Assessments of the Care Environment (PLACE), CHS achieved a score of 8.83 percent for cleanliness and 94.83 percent for the condition, appearance and maintenance of its buildings – the highest scores among South West London acute hospitals.

Against the measure of how well the Trust meets the needs of people with dementia, CHS scored 85.15 percent which was the highest in the South West London region. The Trust also scored an impressive 94.83 percent for how well equipped it is to meet the needs of people with a disability which was the highest score among London's 18 acute hospital trusts.

In the assessments, published by NHS Digital, also showed areas where the Trust could improve further. On food, the Trust achieved an average of 89.85 percent which was just below the national average of 90.2 percent. On privacy, dignity and wellbeing, CHS was rated at 80.44 percent which was below the average for England of 84.2 percent.

Trust among the best in London on waiting times for treatment and suspected cancer

Data published by NHS England this month showed that in June 2018, 93.1 percent of patients who were referred to CHS for consultant-led elective (planned) care waited less than 18 weeks. This placed the Trust above the national average for the third month in a row and at third position among the capital's 18 acute trusts on Referral to Treatment Times (RTT).

The Trust was also at third position among London acute trusts on waiting times for people with suspected cancer with 98.32 percent of people seeing a specialist within two weeks. This was above the England average of 91.10 percent. CHS additionally performed well on the standard that all patients urgently referred by their GP should start cancer treatment within 62 days. During April, the CHS held the top position among London acute trusts for its 62 day performance, and was third in the capital during May and June.

September 2018

CHS support for national Organ Donation Week

Croydon Health Services NHS Trust called on people to support Organ Donation Week (3-9 September) as figures revealed a fall the number of registered organ donors in the borough.

Over the past decade, 20 people at Croydon University Hospital have donated their organs, enabling 57 transplants. However figures from NHS Blood and Transplant showed that the number of people in the borough on the donor list had fallen from 103,798 in 2017 to 101,636 in 2018. In addition to urging more locals to register, the Trust highlighted the importance of people telling loved-ones if they wanted their organs to be donated.

October 2018

New interim Chief Executive joins the Trust

Matthew Kershaw took up the post of interim Chief Executive on 1 October. With more than 25 years of NHS experience, he had previously held a number of senior leadership roles, most recently as Chief Executive of East Kent Hospitals University Foundation Trust where he led the Trust out of Quality Special Measures.

Prior to this, Matthew was Chief Executive of Brighton and Sussex University Hospitals NHS Trust for three years, securing £500m capital to redevelop the Sussex County Hospital. He also worked nationally at the Department of Health, including developing the delivery plan for the 18-week waiting time target and being the first Trust Special Administrator. His career has also seen him work with the Care Quality Commission, Health Education England, and the Kent Cancer Alliance, where he chaired the Kent Surrey and Sussex Clinical Research Network.

Immediately prior to joining CHS, Matthew was a Senior Fellow at The King's Fund, a health think-tank, where he played a key role in its work with health and care organisations to develop integrated care that better meets the needs of patients and service-users.

Innovative approach to stroke care

On 1 October 2018, ITV London News interviewed one of our stroke consultants, Dr Karen Kee, about a cutting-edge initiative we are trialling at Croydon University Hospital.

Dr Kee and her team are piloting the innovative use of virtual reality simulation to aid the recovery of their patients after a stroke. It is understood that CUH is the first Trust in London to use this technique and the only one in the country to be studying its benefits. ITV London spoke to one of our patients, Peter (aged 87), who experienced his stroke in July outside his home in Norbury. Using virtual reality is helping Peter regain his independence.

New 'Could You Be A Croydon Nurse?' campaign

To help fill the 200+ nursing vacancies across the trust, we launched a nursing recruitment campaign to:

- Make potential employees aware of the nursing opportunities in our trust
- Attract the right candidates to apply for our vacancies
- Celebrate the Trust's support for staff
- Bust some 'Croydon' myths by promoting the area as a vibrant, exciting place to be

We hope the campaign will increase applications across all nursing specialities - positioning us as an employer of choice for nursing and encouraging people to #choosecroydon.

'Red bag' scheme rolled out across Croydon

The Red Bag scheme which is designed to make emergency hospital visits safer and speed up discharge was launched in Croydon. The bags for care home residents contain key information including medical conditions and personal belongings. Ensuring people arriving from care homes have it with them when they arrive at hospital gives staff the information they need to speed up clinical decisions. Evidence shows that use of the bags saved an average of 2.4 bed days. Croydon Clinical Commissioning Group began rolling it out across the borough in November including in CUH.

November 2018

Croydon Health and Care event

The Croydon Health and Care event on 20 November offered a chance for local residents to share their views with ourselves, our partners from across the NHS as well as the local authority, the voluntary sector and local schools. The Trust's medical director, Dr Nnenna Osuji spoke at the event to discuss the importance of working collaboratively with our partners across Croydon to improve how well we look after people in our borough. She also spoke about the importance of self-empowerment and community involvement to enhance health and well-being in Croydon.

New app to help manage diabetes in pregnancy

A new app was launched to help NHS clinicians closely support Croydon women each year who develop 'gestational diabetes' which occurs in about 1-in-10 pregnancies in the borough. The free-to-download (for patients) app can connect wirelessly to a blood glucose monitor and means staff at CUH can monitor women and communicate with them easily. In trials the app was found to help avoid unnecessary clinic visits, reduce administration time and improve care. It is believed that good management of the condition can help prevent long term development of Type 2 diabetes.

December 2018

- **Opening of the new Emergency Department**
- **Gifts and visits from our community for the festive season**
- **Complete hepatitis service at CHS**
- **Dubai nurse recruitment success**

New Emergency Department

Our new Emergency Department, which offers modern, high-quality facilities for our community, was opened on 2 December. Designed by our doctors and nurses to create the best environment in which to care for patients, it is 30 percent bigger than our previous Emergency Department and has a dementia-friendly design. It has rooms with doors, rather than curtained cubicles, to increase privacy for patients. There are also separate paediatric areas for children and adolescents including an outdoor space and 14 paediatric patient rooms.

Two mental health liaison rooms offer private and appropriate spaces where nurses can assess people who need specialist care and there is a dedicated Children and Adolescent Mental Health Service (CAHMS). The department, which cost more than £21million to construct, also includes a new Urgent Treatment Centre with six consultation rooms and a treatment room.

Our local media reported on the opening and our social media posts about it reached more than 10,000 people and had 4,600 engagements. We have also able to show the new facility to our local MPs, councillors and Croydon's Mayor.

Festive visits and gifts from our community

On 13 December, Crystal Palace footballers Patrick Van Aanholt and Scott Dann, alongside Palace Ladies Freya Holdaway and Ciara Watling visited CUH to hand out gifts to patients on Rupert Bear and the Acute Care of the Elderly wards. Children on our wards also received generous festive donations from the Sun on Sunday newspaper, London Ambulance, the Metropolitan Police and charities. Our older patients also benefited from a visit and gifts from the Lajna Women's Association, as well as carol singing organised by the Mayor of Croydon and our chaplaincy team.

Complete viral Hepatitis care opens in central Croydon for the first time

Croydon University Hospital began providing complete viral Hepatitis treatment for the first time so that Croydon's residents no longer needed to go outside the borough for treatment.

About 4,000 Croydon Residents have viral Hepatitis, which is higher than the national average. Many need treatments to be as convenient as possible because of the complexities associated with their infections. It is hoped the new service and expects it to significantly improve treatment rates.

Dubai nurse recruitment success

As part of our ongoing nurse recruitment drive, our Deputy Director of Nursing and Lead Matron - Nursing Workforce, visited Dubai to encourage nurses in the region to #choosecroydon. After a rigorous selection process, including interviews and tests, 50 applicants were offered roles in our nursing teams across the Trust.

January 2019

- **Positive results in the CQC Maternity Survey**
- **National award for CREATE project to enhance our stroke ward**
- **Director of Nursing steps down**

Positive results in CQC maternity survey

The CQC 2018 National Maternity Survey revealed that Croydon Health Services NHS Trust is the highest of any London Trust in treating new mums with dignity and respect during their labour and birth of their babies.

The Trust received a score of 9.7 out of 10, fourth highest in the country and a significant increase in the number of new mums responding positively compared to the 2017 survey.

Croydon Health Services also came fourth nationally when allowing women to choose a location for their antenatal appointments and scored higher than many other Trusts in advising mothers of the need for a personal postnatal check-up 6-8 weeks after their child's birth.

Prize for CREATE project

The CREATE research project to enhance the Heathfield 1 ward at CUH to create a more stimulating environment for patients won a national UK Stroke Forum prize. Other innovations in the Croydon ward include patients getting more information and more opportunities to talk and even play together amid attractive wall murals.

The CREATE (Collaborative Rehabilitation Environments in Acute Stroke) project, which also has improved three other stroke wards in London and Yorkshire was for

'Patient, Carer And Public Involvement' and was awarded at the Stroke Forum Conference in December, run by the Stroke Association and the British Association of Stroke Physicians.

Director of Nursing, Midwifery and Allied Health Professionals steps down after five years at the Trust

Michael Fanning, the Trust's Director of Nursing, Midwifery and Allied Health Professionals announced at the end of January he would be leaving in April 2019 after five years at the Trust. During his time at CHS, Michael celebrated the professions of nursing, midwifery and therapists and introduced new roles to raise the profile of district nurses and therapists in providing holistic care for people in Croydon. He also championed dignity and compassion in care to improve people's experience of using services at the Trust.

February 2019

- Home birth midwife wins regional Royal College of Midwives award
- Chaplaincy welcomes Bishop from Zimbabwe
- Stella Vig, Consultant Surgeon, shortlisted in Asian women of Achievement Awards

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Homebirth midwife wins regional Royal College of Midwives award

Kelly Sawyer, a midwife in the CHS homebirth team, was recognised as the Royal College of Midwives (RCM) London's region's 'Emma's Diary Mums' Midwife of the Year 2019'.

Kelly was nominated by local mum Kasia DiMaria, whom she provided care for throughout her pregnancy, labour and postnatal period. The prestigious award is one of the RCM's Annual Midwifery Awards, recognising the incredible work done by exceptional midwives across the country.

Zimbabwe Bishop visits CUH

CHS welcomed Bishop Ignatius Makumbe from Zimbabwe to see the positive work done by the Trust to provide the pastoral, spiritual and religious care to patients, relatives and staff. The visit provided Bishop Makumbe and colleagues with some help and guidance as they prepared to open a hospital to support the local community in Central Zimbabwe, a project which the CHS Lead Chaplain has supported since its early development.

Consultant surgeon Stella Vig shortlisted for award

Stella Vig, consultant surgeon at CHS, has been nominated for the Woman of the Year award at the 2019 Asian Women of Achievement awards. Highly respected by fellow clinicians at CHS and her vascular surgical colleagues across London and the UK, she has been recognised for being an inspirational leader, coach and mentor to many doctors in training each year at Croydon University Hospital, for being a fantastic clinical leader and an outstanding clinical professional. Stella will find out if she has been successful at the awards ceremony in April 2019.

March 2019

- **One Croydon alliance win HSJ award**
- **Recruitment success in Brighton**
- **Race equality workshop**
- **Pharmacy department praised by Health Education England in inspection**

One Croydon alliance win HSJ award

The One Croydon Alliance was crowned winners of the Local Government Chronicle Health and Social Care award at the LGC Awards 2019. Shortlisted along with eight other Health and Social Care projects across the country, One Croydon were praised for their 'impressive scale and system-wide leadership' and quoted as having a 'real impact'.

The national recognition comes after an award win for the Rapid Response team as part of the Alliance last year and wide spread praise of the collaborative working across the borough.

Recruitment success in Brighton

Nursing Times Careers Fair played host to our nursing team for their annual careers fair down on the South Coast. Our three-strong team attended and met student and qualified nurses looking for roles across the South East. Despite the presence of a number of London trusts, our team spoke to nearly 300 prospective employees and offered roles to 63 nurses on the day.

Workforce Race and Equality Standard workshop

The trust welcomed Yvonne Coghill, Director of Workforce Race Equality Standard Implementation at NHS England, for an engaging conversation about race equality across CHS. Colleagues from all levels including senior executives and non-executive directors were invited to join the discussion about how CHS is performing in key areas.

Frank discussions were had and new ideas were suggested to make further improvements going forward which will benefit all staff in their understanding working well together around race equality issues in the Trust.

Pharmacy department praised by Health Education England in inspection

Health Education England (HEE) visited the Pharmacy department to inspect the quality of its training and education and their feedback was overwhelmingly positive. During the inspection HEE were highly complimentary about the caring and supportive environment, the Pharmacy team's impressive record and the way they lead by example.

They interviewed all four pre-registration pharmacists, some year-one trainee technicians and other staff - and saw 'exemplary' work, some of which will be used by the HEE as examples of good practice.

Review of Quality priorities 2018-19

This section demonstrates the Trust's achievement on the quality priorities identified for 2018-19.

To provide an at a glance view of performance we are using, a colour coded system as set out below

: 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 One		
To improve our support and care of people with mental health conditions		Partially met

Priority Two		
To create a culture of safety, shared learning and listening to our patients and service users		Partially met

Priority Three		
Reducing the number of incidents involving violence against staff		Further work required

Priority four		
Improving the ways patients and service users access our care		Partially met

Priority Five		
Implement the recommendations in the February 2018 CQC inspection report		Met objectives for the year

Priority One: To improve our support and care of people with mental health conditions

The targets to be met:

- Mental health triage of the patient within 15 minutes of arrival to ascertain clinical priority
- Development of Internal Professional Standards
- 20% reduction in A&E attendances of the frequent attenders in ED who would benefit from mental health and psychosocial interventions (this was a 2017-19 CQUIN)

Progress in 2018/19:

The Trust acknowledges that this continues to be a priority and will continue in 2019/20; expanding to include people with learning disabilities, autism and dementia to build upon the existing work and bring together existing specialists.

All patients who arrive at the Emergency Department are triaged by a member of our Trust's nursing team. This means that any physical and/or mental health issues are identified straight away and the appropriate care pathway initiated. In the case of a patient presenting with mental health needs a referral is made to our on-site mental health liaison team consisting of mental health professionals from South London and Maudsley NHS Trust.

The Trust has employed a substantive Head of Nursing for Mental Health to support the development of a robust pathway through the hospital and put in place a best practice policy for patients who also have mental health needs. The Head of Nursing will also be supporting the delivery of training for staff, including compliance with the Mental Health Act.

The Trust has developed and implemented Internal Professional Standards for nurses, midwives and clinicians. These clearly set out the expected standards of behaviour and care from staff e.g. dress, responsibilities, medication protocols, observations, assessments and handovers.

Mental health has also been the subject of a national 2 year CQUIN for 2017-19. The aim of this CQUIN was to improve services for people with mental health needs who frequently present to the Emergency Department. The Trust has achieved partial compliance with this CQUIN, however the final confirmation from the CCG is not expected until July 2019. A regular multidisciplinary group meet to discuss frequent attendees and agree personalised care plans. This continues to be monitored each month and reported each month to the Executive Management Board

Priority Two: To create a culture of safety, shared learning and listening to our patients and service users

The targets to be met:

- Sustained improvement in complaint response
- Increase in the number of patient safety champions
- Increase in the learning from excellence submissions
- Hold bi-monthly quality events to share the learning from complaints and incidents
- Increase in the response rates for FFT

Progress in 2018/19:

The Trust's Complaints Management Policy requires complaints to be responded in a timely and open way which affords the complainant a high quality response. The policy is framed around a person centered approach with a strong focus on learning.

The Trust's policy includes the NHS Complaints target that all complaints should be acknowledged within 3 working days. Our average acknowledgement of complaints within 3 working days in 2018-19 was 95%.

The Trust has set an internal complaints response standard of 80% within 25 working days. This can be extended with the agreement of the complainant to 35 or 60 working days to acknowledge the complexity of some responses. The performance throughout 2017-18 started well, however dropped in the latter part of the year to achieve an overall year performance of 70%. As a result each Directorate was asked to carry out a review of their complaints response process and the Quality Experience and Safety Team restructure is providing targeted support to clear the backlog and regain compliance with the standard.

The Trust will continue to build and sustain the work in this area. Last year we launched GREATix and we have started to see and embed the learning from excellence.

The Trust has a statutory requirement through NHS England to offer the Friends and Family Test (FFT) to all patients who use our services. It is important to note that there are no nationally set standards for response rates. The Trust FFT response rates compare well against the South West London sector, however the FFT recommendation rates are generally the lowest. The feedback is discussed at Directorate and Board level and is used to inform staff of positive patient care, and to highlight areas that require improvement.

During 2017-18 the Trust began a phased implementation of FFT text message methodology incorporating set questions and a free text section for comments. This began in quarter 2 and by the end of this reporting period had been rolled out to the Emergency Department, Urgent Care Centre, Inpatients and Maternity. Paper forms are still available; however the change in methodology is in line with national policy to move towards this type of data capture.

The change in methodology has meant that it is not possible to compare response rates throughout the year; however the text message FFT system has been well received by patients and carers. Our external provider is now carrying out a thematic review of the free text comments to highlight areas that the Trust can focus on improving.

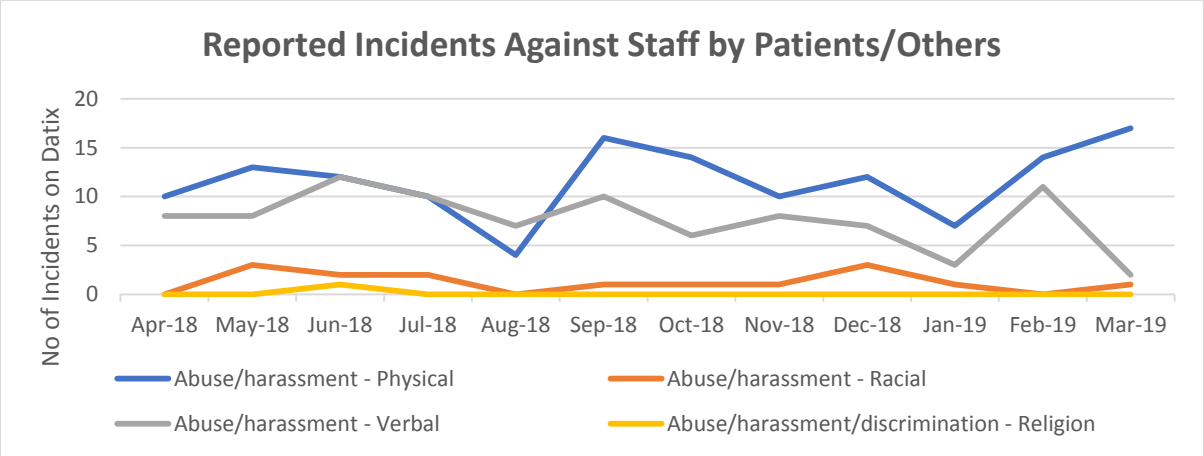
Priority Three: Reducing the number of incidents involving violence against staff

Target to be met:

- 10% reduction in the number of incidents involving violence against staff

Progress in 2018/19:

The following graph shows all physical, racial, sexual, verbal and religious abuse and harassment reported against staff from patients and others during the time period. These are captured on the Datix incident reporting system.



The Trust will continue to monitor incidents and support staff who have suffered from any form of abuse, harassment or discrimination.

Priority Four: Improving the ways patients and service users access our care

Target to be met:

- 50% of service leaflets reviewed and updated
- 33% increase in service information available in other languages
- New service directory in place by 2018

Progress in 2018/19:

In the 2018 Care Quality Commission report inspectors found that People could access services more quickly because of the improvements the Trust had made. Our staff strive to engage with our community to find out first-hand about peoples' experience of our care. The Trust also actively encourages staff to act on their ideas and suggestions for service improvements.

We have launched Croydon Health News – our quarterly newsletter for our local community and partners across the borough. This is sent to local community groups and to the thousands of people who have joined our mailing list to attend regular events.

The Trust's brand new public website was launched in March 2018. The new easy-to-use site has an improved search function and will work on mobile phones and tablets. As part of the new website, our directory of services has been refreshed to make it much easier for our patients and service users to find out information about our services, and for GPs to refer people to our care. This information is constantly being refreshed and updated. The website also has a Google Translate function which will automatically translate the web content into one of 104 different languages.

Patients have access to interpreters and can request information in their preferred language via Languageline, which is a service commissioned by the CCG. Interpreting services are provided over the telephone or face to face.

The Trust is currently working on meeting the Accessible Information Standards. This sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

All Trust leaflets continue to be audited in accordance with the Patient Information Production Policy as part of the Trust's strategy to go 'paper lite'. This resulted in over 100 leaflets being removed from the system. The library of leaflets has been

updated by Directorates through the Health Information Group (HIG); a robust and well established group including patients and staff. New leaflets about services are uploaded to the internet, however the Trust is increasingly encouraging patients and carers to go directly to national online information sources via provided links.

All outpatient letters have been reviewed and updated to ensure that they contain the correct information and enable patients to contact the right people if they require further help or support.

The Trust continues to actively use and promote social media, such as Twitter and Facebook, to support its outreach work to engage with its local community. During the year, Facebook groups have been set up for Croydon Best Start and Breastfeeding support, where Croydon families can to speak to their peers and our healthcare professionals for help and advice. Our Children's Hospital at Home team are also very active on Twitter to reach their younger patients.

This continues to be a priority for the Trust and is included in our Quality Priorities for this coming year.

Priority Five: Implement the recommendations in the February 2018 CQC inspection report

Target to be met:

Delivery of the CQC 'must do' action plans

- Mental health (Trust wide)
- MCA & DoLS (Trust wide)
- Improved medicine management (Critical Care core service)
- HDU – review of fire safety risk and compliance (Critical Care core service)
- Improved storage in ITU/HDU (Critical Care core service)
- Improved infection and control compliance (Critical Care core service)
- Implementation of effective nursing care records (Critical Care core service)
- Improved clinical governance and leadership practices (Critical Care core service)

Progress in 2018/19:

All of the actions from this inspection report have been delivered. A new Head of Nursing for Mental Health has been appointed and a new policy, training plan and support is being delivered. A dedicated task force has been set up to drive forward greater staff awareness and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Within Critical Care, additional storage has been created, with a dedicated medicines area. The existing floorplan has been adapted to ensure the best possible use of available space between beds in the ITU and HDU. Fire safety reviews are carried out weekly, along with Matron Quality Rounds using the Perfect Ward app to monitor a wide range of areas, including infection control. This is in additional to the regular reviews carried out by the Infection Control team. Clinical governance has been strengthened and new Clinical Leadership put in place. The service intranet site has been revised and now contains key performance information, shared learning, audits, learning resources and information for staff. This is available to view by all staff within the Trust.

The CQC visited ITU and HDU to review the changes that had been made to the environment once they were completed and acknowledged the improvements that had been made.

Performance against national priorities

Standards	Target	2016/17	2017/18	2018/19
Meeting the MRSA objective	0	1	0	1
Clostridium Difficile	≤15	13	13	13
RTT Waiting Times for Incomplete Pathways	92.00%	92.81%	92.74%	92.22%
Diagnostic Waiting Times for Patients Waiting Over 6 Weeks for a Diagnostic Test (% of breaches out of total number of referrals)	1.00%	1.83%	1.97%	1.08%
A&E 4 Hour Time in Department (All Types)	95.00%	89.01%	89.95.%	85.25%
Cancer Waits - Referral to First Appointment for Urgent Suspected Cancer (14 Days) Proportion of patients seen within 14 days of urgent GP referral	93.00%	96.94%	96.63%	98.2%
Proportion of patients with breast symptoms seen within 14 days of GP referral	93.00%	98.13%	99.16%	96%
Cancer Waits - Diagnosis to First Treatment (31 Days)	96.00%	98.74%	98.54%	100%
Cancer Waits - Proportion of patients receiving subsequent treatment within 31 days (Drug)	98.00%	100.00%	100.00%	100%

Cancer Waits - Referral to First Appointment for Urgent Suspected Cancer (31 Days) Proportion of patients receiving subsequent treatment within 31 days (Surgery)	94.00%	100.00%	96.30%	100%
Cancer Waits - Referral to Treatment for Urgent Suspected Cancer (62 Days)	85.00%	89.26%	88.99%	85.1%

Infection control

Clostridium difficile (C.diff) target

Croydon Health Services has observed a reduction in the number of hospital acquired infections (HAI) this year.

Total number of HAI C.difficile cases for the time period 1st April 2018 to 31st March 2019 is 13 against the Department of Health annual trajectory of ≤ 15.

There were several driving forces employed in achieving this target, including:

- Antimicrobial prescribing which stipulates that when prescribing Tazocin, Co-amoxiclav Carbapenems e.g. Meropenem, 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.
- Root Cause Analysis meetings on new C.difficile cases within 24hrs of the lab result.
- Weekly Infection Control Team (ICT) C.difficile case review meetings and follow up all inpatients with C.difficile infections/carrier.
- Enhanced Surveillance on wards with a period of increased incidence of C.difficile infection.
- Increased joint antibiotic ward rounds by the Consultant Microbiologist and Antimicrobial Pharmacist.
- Daily ITU ward rounds.
- Antibiotic guidelines have been updated in 2018, and submitted to the Medicine Management Committee for approval.

Antibiotic stewardship activities which include antibiotic prescribing audits and targeted antibiotic ward rounds are also in place, to reduce usage of the high risk agents in i.e. cephalosporins, co-amoxiclav and quinolones.

MRSA target

Total number of Hospital onset MRSA bacteraemia cases for the time period (April 2018 – March 2019) is 1 (one), against the DoH annual trajectory of zero.

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
- There is also on-going training of staff in relation the intravascular device management.
- Close surveillance of IV line care through weekly multi-disciplinary IV ward rounds was also implemented in 2018. An IV line Task and Finish group was set up in 2018 by the DIPC to further address this issue and implement an action plan to improve IV line care.
  This includes training of staff on IV line care and documentation; improving education and training of HCAs inserting IV lines in ED; devising a wall poster on IV line care for clinical areas; re-introducing IV line training for junior doctors.

Influenza

The Trust treated a total of 853 laboratory confirmed influenza cases during the winter season beginning early December 2018 up to end of March 2019. This is a much higher number of cases compared to 2017/18 winter season with 454 lab confirmed influenza cases. The commonest circulating seasonal strain locally was Influenza A. Some of the isolates were typed and were showing to be Influenza A (H1N1) strain which is in keeping with the national picture. A few infections were due to Influenza B.

The rapid influenza/RSV rapid test was implemented locally at CUH site on 19 December 2018. The test is carried out in CUH pathology reception with results available within 2 hours of sample collection. This has enabled early isolation of patients confirmed with flu and/or rapid discharge from A&E with a confirmed diagnosis.

Unlike last season, there have been a large number of young to middle aged adults in the non-high risk groups presenting to ED with severe flu symptoms (365 cases in the age group 14 – 50yrs) during this winter season. Persistent fever, chest pain, palpitations, blackouts, vomiting and severe headache have been the symptoms that have led to these patients presenting to ED or being referred by GPs to ED.

There were more hospital acquired infections than previous season. There were 43 hospital acquired infections. Secondary cases were also diagnosed in some instances where the index case was in a bay. In these situations the affected bay has to be restricted to only admit low risk patients. On occasions where it was not possible to move the index case straight away to a single room, the bay has had to be fully closed to admissions. The influx of flu cases has caused significant bed pressure. A few patients needed ITU/HDU care.

- The Staff uptake for the influenza vaccine was 72%. There were a few confirmed influenza infections amongst staff, but this may not reflect the true numbers. Samples for lab confirmation of Influenza diagnosis are not routinely performed on staff members with flu symptoms.

Norovirus

There were 17 lab confirmed Norovirus diagnoses at CUH April 2018 – March 2019.

This was due to 2 small unrelated outbreaks of Norovirus; one outbreak on a general medical ward and the second outbreak on a Care of the Elderly ward which predominantly manages stroke patients. The outbreaks were well managed and contained within the affected area. Both outbreaks were resolved within a week of onset.

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.

There has been continuing low levels (0 – 2 per month) of ITU/HDU associated GRE colonisation diagnosed on the unit. There were no GRE blood stream infections since April 2018.

The Infection Control Team has worked closely with ITU/HDU staff to identify risk factors for GRE acquisition. Nursing practices, environmental cleaning standards and antibiotic prescribing are kept under review. Changes have been implemented to improve storage facilities and bed spaces to facilitate easy cleaning of the environment.

Gram Negative Bacteraemias

From April 2018 a government initiative extended the surveillance of bacteraemias caused by Gram-negative organisms to include Klebsiella species and Pseudomonas aeruginosa in addition to the existing E.coli data collation with the intention of reducing gram negative bacteraemias by 50% by the financial year 2021. More detailed information has also been requested on the E. coli bacteraemias.

DoH Mandatory reporting of includes Klebsiella and Pseudomonas bacteraemias has been implemented by the Trust 1/4/17. Mandatory reporting of E.coli bacteraemias also continues.

Achieving the 50% reduction by 2020/21 requires close working with the community based healthcare providers, care homes and GPs as majority of these bacteraemias are community onset/associated infections. A urinary tract infection is the predominant cause for these bacteraemias.

An internal quality improvement target has been set for 2018/19: i.e. aim for ≤27 HAI E.coli bacteraemias.

Total number of HOI E.coli bacteraemias for 2018/19 up to date is: 26 and the Trust has successfully achieved the set target.

The Infection Control Doctor (ICD) had been designated as the Trust lead for co-ordinating actions to achieve Gram negative Bacteraemia Target. An Associate Director of Nursing has been designated to lead on catheter care.

The ICD has convened multidisciplinary meetings at the Trust and also attended meetings at the CCG to formulate action plans. The group are initially focusing on urinary catheter care as many of the bacteraemias are due to catheter associated urosepsis. A catheter care pathway protocol has also been produced and awaiting ratification by the Trust.

Urinary catheter care has been reviewed and arrangements are being implemented for more extensive education and audits, in order to monitor practice as well as improve catheter care.

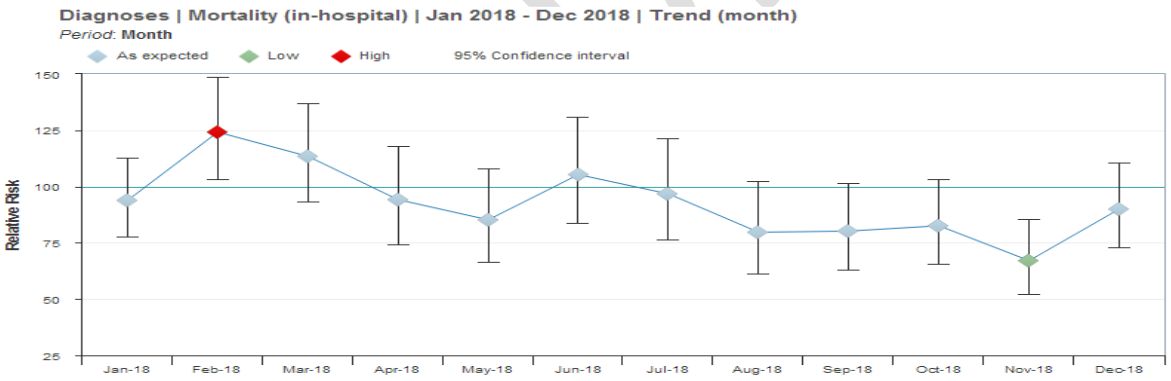
A more enhanced catheter care audit tool has been in place since 2017. The audit tool has been implemented on all adult wards excluding maternity. This is a monthly audit carried out by the clinical area staff and information is recorded on line on “RATE”. The infection control nurses are also conducting independent monthly ad hoc catheter audits. The audit results have been reviewed to guide actions required to improve catheter care.

Mortality Reviews and Learning from Deaths

The Trust has a robust process of retrospective case review of in-hospital deaths; the results of the reviews are securely recorded within the Datix Incident Module. The Mortality Review Group provides assurance to the Patient Safety & Mortality Committee that hospital deaths are subject to a mortality review by the development of a culture and practice of standard clinical audit of mortality.

According to the most recent Dr Foster report in Apr 2019 for the rolling period Jan 2018 to Dec 2018:

- Hospital Standardised Mortality Ratio (HSMR) is 91.1 and is lower than expected
- Standardised Mortality Ratio (SMR) is 92.7 and is lower than expected
- There are no cumulative sum control chart (CUSUM) alerts for the latest 3 month reporting period and there are no diagnosis groups within the Hospital Standardised Mortality Ration (HSMR) bracket that are statistically significant
- Two of the patient safety indicators relating to Mortality are within the expected range - Death in low risk diagnosis groups- 61.4 and Deaths after surgery – 125.4



Mortality Outlier Alert

In 2018-19 the Trust received a notification from the Dr Foster Unit at the Imperial College London University that analysis of mortality data indicated higher than average mortality rates for Fractured Neck of Femur (FNOF) within the Trust. A comprehensive retrospective note review from the Cerner electronic system was undertaken and an action plan was developed to address the issues identified.

Progress on CHS Mortality review process

All mortality reviews that identify issues with standards of care are listed for discussion at Clinical Governance to ensure dissemination of learning points. Documentation and communication between teams remain an area of focus for improvement.

The Trust has piloted the Medical Examiners system and a proportion of deaths are now scrutinised by the Medical Examiner. This will include a conversation with the junior doctor completing the death certificate and a phone call to the bereaved relatives to explain/discuss this.

- Croydon Council Registry Office have a satellite office situated within the bereavement team
- The Trust Clinical Coding team receive regular reports on coding issues identified following mortality reviews
- Coders have been provided with a list of comorbidities that affect the mortality score and they have been reminded to be vigilant when coding and assigning these specific comorbidities and the palliative care code
- An automated dashboard has been created to enable auditing/validating of all deceased patients with potential use of palliative care codes

1. The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.				Quarterly breakdown		
	Ward	**A/E**	**Total**	**Ward**	**A/E**	
Apr-18	76	7	83	220	21	Q1
May-18	69	9	78			
Jun-18	75	5	80			
Jul-18	73	6	79	203	14	Q2
Aug-18	61	3	64			
Sep-18	69	5	74			
Oct-18	84	11	95	248	26	Q3
Nov-18	73	4	77			
Dec-18	91	11	102			
Jan-19	97	8	105	265	18	Q4
Feb-19	81	4	85			
Mar -19	87	6	93			

2. The number of deaths included in item above which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure	Reviews completed of the total above	Quarterly breakdown	
Apr-18	78	224	Q1
May-18	72		
Jun-18	74		
Jul-18	77	202	Q2
Aug-18	57		
Sep-18	68		
Oct-18	88	249	Q3
Nov-18	71		
Dec-18	90		
Jan-19	82	191	Q4
Feb-19	57		
Mar-19	52		
3. An estimate of the number of deaths during the reporting period included in above for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this	Number of cases identified as suboptimal care	Quarterly breakdown	
Apr-18	10	25	Q1
May-18	11		
Jun-18	4		
Jul-18	4	14	Q2
Aug-18	3		
Sep-18	7		
Oct-18	8	24	Q3
Nov-18	6		
Dec-18	10		
Jan-19	4	10	Q4
Feb-19	3		
Mar-19	3		

Learning from deaths deemed preventable

- Education regarding the appropriate escalation and management of Early Warning Scores as per Trust Deteriorating Patient policy. The Trust is adopting NEWS2 from March 2019. Post deployment and clinical adoption will be monitored through the Deteriorating Patient Committee.

- Inter-hospital repatriation of patients - out of hours transfers with no accountable named consultant; this is currently being reviewed with the site practitioners.
- Safe sedation competencies to be developed and to make safe airway for non-anaesthetists training become mandatory.
- Staff meetings and handovers to include guidance on the enhanced care delivery.
- Implement BMDI (device integration) solution to allow rapid and frequent documentation of observations.
- Patients in side-rooms with the potential to deteriorate rapidly or with reduced communication or cognitive ability should be assessed for enhanced care need in line with policy.
- Importance of contemporaneous documentation.
- Clear signage in clinical areas as to location of nearest cardiac arrest trolley.
- Teaching sessions on post resuscitation care.
- Simulation/ anaphylaxis drills at Grand round and local governance meetings.
- Drug charts are best done during the clerking phase in the Emergency Department (ED). The inability to prescribe while in the ED was a contributory factor. However as of 14 June 2018 this facility is now available in the ED and this should reduce the lack of documentation when patients are transferred out of the ED.
- Increased awareness from medical and nursing staff on the recognition and treatment of delirium.

Patient Safety Incidents

Patient Safety

The Trust is committed to the reporting of all incidents to support the processes of learning and improving care across both acute and community services. To support this CHS has begun the process of upgrading the Trust's web-based incident reporting system (Datix) with the Datix Cloud IQ. This is currently in the early stage of the project, with an expected implementation during the coming year. This will enable incidents to be reported from multiple devices, including a mobile phone. This will support our community services to report incidents more easily. The current web-based incident reporting system continues to support intelligent incident, risk, mortality review and complaint data capture, interrogation, analysis and investigation to support the provision of quality patient care outcomes.

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. The Trust actively encourages the reporting of all incidents or near miss incidents throughout the Trust in order to learn and foster a culture of being open and reporting. As a result incident reporting increased from

21,613 in 2017/2018 to 29,792 (27,482 clinical incidents and 2,310 non-clinical incidents) during 2018/19.

Approximately 90% of the incidents reported had resulted in no harm. Moderate harm continued to decrease year on year from 2.4% to 1.86%. Incidents with harm level above level 3 (moderate) constituted 0.3% of the total incidents for the year. In the year, a total of 75 serious incidents were declared for investigation following an initial review of the incidents and in accordance with NHS serious incident framework in the year. Of these, 12 were subsequently assessed as not meeting the criteria of the Serious Incident Framework and were downgraded. This number represents a reduction compared to the number of incidents declared in the previous year. The incidents were mainly related to diagnosis problems, causes for concern about suboptimal care, security and violence and patient access/admission/ appointment issues. All the incidents were reviewed and either investigated or de-escalated. The Trust continues to emphasise learning from incidents and closing the loop by auditing the effectiveness of the learning from the incidents.

All serious incidents are investigated by a panel comprising of multidisciplinary senior colleagues using the RCA methodology. The Trust ensures that the patient and/or carers are involved in the investigations and receive regular updates as well as a copy of the final report. All incident reports are discussed at the Trust Serious Incident Review Group (SIRG) before being formally approved and signed off by the Medical Director or the Joint Chief Nurse. The reports are then shared with the Clinical Commissioning Group for external scrutiny of the report and of the appropriateness of the actions before final closure of the incident.

Never events

There were no ‘never events’ in the Trust during 2018/19.

Duty of Candour

In accordance with CQC Regulation 20 the Trust has a Duty of Candour responsibility to patients and their families if patient care results in moderate or severe harm. The process requires that healthcare professionals are open with service users, their next of kin, carers and advocates, when something goes wrong with their treatment or care. This ensures that we are open and honest about care and treatment and provides the opportunity for continuous improvement.

The Duty of Candour process involves a health professional:

- having a full conversation with patient or next of kin and giving true account of what has happened and answering any questions.
- giving an apology and offer of appropriate support.

- advising on the investigation being conducted.
- sharing the findings and learning to prevent it happening again.

Croydon Health Services continues to demonstrate its commitment to the Duty of Candour principles through an established process. The Trust has a dedicated Senior Quality Facilitator within the Quality Experience and Safety Team (QES) who has a specific responsibility for ensuring Duty of Candour is completed in a timely manner by the Directorates.

The QES team reviews every reported incident that is graded moderate harm and above on either the day that the incident is reported, or the next working day and works with the responsible Directorate or staff to confirm the assigned harm level.

The QES team works with the relevant clinical staff to ensure the patient or family is told about the incident, and that an appropriate apology with a letter is given within 10 days of the incident being reported. CHS continues to offer the hospital's Chaplaincy Service to provide support to patients, next of kin and carers in situations where appropriate. Regular group and individual training sessions are delivered by the QES team to ensure that staff have the requisite knowledge and confidence to perform Duty of Candour effectively and in a timely manner.

The Duty of Candour process is continually monitored and reports weekly to the Executive Review Group to ensure compliance. An annual Duty of Candour audit is also carried out to provide assurance that the Trust is meeting all aspects of CQC Regulation 20. Duty of Candour also forms part of the monthly Trust Integrated Quality and Performance Report (IQPR).

Friends and Family Test (FFT)

In 2018/19 the Trust rolled out text message (SMS) FFT to all of the acute services. The roll-out will continue in order to include community services throughout 2019/20. The SMS includes standard questions and a free text section for any comments.

The results of the FFT can be accessed for each service, allowing real time response to comments or concerns. The Trust continues to advertise the availability of the Friends & Family Test in patient facing areas and importantly, continues to offer a paper option to ensure that all patients/carers have the opportunity to provide their feedback.

The Trust is currently working with our external provider to analyse this year's free text themes which will enable future quarterly qualitative as well as qualitative reports to be produced at both ward and service level.

Patient Advice and Liaison Service (PALS) and Complaints

PALS

The Patient Advice and Liaison Service (PALS) provides impartial advice and assistance in answering questions and resolving concerns that patients, their relatives, friends and carers might have. The Trust encourages concerns to be raised at ward and department level but in line with CQC best practice the Trust widely advertises the PALS office through its web page, literature and public facing posters.

It is expected that each PALS contact has the potential to resolve the specific concern, preventing escalation to a formal complaint.

During 2018/19 the PALS team received 2714 cases. Of these 2439 (90%) were resolved and closed within 2 working days.

The PALS team is located and visible at the front entrance to CUH and posters informing patients and visitors are displayed throughout the Trust. The PALS team are visible in wards and departments as they try to resolve concerns and they use robust procedures to ensure that cases are resolved either at the time or within two working days.

Over the past year the profile of PALS has been raised and concerns are resolved much earlier. The PALS team is supported by volunteers who help to put the public at ease when they visit the department.

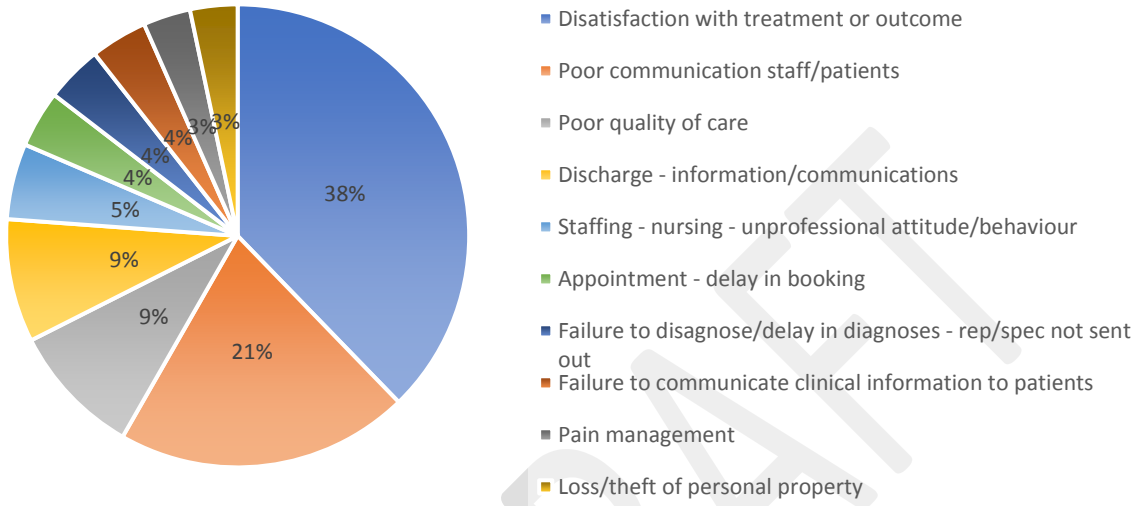
Complaints

During 2018/19 the complaints team received 622 formal complaints compared to 585 received during 2017/18.

The Trust has internal standards for acknowledging complaints (100% within 3 working days) and also that a final response is produced within the agreed timescale (target of 80%). The Trust is committed to achieving these targets and ensuring that all of our complainants receive an acknowledgement and a detailed response to their complaint within the timescale. The Trust achieved 95% compliance for acknowledging a complaint within 3 working days and 72% compliance in the provision of a final response.

In order to support the compliance with these standards the Trust introduced a new Quality, Experience and Safety Team in March 2019.

The following chart shows the breakdown of incidents recorded by theme on the Datix recording system during 2018/19:



Learning from complaints

During the year the Trust has reviewed the ways in which learning from complaints, incidents or Parliamentary and Health Service Ombudsman (PHSO) outcomes can be shared across the organisation. In 2018-19 one complaint was recorded as being referred to the PHSO. This complaint was not upheld by the PHSO.

There are systems in place to highlight key changes to practice or process via the following methods:

- The '3 Key Messages' initiative. This is a Trust wide sharing of information which is updated regularly and disseminated throughout the Trust via email, communication department weekly updates and at local staff group meetings. These key messages originate from a wide range of sources, including complaints and compliments, e.g. reminding staff of the need to include a patient's family and carers (where appropriate) in all discussions and decisions relating to discharge.

- Patient Stories. Patients or patient advocates attend forums such as the Grand Round or the Trust Board to share their experiences of their care.

- Clinical Governance meetings. These are held regularly throughout the Trust at specialty level to support learning throughout the Directorate and across different staff groups.

- Croydon Cares initiative – front line nursing staff sharing learning from incidents and complaints.

- Directorate Quality Boards. These are held each month in the Clinical Directorates to discuss a wide range of quality related areas, including complaints and compliments received. This allows a wide discussion across a variety of staff groups within the Directorate, e.g. to familiarise teams with policies and local practices specific to areas.

- Shift briefs. These are held at the beginning of each shift to update staff on all relevant matters and are also used to highlight learning from complaints to support reflection and learning.

- Professional Forums. These are staff group meetings e.g. Sisters and Matrons, which are used to highlight learning from complaints to support reflection and learning.

Each year the Trust welcomes our local PHSO Liaison Manager to provide a training event for key complaint handlers from within the Complaints Team and the directorates. In February 2019 the training focussed on:

- Getting it right first time

- Carrying out good local investigations

- Ensuring feedback and complaints are a part of every team meeting when discussing 'how are we doing'

- Learning from complaints

Volunteers

The Trust currently has 420 active volunteers who give their time to help in both the hospital and community. Volunteers carry out many valuable roles throughout the Trust and are highly valued. Some of the many roles they carry out include ward helpers, patient feeders, administrators, 'welcomers' to the Trust and also provide support to the Chaplaincy team.

The Volunteer team run various volunteer initiatives to support patients:

- ‘Lunch Club’, which is an innovative programme enabling patients recovering from long-term conditions to eat lunch in the Oasis Restaurant as part of their rehabilitation
- Activity Arts & Crafts Clubs in both the elderly care and stroke wards,
- Poetry club for the elderly
- Knitting clubs that provide sensory items for the elderly and baby items for the Special Care Baby Unit (SCBU)
- Volunteers that visit inpatients to sign post them to smoking cessation services
- Volunteers who call patients to support them to attend appointments
- Stroke Exercise group on Saturdays
- Assistance with feeding patients
- Volunteers in the community

There are also over 70 volunteer peer supporters helping in the Baby Cafes across Croydon borough, supporting new mums with breast feeding.

Staff Survey

The annual national NHS Staff Survey results were published in March. They are the most complete picture of the opinions and concerns of NHS staff throughout the country.

This year it revealed progress across England in areas including developing and training staff, while also reflecting the additional pressure caused by growing demand on NHS and other services. This is also reflected in the findings for Croydon.

Our Trust did ‘significantly better’ than the national average in two areas, which were identifying training needs and providing the right development. This is a big step forward and reflects our emphasis on finding the right opportunities for staff at our Trust. However our staff gave lower scores regarding career progression, highlighting that more work is needed to help staff with their development needs.

We equalled the national average on the vital question about being ‘able to give the care I aspire to’. It was a good score (67%) although 2% lower than our strong result last the previous year.

It is very encouraging to see that more of our staff look forward to coming into work than the national average, 61% compared to 58% across all NHS Trusts. This is an improvement on last year too.

The number of staff that said the Trust had made adequate adjustments to help them carry out their work rose to 70% compared to 66% the previous year. Similarly, fewer staff said they had experienced discrimination at work, both from colleagues (89% positive) and public (90% positive) although both are 2-3 percentage points lower than the national average.

A total of 94% of our staff said they know how to report unsafe clinical practice, however our overall score for our trust's 'safety culture' was below the national average. In particular only two-thirds of our staff feel confident to raise concerns about unsafe clinical practice and only half feel confident that doing so would be acted upon. A fundamental part of our duty of care is that staff must be fully supported when they raise concerns about anything safety-related. Our Guardian of Safe Working (for junior doctors) and Local Freedom To Speak Up Guardians are available for staff to raise any concerns about care and we are reiterating our guarantees to staff that they can raise any concerns about care without fear of recrimination.

Out of 90 questions, we scored 'significantly worse' than other trusts in 31 and 'significantly better' in two. This means we ranked 15th out of the 16 Combined Acute Community Trusts.

As a result we have begun a new and engaging campaign with our 3,800 staff to ensure they are listened-to, informed, reassured and supported. It includes a strong emphasis on finding solutions to issues raised by the NHS Staff Survey, which include:

- 56% of staff said they would recommend our care to a friend or relative. This is 1% more than last year but still lower than the 69% national average.
- 76% of staff were satisfied with support from colleagues – almost 6% below the national average and 2% below last year.
- 21% of staff felt their health and wellbeing is supported, which is lower than the 27% national average and lower than our 32% score last year.
- Several indicators suggest staff sometimes experience discrimination from colleagues, from the public or even in their career progression.

All of these areas are very important to us. Behaviours like discrimination are not acceptable and will receive rigorous appropriate intervention. Other issues such as workplace pressure have an NHS-wide aspect, yet can still be improved locally, and we will work hard to do so.

The NHS Staff Survey was undertaken before our new Emergency Department was opened, which is now giving many staff an excellently equipped and 30% more spacious environment to work in.

Staff and public engagement

In direct response to the opportunities highlighted in NHS Staff Survey, we have refreshed our internal engagement strategy. Expanding on the work of our Listening into Action programme (which ended in 2018), staff now have even more opportunities to shape the workplace and share ideas.

A series of new engagement events have begun, attracting both staff and public, and a special mobile device App is under development. There will also be more local awards for staff so that excellence is recognised and shared, including a Croydon Star of the Month.

Public engagement is being increased and we ended the year with a detailed workshop evening, in which dozens of local community members explored how we can fulfil their expectations for future care, and how they can become more involved.

Freedom to Speak Up Guardian and Whistleblowing

At Croydon Health Services NHS Trust, we are ready and willing to listen and respond to concerns raised.

The Trust has a team of Freedom to Speak Up Guardians (FTSUs) to encourage and support all employees, students, contractors, bank/agency workers and volunteers to raise and discuss genuine concerns about possible wrongdoing, corruption, malpractice and danger that is either currently happening, has taken place in the past or may be likely to happen in the future.

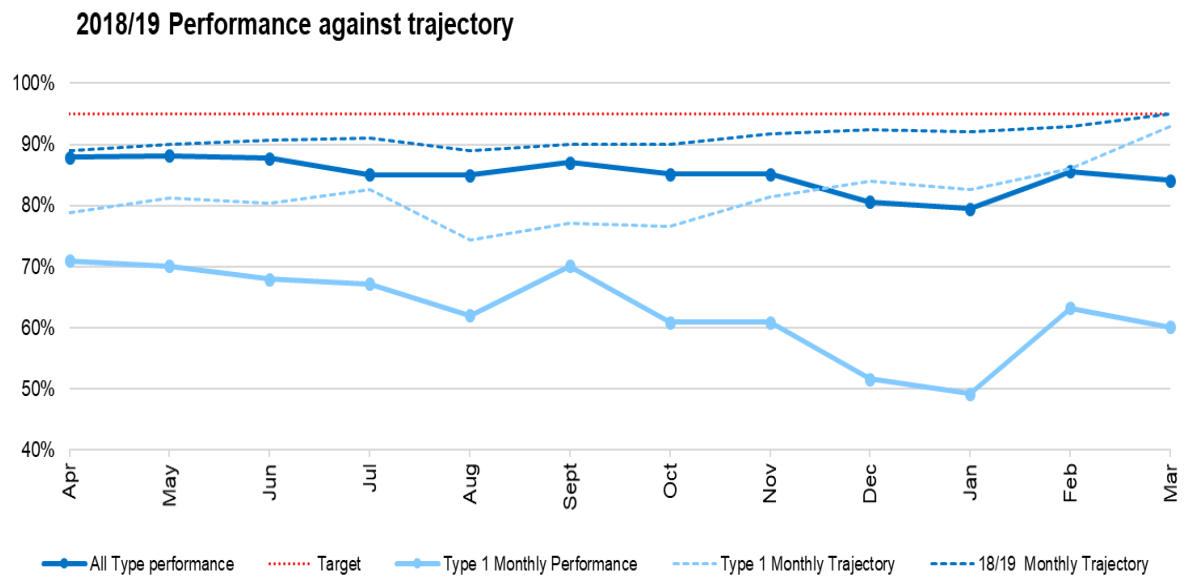
We are currently reviewing our Dignity at Work and ABC policies in partnership with our Respect at Work Advisors, Equality & Inclusion Manager, Human Resources and FTSU Guardians. Once the revised policy is agreed by the People and Organisational Development Committee (POD) and ratified by the Risk Assurance & Policy Group we will carry out a series of workshops for managers and staff so they are aware of what they can do to raise concerns. This will help to build a culture where our staff can raise concerns confidentially or anonymously, either through our FTSU Guardians or Respect at Work Advisors.

Emergency Department

Emergency Care Standard Performance

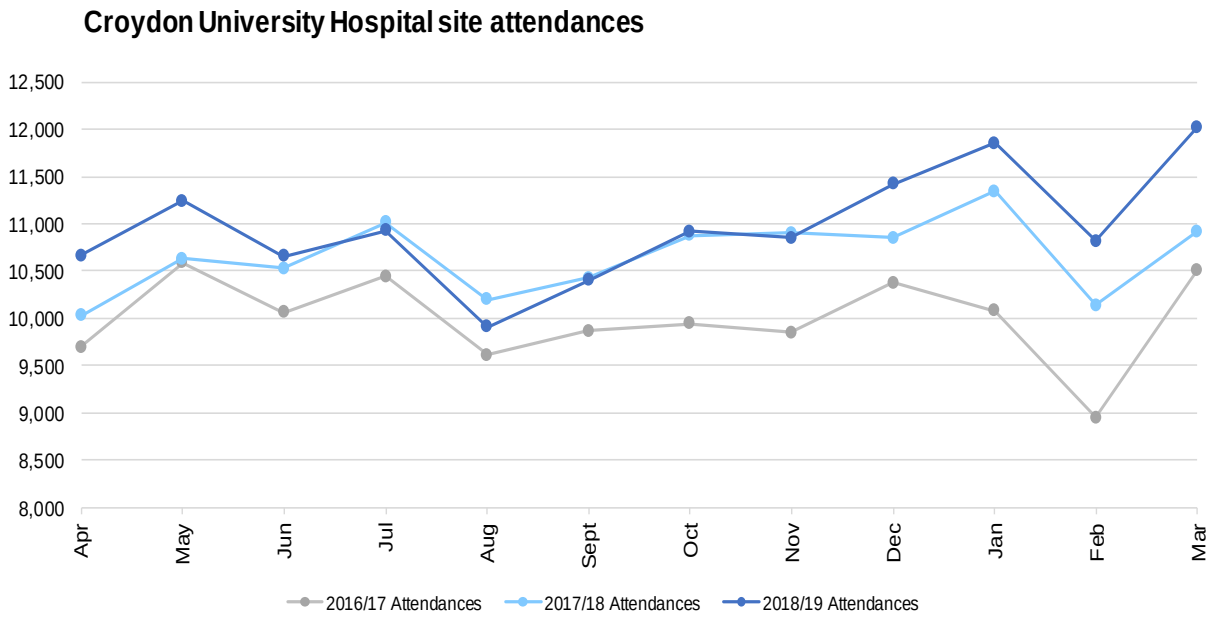
For the year 2018-19 the Trust agreed to work towards a performance trajectory of improvement towards achieving the ‘all types emergency care standard’ performance of 95% by March 2019. Throughout the year this trajectory has not

been achieved despite considerable hard work across the emergency care pathways.



Similar to many other London trusts we have underperformed against the emergency care standard. Although starting the year well in April 2018, the Trust endured a very challenging winter in 2018-19, with type 1 care performance falling to 49% in January 2019. To support improvement four workstreams were established under the High Impact Improvement Programme for Emergency Pathways at CHS, encompassing emergency flow, medical model review, discharge process and operational management. At the year-end we are midway through the High Impact Improvement Programme.

Overall attendances to emergency and urgent care at Croydon University Hospital has continued to grow, reaching a peak in March 2019 above 12,000 attendances. Despite the summer and autumn months being relatively flat, activity has stepped up year on year over the winter. Average daily attendances in February 2019 was 405 per day compared to 366 in January 2018; which was the month with the highest average daily attendances in 2017-18.



ED Patient Experience

Patient experience feedback has been a consistent challenge within the emergency department, with response rates for the Friends and Family test often falling below the required 10% of patients using the emergency department. In September 2018 the Trust commenced using a text message based test for Friends and Family. The response rate improved significantly from a mean of 9.2% to a mean of 22.8%. This is important as the confidence in the validity of the comments improves with the volume of responses. As a consequence of the increase in response rate, and in combination with the increase in waiting times over the winter period, the proportion of responders willing to recommend our emergency department to friends and family has fallen. This is an important metric to monitor as part of our improvement work to improve the speed of care provided to patients throughout the emergency pathway.

New Emergency Department Opens

In September 2017 the Trust opened the new Resuscitation Unit, the first phase of our new emergency Department. This increased the number of beds and delivered a range of improvements including new technology and rooms that were almost twice the previous size. In December 2018 the Trust opened phase 2 with the opening of our new Emergency Department encompassing the new expanded adult majors area increasing cubicle capacity from 16 to 28. Also included is a new children's Emergency Department with dedicated young child and adolescent areas.

The new ED also contains a new Urgent Treatment Centre and dedicated Mental Health assessment suites for adults and the first dedicated assessment suite for children and adolescents in the country.

The new footprint has provided a quieter care environment across the busy areas, particularly in Adult Majors which is now enabling private, confidential assessments to be carried out without neighbouring patients from overhearing.

Referral to Treatment (RTT) Waits

RTT performance

The Trust has successfully delivered against the incomplete performance target for RTT during 2018/19. Performance has continued to improve on an upward trend since April 2018 ending the year on 92.22%. The Trust's performance has consistently been positioned around 11th out of the 24 London Trusts since November 2018. This continued improvement is representative of the significant work being delivered across the specialties to drive productivity and performance is expected to continue on this sustained and upward trend in 2019/20.

Type	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Open pathways	92.76%	92.9%	93.12%	93.19%	93.30%	93.01%	93.24%	93.31%	92.01%	92.02%	92.15%	92.22%

In 2018/19 there has been a strong focus on administrational and clinical education, root cause analysis, demand and capacity modelling and clinic and theatre utilisation. This has contributed to the reduction of long waiters and continued RTT compliance.

Long Waiters

The Trust has improved its approach to validating the Patient Transfer List (PTL) which has removed a large proportion of long waiting patients. There has been the opportunity for cross-speciality education through learning lessons from complex patient pathways and strengthening overall adherence to the access policy. Strategies are also being led to better manage waiting lists to ensure long waiters are flagged earlier and processes put in place to prioritise these patients. A live PTL has also been in use in since November 2018 which has greatly improved data quality in the system.

52+ week waiters

Zero 52+ week waiters have been reported in March 2019. The Trust has reported 36 breaches in total for 2018/19.

Specialty	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	TOTAL
Vascular	0	0	0	0	0	0	0	0	0	1	1	0	**2**
Gynaecology	0	0	0	0	0	0	0	0	0	0	0	0	**0**
ENT	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Max Facs	2	2	2	4	2	0	2	4	5	2	1	0	**26**
Pain Management	0	0	1	0	0	1	0	0	0	0	0	0	**1**
Orthodontics	0	0	0	0	0	1	0	0	0	0	0	0	**2**
Dermatology	0	0	0	1	0	0	0	0	3	0	0	0	**4**
TOTAL	**2**	**2**	**3**	**5**	**2**	**3**	**2**	**4**	**8**	**3**	**2**	**0**	**36**

Cancer

Croydon Health Services NHS Trust has performed well against all the cancer targets for this financial year. We have consistently performed within the top Trusts in London during 2018/19 and met the 62 day performance standard target 10 out of 12 months in 2018. This is exceptional performance by the teams at CHS who have worked tirelessly to drive the 28 Day Faster Diagnosis standard and 38 Day Inter Provider Transfer targets in advance of the official go live dates.

We have consistently maintained a high position within South West London and have generally been within the top 5 performing Trusts in London for the Cancer Waiting Time targets. The Trust was one of the first in London to implement direct booking via eRS for the majority of its tumour sites, with the exception of those pathways that go straight to test in 2018. The Trust has also implemented the RM Partners Telephone Assessment Pathways for Lower GI and Upper GI tumour sites.

Macmillan

The Trust has recruited Macmillan Support Officers for Lower GI, Gynaecology, Breast and Lung to support patients and Cancer Nurse Specialists and be a direct point of contact for patients with a confirmed cancer diagnosis, as well as those on the Stratified Follow Up and Open Access Follow Up. The Trust will be going live in 2019 with electronic Health Needs Assessments via Macmillan.

Appendix A

In May 2019 we sent a draft version of the Quality Account to a number of local stakeholders for their scrutiny, input and comment:

- Croydon Clinical Commissioning Group
- Healthwatch Croydon
- Croydon Council's Health, Social Care and Housing Scrutiny Sub Committee

Formal written responses were received and are included below.

Statement from Croydon Clinical Commissioning Group

Croydon CCG has welcomed the opportunity to review CHS Quality Account for 2018–19. We are able to confirm that it complies with the requirements as set out by the Department of Health. This draft Quality Account provides an open and transparent declaration of the status of the quality of the services the Trust provides which is well written and generally easy to navigate.

We would like to congratulate the Trust on a very successful year, which included the opening of their new Emergency Department which includes a new Urgent Treatment Centre and successfully delivering against the targets for RTT incomplete pathways and cancer.

We have been grateful to the Trust for the way that colleagues have worked openly with us – supporting our assurance processes – taking our concerns seriously and responding to questions helpfully and in a timely way.

We acknowledge the ongoing challenge with the ED performance, and the Trust has prioritised work to address this. We welcome the action plan and the work to improve this.

We also welcome the Trust's engagement and commitment to working in partnership and their open and honest approach to quality. The strengthened partnership with CHS working as an ICS is already seeing considerable benefits at the monthly Integrated Quality Committee, enabling transparent productive discussions.

Croydon CCG is pleased to see that the 2018-19 priorities continue to be a priority in 2019-20. We would like further assurance in how the Trust is learning from the incidents reported and how the Trust is responding to patient feedback.

In reviewing this Quality Account, Croydon CCG was disappointed that the CQC inspection outcome was still "requiring improvement". We look forward to receiving further assurance regarding the improvement work, particularly in the area of safety.

It was disappointing to see that there was no reference made in this Trust Quality Account to safeguarding children and adults and how the Trust has met its responsibility in this area. The CCG expect this information to be included in future Quality Accounts.

We are pleased to see feedback about the work of the Freedom to Speak up Guardians and a clear plan for how the Trust intends to learn from this.

Croydon CCG is looking forward to continuing to work collaboratively with the Trust on the key priorities over the coming year. This will include building on success, and further developing and monitoring the quality of services it provides to the populations it serves. This will include several quality assurance visits in 2019-20.

Statement from Healthwatch Croydon

It is good to see the improvements that have been made towards measuring and delivering quality of services. It is clear to see that patient experience has been applied in monitoring quality, but it would be beneficial to see specific examples of where policies or processes have changed in response to patient feedback. We suggest that this is presented publicly and actively promoted, so that patients can see the impact that their experiences are contributing to service improvement.

We look forward to further strengthening our relationship with Croydon Health Services NHS Trust in the coming year and contributing to their quality agenda through analysis of patient experience.

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

12.6.19 - No comments received from Croydon Council

Changes to the Quality Account following statements received

Appendix B

Statement from External Auditors

12.6.19 - Grant Thornton are completing their report which is expected 17th June 2019.

Annex C

Details of specific actions undertaken from the National Clinical Audit and Local Clinical Audits

National Audit	Action to Improve Quality
National Audit of Dementia	The Trust ensures all patients are assessed on admission, but reassessment remains an issue. Individuals do not always recognise the difference between dementia and delirium. New training programme has been devised which is open to all staff, including the junior medical and surgical team.
National COPD audit	The Trust worked with the Live Well team and Junior Doctors to create a clerking document that automatically refers to the Smoking Cessation Team for appropriate patients. The Trust implemented a number of solutions to reduce bed occupancy (facilitated discharge work and therapy ward) to enable respiratory patients to be repatriated to the respiratory ward as soon as possible.
The Learning disabilities Mortality Review (LeDeR) Programme	Learning disability awareness training at the Trust has recently been reviewed and updated for CHS staff. The training is being delivered by members of the CLDT, in conjunction with people with Learning Disabilities and carers. Two sessions are scheduled for this year.
National Oesophago Cancer Audit	The Trust needs to explore ways to improve rates of early diagnosis and, in particular, investigate the reasons for high rates of emergency diagnoses.
National Diabetes Transition Audit	It has been recommended that the Trust should specifically contract Paediatric and Adult Multi-disciplinary team's services to deliver appropriate, joined-up services during this period, so essential key healthcare checks are not missed, and DKA admissions do not increase. The trust has paediatric MDT in place and our adult diabetes service is actively expanding numbers of staff. The Trust has a transition pathway designed to make the process user-friendly but focussed on sustaining stable HbA1c and minimising DKA. This transition is outlined in our Transition Policy section of the Paediatric Diabetes Operational Policy

Local Audit	Actions to improve quality
Management of acute asthma in ED	The audit demonstrated that the Trust is good at prescribing salbutamol; sometimes ipratropium was omitted and are prescribing correct dose steroids, promptly, in accordance with guidelines, and met targets for prescribing TTO steroids, generally good at recording Peak expiratory flow rate at admission but requires improvement for recording after treatment.
Traumatic Injury : Foot and Ankle Imaging	The audit compared local guidelines and practices for images obtained from foot and ankle trauma to the American College of Radiology Appropriateness Criteria. The Trust was partially compliant to the standards audited.
Protected Mealtime audit (PMT)	The recommendations are make all wards aware of their own results and target lowest performing wards, review of ten steps of meal distribution to make it more clear and reduce the risk of error, to display a PMT poster or stand at the ward entrance of: RAMU, Wandle 1, 2, 3, Queens 2, Purley 3, ACE, make all patients aware of the hand wipes on receiving the meal.
Evaluating current practice regarding C-reactive protein concentration and performance of lumbar puncture	The audit was compliant to NICE guidelines for neonatal infection (early onset): antibiotics for prevention and treatment. The audit found that majority of LPs were being carried out where CRP result was >10mg/L, however there were no truly positive CSF results, thus recommend that CRP threshold for performing LPs be increased to 20mg/L unless clear clinical indication to do so at a lower concentration.
Audit of Shared Care process from Rheumatology to Primary Care for Disease Modifying Anti Rheumatic Drugs	The audit aimed to Improve process of transfer / shared care for DMARDs to primary care. Actions following audit include - Rheumatology nursing team to create a live dashboard of DMARD shared care to review when acceptance, rejection and no response occurs and to then more easily liaise with GP practices to complete shared care agreements in a timely manner, Liaise with CPC to discuss results and inform Primary care.
Audit of women with preterm pre-eclampsia against NICE Quality Statement	The audit demonstrated partial compliance to the standards audited. The Trust predominantly managed women in outpatient care. The average frequency of outpatient visits in our trust was once every 4 days and in the other two trusts was once every 3 days A re-audit is planned as the limitation of this audit was that there was only a small cohort of patient eligible for the audit
Follow-up care on Post-natal Ward	The audit monitored whether the follow up plan made by Clinicians attending Paediatric and Neonatal Outpatient Department is being followed. Consultants/ Registrars will ensure that the outcome form is filled after their clinics and document telephone follow-ups in preformatted sheet where the plan is clear.

Appendix D

Glossary

Acute Trust	A trust is an NHS organisation responsible for providing a group of healthcare services. An acute trust provides hospital services (but not mental health hospital services, which are provided by a mental health trust).
Audit Commission	The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trusts, primary care trusts and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for-money studies. Visit: www.audit-commission.gov.uk
Board (of Trust)	The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community.
Care Quality Commission	The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk
Cerner millennium system (CRS)	Cerner millennium is the Electronic Patient Record system used at Croydon Health Services.
Clinical Audit	Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.
Clinical Coding	Clinical Coding Officers are responsible for assigning 'codes' to all inpatient and day case episodes They use special classifications which are assigned to and reflect the full range of diagnosis (diagnostic coding) and procedures (procedural coding) carried out by providers and enter these codes onto the Patient Administration System. The coding process enables patient information to be easily sorted for statistical analysis. When complete, codes represent an accurate translation of the statements or terminology used by the clinician and provides a complete picture of the patient's care.
Clinical Directorate	During 2015/16 Croydon Health Services clinical services were organised into three directorates: Integrated Adult Care (IAC), Integrated Women, Children and Sexual Health (IWSCH), and Integrated Surgery, Cancer and Clinical Support Services (ISCCS).
Clostridium difficile or C. Difficile	Clostridium difficile also known as C.difficile or C. diff, is a gram positive bacteria that causes diarrhea and other intestinal disease when competing bacteria in a patient or persons gut are wiped out by antibiotics. C. difficile infection can range in severity from asymptomatic to severe and life-threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. difficile infection in the community and outpatient setting is increasing.
Commissioners of services	Organisations that buy services on behalf of the people living in the area that they cover. This may be for a population as a whole, or for individuals who need specific care, treatment and support. For the NHS, this is done by primary care trusts and for social care by local authorities. The host commissioner is Croydon Clinical Commissioning Group (CCG)
Commissioning for Quality and Innovation	High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Visit: www.dh.gov.uk/en/

	Publications and statistics/Publications/ PublicationsPolicyAndGuidance/DH_09 1443
Community Trust	A trust is an NHS organisation responsible for providing a group of healthcare services. A community trust provides services within the community, working closely with other health organisations, e.g. social care and public health.
Complaint	An expression of dissatisfaction with something. This can relate to any aspect of a person's care, treatment or support and can be expressed orally, in gesture or in writing.
Croydon Clinical Commissioning Group (CCG)	The CCG became legally responsible for commissioning/buying healthcare services for Croydon residents from 1st April 2013 as authorised by NHS England
Culture	Learned attitudes, beliefs and values that define a group or groups of people.
Datix	This is the name of the electronic incident reporting system at Croydon Health Services. It is also used to capture complaints and compliments.
Department of Health & Social Care	The Department of Health & Social Care is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.
Dignity	Dignity is concerned with how people feel, think and behave in relation to the worth or value that they place on themselves and others. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual views and beliefs.
Discharge	The point at which a patient leaves hospital to return home or be transferred to another service, or the formal conclusion of a service provided to a person who uses services.
EWS	This is the Early Warning System is based on vital signs such as blood pressure, heart and breathing rates
Family and Friends Test	Introduced in 2013 this is an opportunity for family and friends to give feedback to hospitals regarding their care and experience. At Croydon Health Services this is a blend of paper feedback and mobile SMT messaging.
Foundation trust	A type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS foundation trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS foundation trusts have members drawn from patients, the public and staff, and are governed by a board of governors comprising people elected from and by the membership base.
Global Trigger Tool (GTT audit)	The Global Trigger Tool is a recognised and validated audit tool developed by the Institute for Healthcare Improvement (IHI) In Boston USA. It can be used as part of an organisation's safety improvement programme to identify and so learn about harm and safety incidents which occur as part of the patient's treatment. Twenty records are reviewed each month using the GTT and the findings plotted over time on a run chart to establish a harm rate. Barts and The London NHS Trust has been undertaking GTT auditing since 2008.
HealthWatch	HealthWatch is made of individuals and community groups which work together to improve local services. Their role is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. HealthWatch also have powers to help with the tasks and to make sure changes happen.
Healthcare	Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery.

Healthcare-associated infection	An avoidable infection that occurs as a result of the healthcare that a person receives.
Hospital Episode Statistics	Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.
Indicators for Quality Improvement	The Indicators for Quality Improvement (IQI) are a resource for local clinical teams providing a set of robust indicators which could be used for local quality improvement and as a source of indicators for local benchmarking. The IQI can be found on the NHS Information Centre website at: www.ic.nhs.uk/services/ measuring-for-quality improvement
Information Governance	The structures, policies and practice to ensure the confidentiality and security of health and social care service records, especially clinical records which enable the ethical use for the benefit of the individual to whom they relate and for the public good.
Joint Advisory Group (JAG) accreditation	The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) was established in 1994 under the auspices of the Academy of Medical Royal Colleges. It aspires to: • set standards for individual endoscopists • set standards for training in endoscopy • quality assure endoscopy units • quality assure endoscopy training courses
MRSA	Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to antibiotics including the penicillins and the cephalosporins. MRSA is especially troublesome in hospitals, where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.
Malnutrition Universal Screening Tool (MUST)	'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
National Confidential Enquiry into Patient Outcome and Death - NCEPOD	The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of which are then published. Clinicians at Croydon Health Services NHS Trust participate in national enquiries and review the published reports to make sure any recommendations are put in place.
National Institute for Health and Clinical Excellence	The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk
National Patient Safety Agency	The National Patient Safety Agency (NPSA) is an arms-length body of the Department of Health, responsible or promoting patient safety wherever the NHS provides care. Visit: www.npsa.nhs.uk
NHS Number	This is the national unique patient identifier that makes it possible to share patient information across the whole of the NHS safely, efficiently and accurately. The NHS Number is fundamental to the development of the National Programme for IT.
NHS Resolution	NHS Resolution is a special health authority in the NHS responsible for handling negligence claims made against NHS bodies in England. In addition it has developed an active risk management programme to raise NHS safety standards and reduce the incidence of negligence. It also monitors human rights case law on behalf of the NHS, co-ordinates claims for equal pay in the NHS and handles

	Family Health Service appeals (i.e. disputes between doctors, dentists, opticians and pharmacists and NHS Primary Care Trusts).
Overview and Scrutiny Committees	Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and Scrutiny Committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.
Patient	A person who receives services provided in the carrying on of a regulated activity. This is the definition of "service user" provided in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Patient and Public Voice	This used to be called Patient and Public Involvement (PPI) but has recently been renamed. It highlights ways in which the public and patients are involved in a trusts patient care
Periodic reviews	Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term 'review' refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/1 0.cfm
Picker Institute UK	The Picker Institute Europe is a not-for-profit organisation that supports the healthcare sector to help make patients' views count in healthcare. It works to build and use evidence to champion the best possible patient-centered care working with patients, professionals and policy makers to achieve the highest standards of patient experience. In Europe and the UK, Picker research and gather patient's views of healthcare using surveys, focus groups and other methods as for example by supporting the national survey programme in the NHS for the Care Quality Commission.
Privacy and dignity	To respect a person's privacy is to recognise when they wish and need to be alone (or with family or friends), and protected from others looking at them or overhearing conversations that they might be having. It also means respecting their confidentiality and personal information. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual beliefs
Providers	Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.
Quality monitoring	A continuous system of monitoring to ensure that local quality measures are effective. Quality monitoring is part of quality assurance.
Quality Committee	The Quality Committee monitors, reviews and reports on the quality of services provided by the Trust. This includes the review of governance, risk management and internal control systems to ensure that the Trust's services deliver safe, high quality, patient-centered care. Performance against internal and external quality improvement targets and follow-up whenever required. Progress in implementing action plans to address shortcomings in the quality of services – if any have been identified.
Registration	From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC). Croydon Health Services is registered with the CQC to provide a variety of acute and community health services: https://www.cqc.org.uk/provider/RJ6/registration-info.
Research	Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Safeguarding	Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded. For children, safeguarding work focuses more on care and development; for adults, on independence and choice.
Secondary Uses Service (SUS)	A single repository of person and care event level data relating to the NHS care of patients, which is used for management and clinical purposes other than direct patient care. These secondary uses include healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance. Visit: www.ic.nhs.uk/services/the-secondary-uses-service-sus/using-this-service/ data-quality-dashboards
Adult social care	Social care includes all forms of personal care and other practical assistance provided for people who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs or any other similar circumstances, are in need of such care or other assistance. For the purposes of the Care Quality Commission, it only includes care provided for, or mainly for, people over 18 years old in England. This is sometimes referred to as adult social care.
National Early Warning Score (NEWS2)	A weighted algorithm in which physiological observations are used to produce a single score. Increasing NEWS2 score reflect the severity of illness/physiological derangement. The NEWS2 score informs the escalation process
VitalsLink®	VitalsLink® electronically captures patient's vital signs using a Welch Allyn monitor, then puts them directly into patients' CRS Millennium records. VitalsLink®, which is a Cerner integrated solution, no longer requiring separate devices to upload Vital Signs onto Patient Records

Excellent care for all

Home | Community | Hospital

Professional
Compassionate
Respectful
Safe

www.croydonhealthservices.nhs.uk

#choosecroydon

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WE ARE CROYDON HEALTH SERVICES

Croydon Council Health Overview & Scrutiny Committee

24 June 2019

NHS
Croydon Health Services
NHS Trust

Excellent care for all

Home | Community | Hospital

Our Vision

Croydon Health Services NHS Trust

Excellent care for all, and to help people in Croydon lead healthier, longer lives

- **Realising this vision requires integrated care at every stage of life**
- **CHS has integrated services:**
  - **at home**
  - **in our community**
  - **in our hospitals, both at CUH and PWMH**
- **Meeting increasing demand from a growing and ageing population also requires closer collaborative working**

9/10

PEOPLE WOULD RECOMMEND OUR SERVICES

to their friends and family

(2018)



What we delivered in 2018-19 – in numbers

NHS
Croydon Health Services
NHS Trust

Community

- 140 full time Adult Community Nurses managed more than 435,000 care contacts
- Adult Therapy Services also managed more than 125,000 contacts to people in their homes and in our clinics

Emergency

- Looked after 131,933 attendances (urgent and emergency care), including:
- 30,393 emergency admissions
- 82,522 emergency attendances at GP hubs
- 95 blue-light ambulances every day

Maternity

- Delivered 3,444 babies
- These included 2.2% home deliveries
- Received 92.98% positive recommendations

Planned care

- Provided 2,486 inpatient operations
- 25,992 day case procedures
- 392,989 outpatient appointments

Income

- Total income during 2018/19 of £318.8m.
- 8.8% growth compared to the previous year

All delivered by ….

Dedicated staff

- 3,680 staff
- 420 volunteers

Integrated Trust

Croydon Health Services NHS Trust

Our staff cover every corner of the borough

More than a third of CHS staff work in the community, alongside primary care and social services

- **Experienced community nursing teams**, matrons, midwives and allied health professionals
- **Senior consultants**, speciality doctors and middle grade trainees across community medical teams
- **Caring for 1,000s of people** every week
- **Across 44** community services
- **Ranging from** health visiting support for new parents and babies through to home visits and rehabilitative & independent living services for older people

Building partnerships

The story so far…

0-5s: Joining-up services with local authority to give Under 5s the "Best Start" in life

Croydon Urgent Care Alliance

ALL AGES

GP appointments 8am-8pm, including weekends

OVER 65s: Alliance between the local NHS (CCG, acute, mental health), GPs, Croydon Council and Age UK Croydon to improve the health and wellbeing of Croydon citizens

Next steps on the journey to 'total place'

- Joint leadership team
- Governance
- Place-Based committee
- Devolved budget
- Social care integration
- Accommodation of primary care and mental Health
- ICN+
- Empowered neighbourhoods

Quality

Croydon Health Services NHS Trust

We do better than the national average in three out of the four key performance indicators

As reported by the **BBC** on 13 June 2019, **our Trust significantly exceeds the national average in three of the four key NHS performance indicators**:

- Patients starting **cancer treatment within 62 days** of urgent GP referral: **85.1%** (compared to 79.7% for England). Meeting the 85% national target.
- Patients having **planned operations & care within 18 weeks** of referral: **92.2%** (compared to 86.7% for England). Meeting the 92% national target.
- Patients starting **mental health therapy within six weeks** of referral: **99%** (compared to 89.5% for England). Meeting the 75% national target.
- Patients **treated or admitted within four hours** of arrival at A&E: **84%** (compared to 85.1% for England). Not meeting the 95% national target.

Quality

NHS
Croydon Health Services
NHS Trust

Some of our other successes

- Consistently top five in London on **short cancer waiting times**.
- **Inpatient Survey** results improving well each year.
- **RTT performance consistently about 11th** among the 24 London Trusts since November 2018.
- **Highest % increase in clinical trials** participation of all acute trusts in England.
- We rated **top in South West London for cleanliness** and maintenance by PLACE.

Quality

NHS
Croydon Health Services
NHS Trust

….. However there are areas we need to improve. Here are our four quality priority areas:

Continue embedding a culture of patient safety and shared learning:

- Medication management – ensuring patients are discharged with the correct medication first time and reducing the number of inpatient omitted doses from 5% to 3%
- Continue to improve reporting of incidents and sharing learning throughout the Trust
- Reduce laboratory confirmed catheter associated e-coli blood stream infections by 5%

Improve accessibility to our services:

- Continue to roll out ERS
- Improve the signposting and provision of information in preferred languages
- Be compliant with the Accessible Information Standards
- Continue to improve the access & flow from ED to discharge
- Continue to improve our support and care of people with mental health conditions, learning disabilities, autism and dementia who access our services

Continue to listen to our patients and service users:

- Involve patients and service users in the co-design of services
- Review and respond constructively to patient feedback
- Respond to complaints within agreed timescales and reduce number of re-opened complaints
- Review and improve upon our public engagement

Embed the Trust's vision and values: "Excellent care for all and helping people in Croydon live healthier lives" by being professional, compassionate, respectful and safe:

- Continue to strengthen our governance processes
- Develop and embed quality improvement methodology
- Delivering the Quality Improvement Strategy
- Delivering the Staff Engagement plan

Excellent care for all

VALUES

We are:
professional, compassionate, respectful and safe

VISION

Working in partnership to provide excellent care for all and improve the health and wellbeing of our population

STRATEGIC PRIORITIES

1. High quality care	2. Supporting our staff	3. Sustainable finances	4. Improving health for all

2019/20 ANNUAL OBJECTIVES

1. High quality care	2. Supporting our staff	3. Sustainable finances	4. Improving health for all
• New quality improvement methodology • Acute and community closer working • Completing CQC 'Must Dos' • Delivering Quality Account priorities • Meeting national performance standards • Use of digital technology	• New staff engagement programme • Demonstrable progress in annual staff survey • Improved value from staff appraisals • Increased recruitment and retention • Building our workforce • Demonstrating our WRES commitment to improving equality and diversity	• Working together with Croydon CCG to meet financial targets • Ensuring system improvements benefit people in our community • Improving medical and nurse staffing • Efficient corporate services • Plans for IT, estates and medical equipment • Greater accountability • Planning for the long term	• Partnership with Croydon CCG • Growing our One Croydon alliance to benefit more people • Increasing consistency in SW London as part of the Acute Provider Collaborative • New services with the GP Collaborative • Increase our focus on population health with the borough's Director of Public Health • Becoming an Integrated Care System for SW London by 2021

Croydon Health Services NHS Trust

Developing our quality priorities 2019/20

The quality of care that we provide and the safety of our patients are both very important to the Trust and we strive to deliver continuous improvements in these key areas every day. The annual development of our quality priorities makes sure we focus on the most important areas.

Following a review of our 2018/19 priorities we kept those which remain key, or where we can continue to make improvements - allowing us to build on the work achieved in the previous year

Further priorities were developed using data from serious incident investigations, complaints, and feedback from staff and patients – from these key themes were identified to help inform priority setting

Priority setting discussions took place with clinical directorates, our patient safety and mortality committee, and quality committee

A public survey was opened up to staff, patients, members of the public and stakeholders to feedback on the proposed priorities

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healthwatch Croydon

How do I register?

A mystery shop of Croydon GPs on registration

March 2019

Findings in brief

Average waiting time: 2 minutes 34 seconds with 36 surgeries picking up earlier than this.

Staff attitude was positive at 68% of practices - just 8% of practices were seen as negative.

Staff helpfulness was positive at 70% of practices - just 9% were negative.

Just 15% of GPs gave accurate registration information where no ID or address is requested.

58% of GPs gave consistent registration information between phone and website.

18% did not have information on registration or did not have a website.

Recommendations in brief

No ID needed:
GPs should register people without ID or address in line with Primary Care contract

Use NHS standard information:
GPs could use registration information from the NHS website.

Adopt the GMS1 form as standard:
This ensures all relevant data is received from patient at the start.

Offer practice address to register:
GPs should use practice address for those with temporary or no fixed address.

Dedicated staff and phone lines:
This will improve patient experience and also support staff to do their best.

Focus on the 'service' aspect:
GPs could apply customer service training to improve patient experience.

Executive Summary

Registering at your GP is crucial to ensuring that patients can get access to health services. Unfortunately, there seems to be barriers to registration concerning information on registration processes. This means people cannot gain access to services they need and are more likely to end up in accident and emergency departments where they know they will be seen.

It also affects the health economy, as thousands of unregistered patients seeking services usually in urgent care and accident and emergency settings can cost providers significant income. Last year, Croydon Health Services NHS Trust lost £1m due to unregistered patients using services. Registration numbers also help define how much money Croydon's health and social care services can get in terms of funding from central government so it is important that all who can register.

Our research comprised of a simple mystery shopping exercise. Our staff and volunteers rang up every one of Croydon's 57 GP practices three times over a five-week period in November to December 2018 to ask one question:

"How do I register with your practice?"

We assessed the response in terms of waiting time to pick up(how long it took to speak to a person not connection to a number), staff attitude, staff helpfulness and accuracy in line with the standards of the NHS Primary Care contract that states that anyone can registered without a request for identification, and in the case of homeless people, without an address or formal identification.

These are our findings:

Waiting times: The average waiting time was 2 minutes and 34 seconds, with 36 surgeries below this time, and 21 above this time. However, there were two which had a hold time of 11 minutes.

Staff attitude and helpfulness: 68% of practice's attitude was positive and just 8% of practices were negative, and with helpfulness 70% of practices were seen as helpful and 9% of practices were unhelpful.

Accuracy: 77% of practice's did not give the national standard information that they could just fill in a form without any identification. Just eight practices (15%) did give the correct information.

Websites: While 58% found themselves consistent with what they said on the phone, only 7% had placed accurate information on their websites. 18% did not have a website or any information on registration that you can access.

These are our recommendations linked to provider and commissioner:

Based on our findings we make the following recommendations for the Croydon Clinical Commissioning Group (CCG) and GP Collaborative (GPC).

- **No ID needed:** GPs should meet national standard as defined in the Primary Care Contract in registering people without any ID.
- **Use NHS standard information:** GPs should make the process of registering easier, applying the well-written and clear information as shown on NHS website to their own websites.
- **Use GMS1 as the standard form:** While they might want to know more, this consistency ensures all relevant data is received.
- **Offer practice address:** GPs should clearly show that people with temporary or no fixed address can register under their GPs practice address.
- **Focus on the 'service' aspect:** It is after all the National Health Service. Practices that have applied customer service principles from service industries register better patient experience.
- **Dedicated staff and phone lines:** By placing dedicated phone lines with staff specially trained for call answering, waiting times on the phone will be reduced and positive patient experience will increase. Staff will feel supported too.

A response from NHS Croydon Clinical Commissioning Group is shown in section 4.

Contents

1 Background

1.1 Context

About Healthwatch Croydon

Healthwatch Croydon works to get the best out of local health and social care services responding to your voice. From improving services today to helping shape better ones for tomorrow, we listen to your views and experiences and then influence decision-making. We have several legal functions, under the 2012 Health and Social Care Act.

National level - Registration

As part of the Primary Care contract that every GP practice has to agree to, it states that any person can be registered irrespective of their circumstances, including without an address or the need to provide any identification

Recent General Data Protection Regulation legislation also considered how private information is being gathered and used.

On the NHS website on registration, it clearly states how to register, see https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/

Patient registration can also affect how much money Croydon gets to deliver services. If the numbers are not reflective of true demand, there is less money to be spent on services. GP registration numbers are also used to plan future demand not just for health services but also for council services as well. They need to accurately represent the population they serve.

This is all the more relevant with the introduction of Integrated Primary Care Networks, where groups of GPs in specific localities will design services to meet

those neighbourhood needs. Each of these will be defined by the number of registered patients, and reflect how much resource will be available to spend.

Local level:

Within Croydon, we found this to be an issue amongst those who were homeless. When we published research on the experiences of homeless, February 2018[1], and street homeless July 2018[2], we found that street homeless were unable to gain access to services they need such as mental health services, because they were not registered with a GP. In some cases, some GPs refused to register homeless people, which is against the Primary Care Contract they signed up to.

The impact of non-registration affects the patient significantly, but also the health economy too, as those unregistered are more likely to use services such as urgent care and accident and emergency as their first service. Some also may arrive in crisis, costing the service more as well as bring significant negative experience to the patient.

At the Croydon Health Services NHS Trust AGM in 2018, it was mentioned that the cost of unregistered patients using their services was £1m.

It is therefore important that everyone who needs access to health services, irrespective of situation or background, is registered with a GP.

[1] https://www.healthwatchcroydon.co.uk/wp-content/uploads/2018/06/Healthwatch-Croydon-The-Experiences-of-Homeless-People-using-Health-Services-in-Croydon-February-2018.pdf

[2] https://www.healthwatchcroydon.co.uk/wp-content/uploads/2018/07/Street-Homeless-experience-of-health-services-in-Croydon-June-2018.pdf

1.2 Rationale and Methodology

We wanted to gain insight into the experience of trying to register as a new patient in Croydon. A simple mystery shopping exercise, would reflect the experience and would also see differences in services across the network.

Unlike hospitals which are the responsibility of the state, GPs take NHS contracts, but are privately-run practices. Therefore, no two practices, organise and deliver their services in exactly the same way. As long as they deliver services according to the Primary Care contract, the way they do it is defined by the partners and practice managers. This can allow for differentiation between one practice and another.

However, from the customer's perspective, they should receive a constant and effective service irrespective of which practice they go to.

1.3 Method

Our research comprised of a simple mystery shopping exercise. Our staff and volunteers rang up every one of Croydon's 57 GP practices, three times over a five-week period in November to December 2018 to ask one question: "How do I register with your practice?"

Each of the three calls to each surgery was made at varying times on a different day to allow for changes in staff and pressure times.

We assessed the response in terms of waiting time to pick up, staff attitude, staff helpfulness and accuracy in line with the standards of the NHS Primary Care contract that states that anyone can be registered without a request for identification, and in the case of homeless people, without an address or ID.

Thank you

We also thank our Healthwatch volunteers who supported the staff team in collating and analysing the data: Making the calls – Olaide Hamed, Carole Hembest, Michael Hembest, James Kotei, Brenda Namabo, Megan Nash and Tariq Salim; Analysis – Ruth Busia, Megan Nash and Beatrice Owusu-Amankrah.

Limits of the insight

As with any mystery shop, this is a snapshot on the days we called. We managed the issue by deciding to call three times, each on a different day and time. The aim is to ensure we had consistency in terms of what question we asked, the time it took to speak to someone, and the recording of answers. This were checked carefully

We could only ring three times. In some cases, we could not get through after 11 minutes and so we have no idea what the experience or information given would be like, but these instances were few. The fact we could not connect for a call shows a barrier in itself.

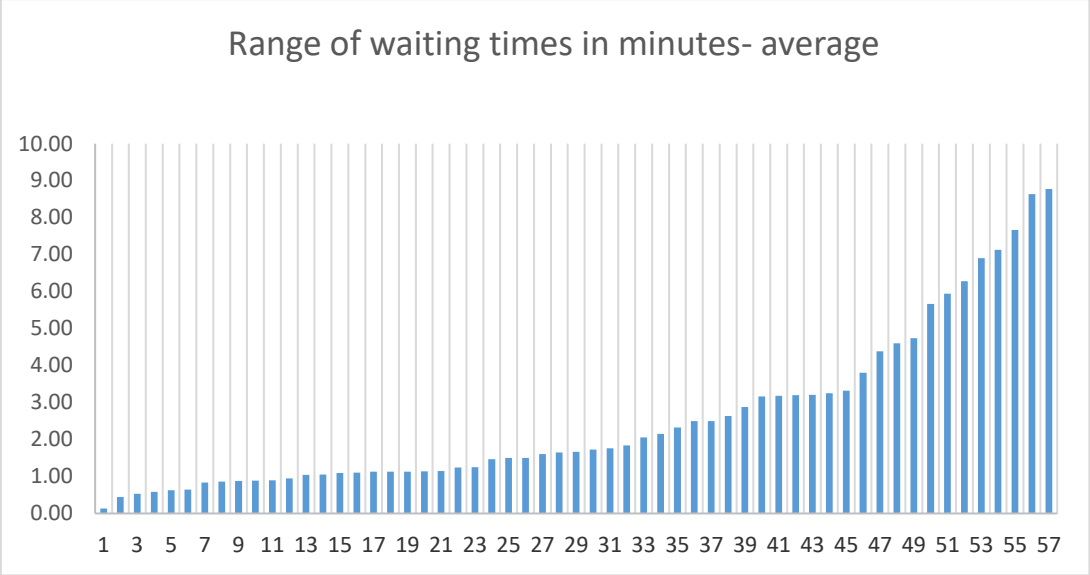
In defining trends, we set our own standards across three calls. Three of the same experience was ‘all positive/negative’, two of one, was ‘mostly positive/negative’ and if it was mixed, it was defined as such. There were some places where we did not get data and this is recorded.

In terms of accuracy, we set against the high standard of the Primary Care contract that anyone can be registered without ID or address. So even though the staff may have been professional, helpful and supportive, if they mentioned ID or address proof, it was recorded as not accurate.

Likewise, website assessment was based on the day we looked in December 2018 and so may have been updated since then.

2 Insight results

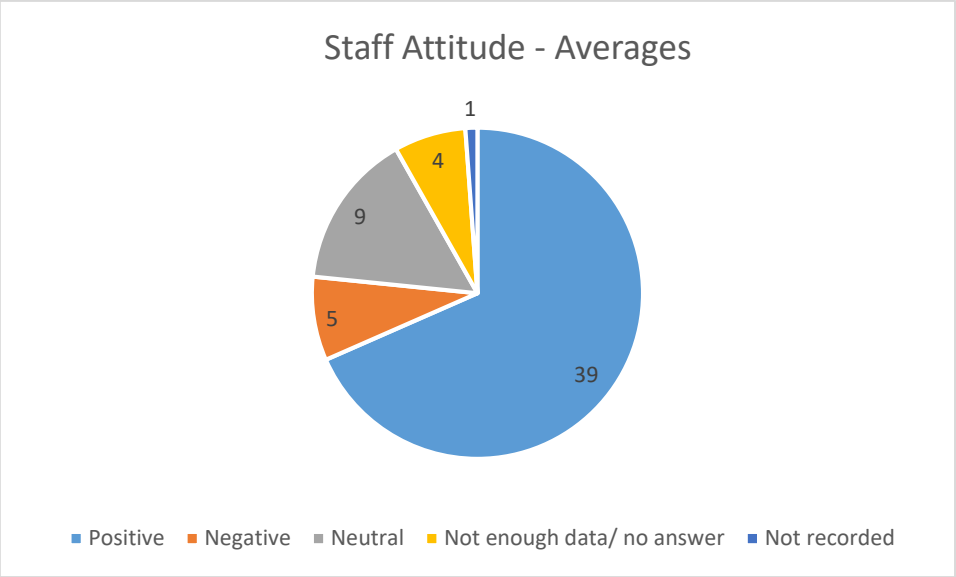
2.1 How long did it take to speak to a receptionist?



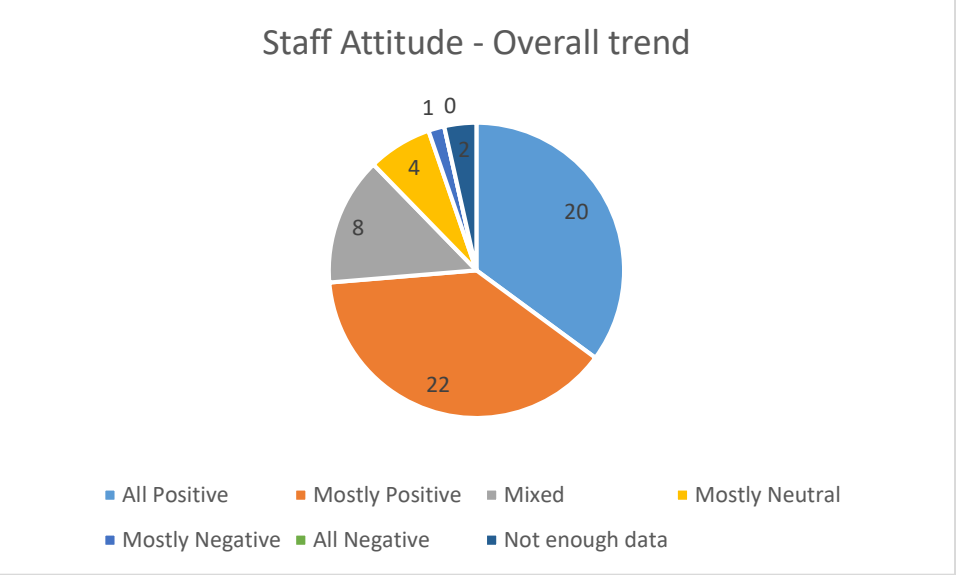
The average time that our mystery shopper had to wait for the call to be picked up was 2.55 minutes equalling 2 minutes and 34 seconds, with 36 surgeries below this time, and 21 above this time.

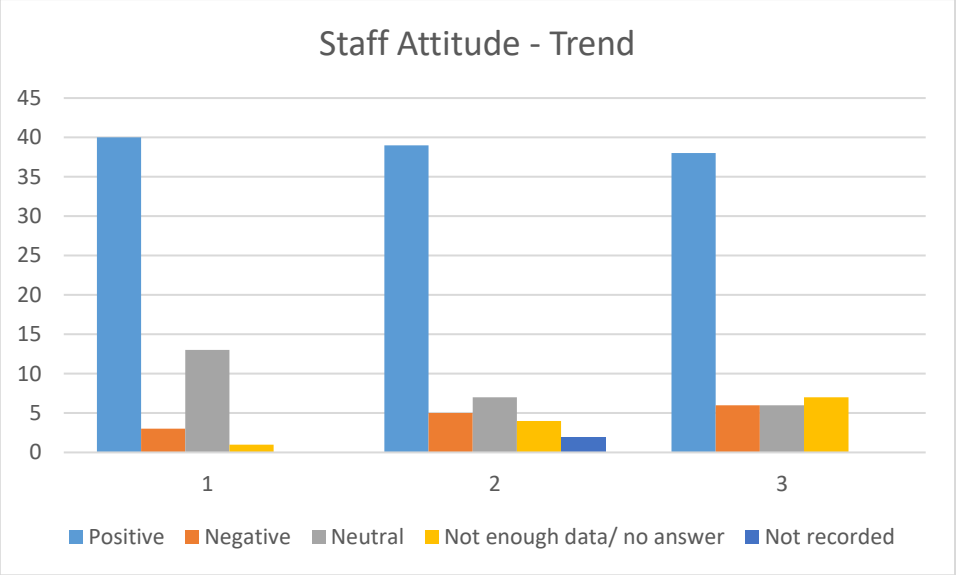
However, there were two which we did not pick up after 11 minutes.

2.2 What was the attitude of the staff when enquiring about registration?



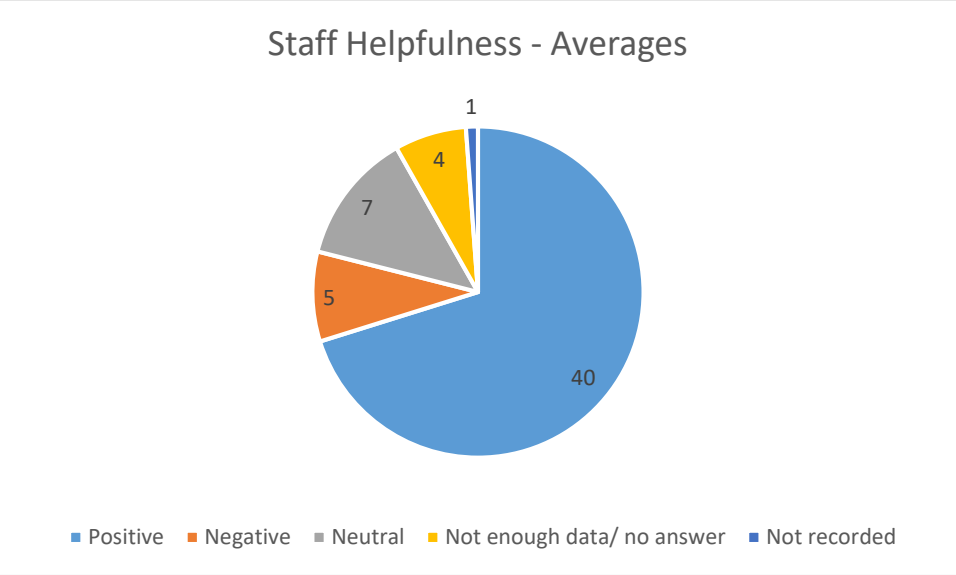
When mystery shoppers asked about registering at their practice, 68% of practice's attitude was positive and just 8% of practices were negative. On the trend across the calls, 35% were positive every time, with a further 39% mostly positive, (positive two times). Only one surgery was mostly negative (two times) and none was negative all the time, with 7% we could not get to speak to as we could not get through.



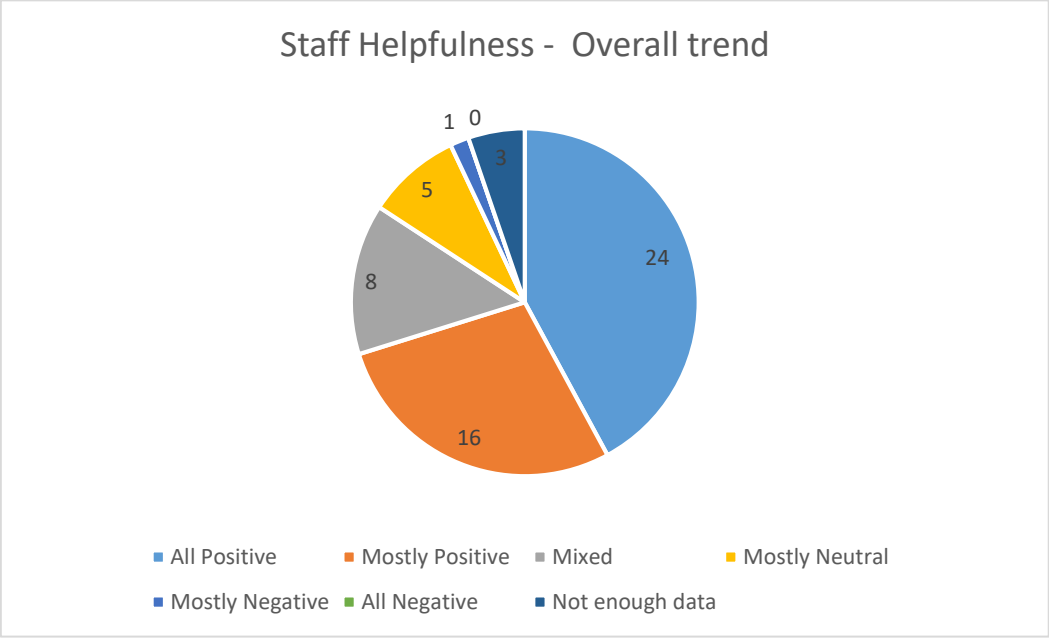


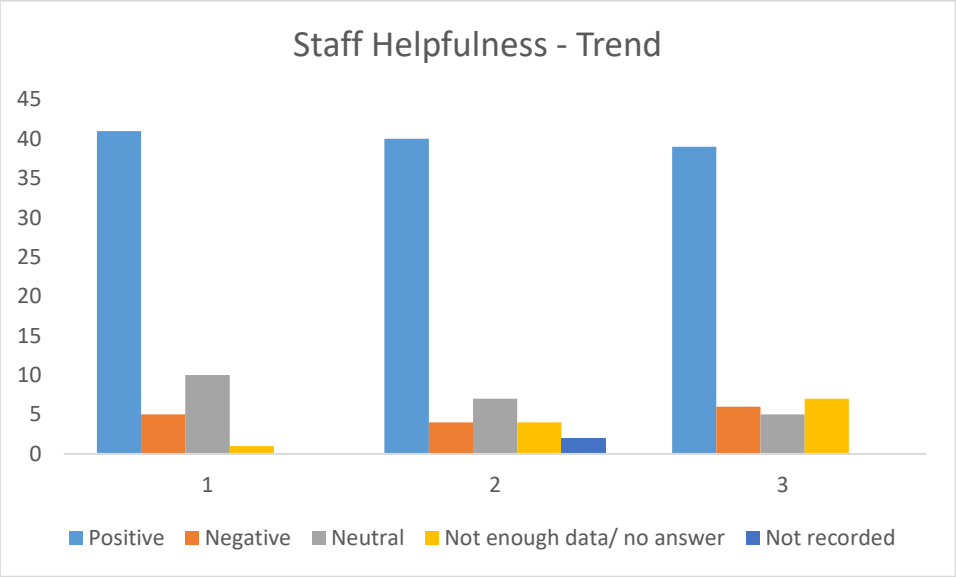
The trend across the three calls shows a consistent number scored positively for staff attitude.

2.3 How helpful was the staff when asking about registration?



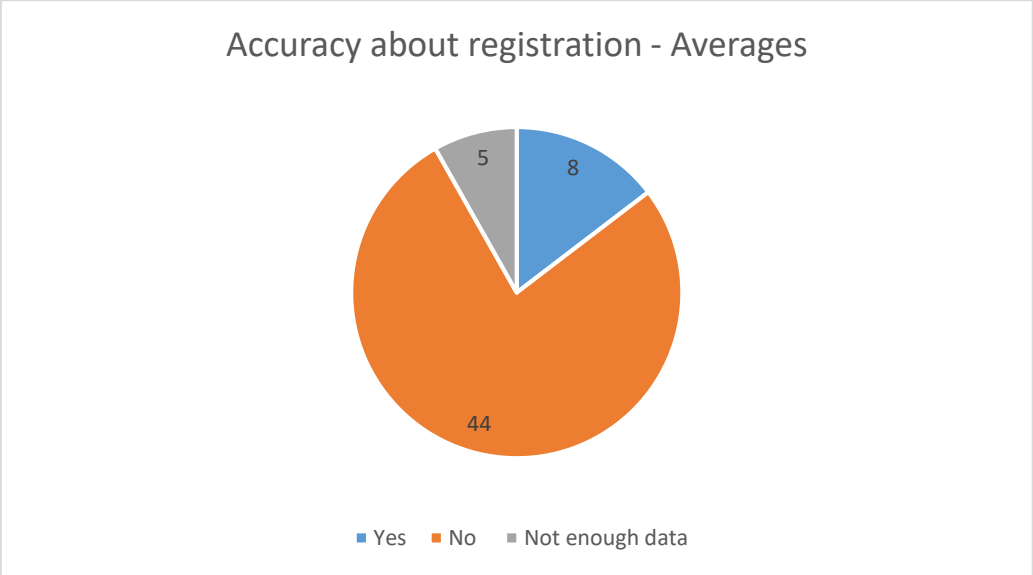
When mystery shoppers asked about registering at their practice, 70% of practice were helpful and 9% of practices were unhelpful, with 13% neutral. On the trend, across the calls, 42% were helpful every time, with a further 28% mostly helpful, (helpful two times). Only one surgery was mostly unhelpful (two times) and none was unhelpful all the time, with 7% we could not get to speak to as we could not get through.



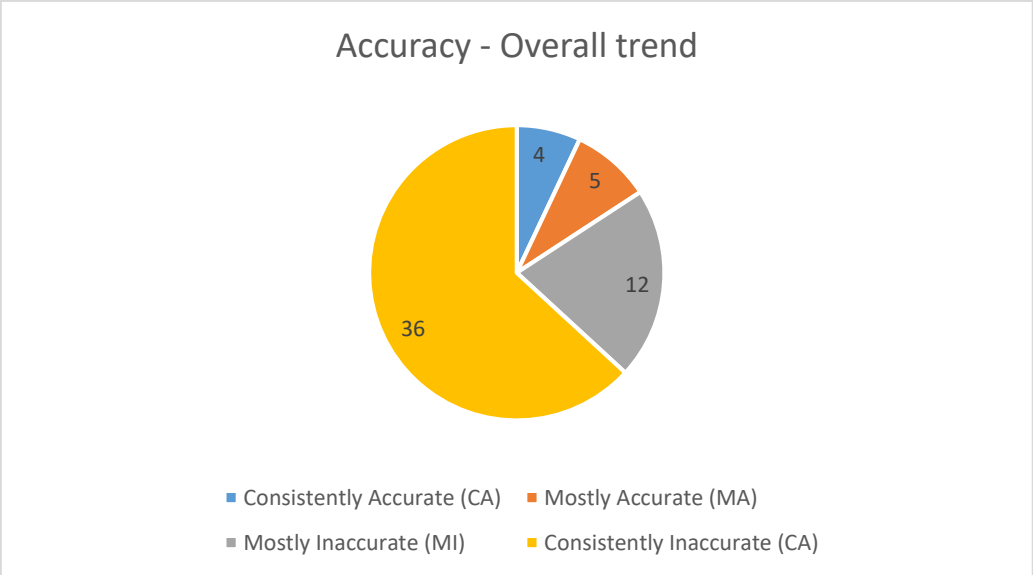


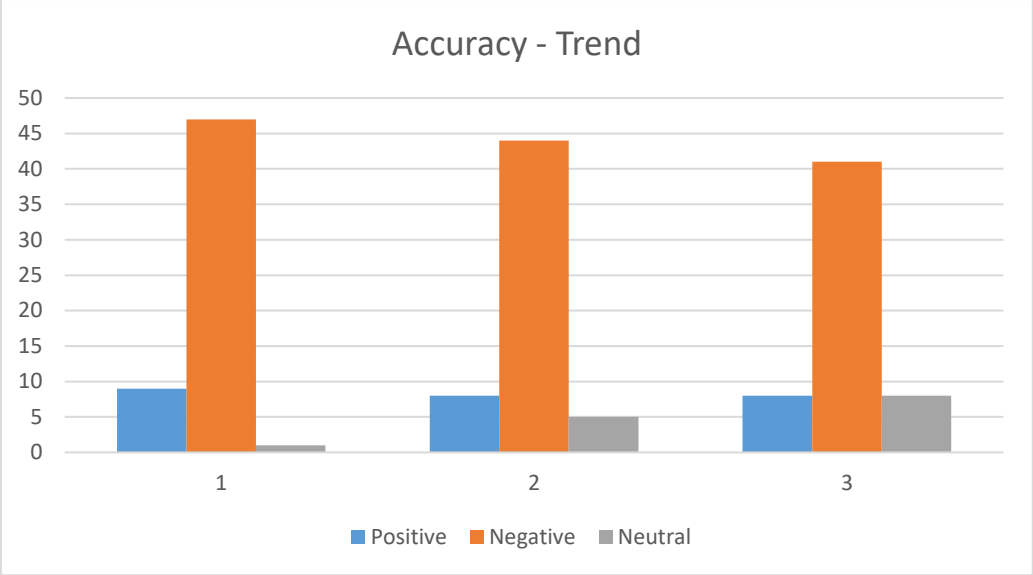
Again, the trend across the three calls shows a consistent number scored positively for staff attitude.

2.4 How accurate was the information given on registration?



However, when mystery shoppers asked about registering at their practice, 77% of practice's did not give the national standard information that they could just fill in a form without any identification. Just eight practices (15%) did give the correct information. On the trend across the rounds of calls, just 4 surgeries (7%) were consistently accurate, and 5 surgeries (9%), mostly accurate two times. 63% were consistently inaccurate (inaccurate every time), and 21% mostly inaccurate (inaccurate on two occasions).





Again, in terms of numbers across the calls the trend was consistent, with slightly higher of those who we could not get data for.

2.5 Good practice - a selection of responses:

These are examples of good practice, where GP practices put no barriers in terms of registration. All of these are in line with the Primary Care contract that each GPs sign up to.

"Just come in and get a form at the surgery."

"Pop in - application form, can use any surgery. NO ID, just bring yourself. Takes 48 hours to be put on the system, can still book an appointment."

"Come and get registration pack."

"Come in, name and address. Homeless? Just come in."

"Registration form."

"If homeless, should have a card/note to say that they're homeless."

"Come in, name and address. Homeless? Just come in."

"Pick up the registration form, have health check with the nurse."

"Meet and greet, after 11am pop in."

"Come in to collect the form, if no proof staff says she will query it for me when I come down to the surgery." (She's helpful)."

"Pick up the registration form, have health check with the nurse."

2.6 Below standard practice - a selection of responses:

This list shows responses we received highlighting barriers in terms of ID requirement, area consideration or exclusion based on circumstance, such as not being digitally connected or homeless. All of these are in contradiction of the Primary Care contract that each practice signs up to.

ID requirement

"Come to surgery. Bring two forms of ID ie personal, passport, proof of address."

"Form to collect from surgery. Need proof of address. Need proof of ID, passport, driving licence, bank statement, utility."

"We ask for proof of address, bill, bank statement, driving licence. If I have children, they need proof of immunization. The prefer to register the whole family in the surgery."

"Fill in a form (10-4) two proofs of ID, bill within 6 months. Photo ID." (Put back on hold mid-sentence)."

"Download the forms or collect at reception. Two types of ID, photo and proof of address."

"NHS No. passport, proof of ID, you need something to show your identity"

"Proof of address, proof of ID, form to fill out. 7 Days unto system."

"Come in at 1:30. ID- passport, driving license, address- utility bill, bank statement."

"Bring NHS no. Photo ID/utility Bill, will take 3-4 weeks as they are changing their system."

"Need proof of address, ID, if no proof of address we don't register you, no one will register you without proof of address."

"Come in and complete the form. You need proof of address i.e. tenancy agreement, birth certificate or Photo ID."

"3 IDs, picture with bill etc. Passport or driving licence, some ID necessary. No registration otherwise."

Area requirement

"Need to be your area, I.D. proof of address, bank statement. If you are not in this area you cannot register."

"Need to be in borough. Photo ID, Utility bills, Bank statement."

"You need to be in this postcode."

"Have a meeting with the doctor then I can have a form. Only if you live in the area."

"Catchment area, "Oh my God". Photo ID, collect forms, proof of address. All right we'll register you."

"Can't give information unless you are living within the catchment area."

"Come in. In area." (Would not give information without postcode).

"Asked for DOB then I had to have meeting with the GP. Advised that this is <<a specific location in Croydon>> and there are other surgeries in Croydon."

"The receptionist said that if one doesn't live within the area, they can't register. She asked for the area where I live, I just hung up. She sounded very rude."

"Registration form, driving licence, passport, proof of address, photo ID (If you don't have DL or passport). Must be with catchment area. Homeless- not sure of what to do if the person is homeless." (The receptionist was polite and helpful. She didn't rush through the call)."

"If you are in catchment, collect forms, two IDs. If you don't have stuff there are ways. But no one to check. Call back on Monday, Manager will be in then."

"Zero tolerance policy. States they will terminate the call. In catchment area., proof of address if you have it. Bank statement less than 3 months, passport clarify your name, under16 birth certificate, re passport: can't refuse but have to make sure you register right name. not essential, take 48 hours to process."

"Don't cover Croydon, only if you live in <<specific location in>>."

"Need a postcode before they can talk to me."

Barriers due to circumstance

"Not taking any more patients."

"Call dropped after 30 seconds, 3 times."

"No patients at the moment. Maybe call back in a month."
"Registration at surgery. Proof of ID, passport, utility, proof of address. Don't register homeless people."

"Use online, homeless still use online."

"Online. Go online, don't know how to register if you are homeless."

"Not taking registration at the moment but you can go to your local chemist."

"Asked a lot of questions about where I was but, in the end, told me to go to a nearby pharmacy who would advise me."

"Personally, not taking registrations."

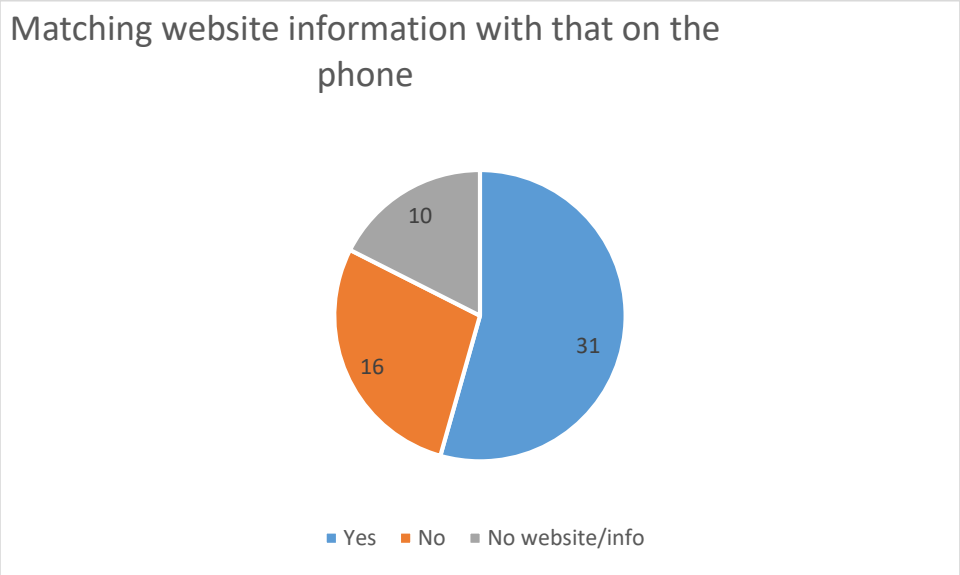
"No new registration, cap on it. Couple of weeks, local chemist ask there."

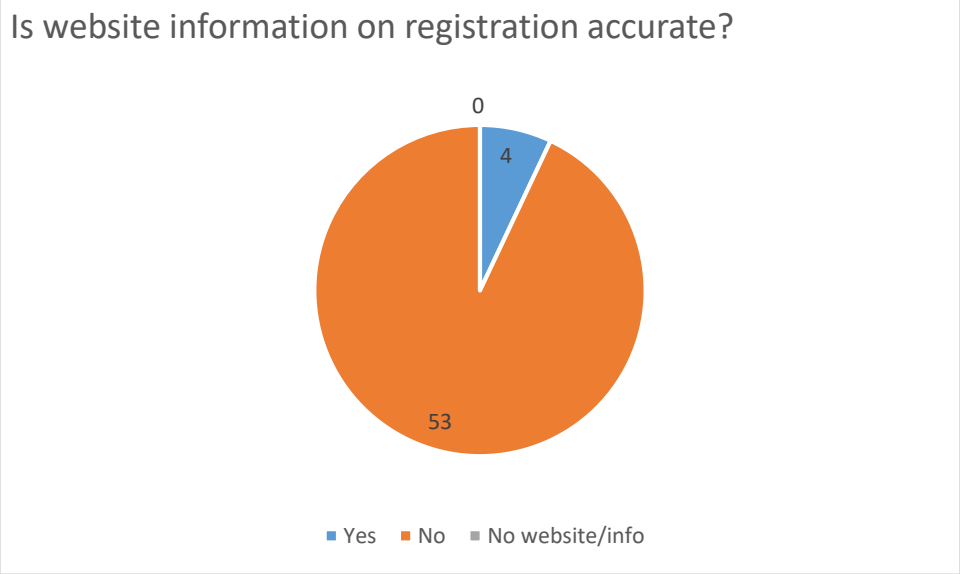
"Website. Go to library or come to the surgery."

"Website- use computer surgery, IT room. Registration <<web address>>. We will sort it out for you. Me: 'no computer' she: 'oh, do it on your phone'. Me: 'No smart phone', she: 'why is that?'."

2.5 Website information

Consistency with what was said on the phone and overall accuracy.





We analysed what GPs had presented on their website concerning registration and found that 54% found themselves consistent with what they said on phone conversations, with 28% inconsistent and 18% not having a dedicated website page or information about registration. When it came to accuracy only 7% (four practices) gave accurate information in line with national standards.

2.6 Case studies of good practice

As a result of doing this insight we found that three surgeries have achieved positive results in all areas of staff attitude, helpfulness and most importantly accuracy in line with the Primary Care contract.

We spoke to them to find out more about what they had done in their surgery to achieve these results and so gain insight into best practice taking place in Croydon.

North Croydon Medical Practice:

Accuracy:

"Five years ago, we looked at the NHS Primary Care contract and saw we had a responsibility just to register people at the practice. Also there needs to be consistency in how we do this so that each person is treated the same. We realise there are barriers to the homeless and there are barriers to those who are under addiction and may not have their paperwork organised but need care. We believe that patients that need the care must just get it.

The CCG also sent a document within the last nine months, reminding us of the protocol[3]. This was cascaded to all staff so they know the importance of registering all people, irrespective of background and only on patients say so. We also incorporated the new General Data Protection Regulations into

[3] This was an action by the CCG in response the Healthwatch Croydon report on Street Homeless published in July 2018.

communication, in particular into recording, copying and keeping of private data at registration."

Waiting times:

When the phone rings, we aim to pick it up within three rings. We have three staff at any time to pick up the phone. If there is an overflow, the calls will go upstairs to the administrative team who are trained to take the additional calls. We have increased the number of telephone lines from 4 to 10 with 3 dedicated to phone enquiries.

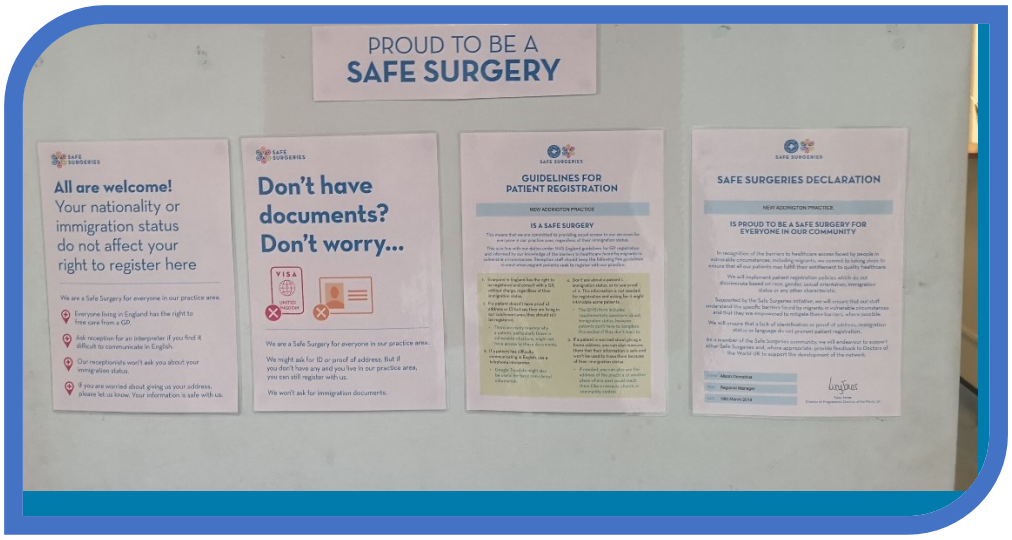
Helpfulness:

"It is after all called the National Health Service, whilst care is important, we also focus on the service aspect The GP partner greets staff each day to find out how they are doing to remind them of the importance of good customer service. We invest in professional training from a consultant who works in the hospitality industry to ensure good customer service is given by the team."

Attitude:

"The team has a meeting every Thursday where issues can be discussed. The appreciation of the staff is needed so they feel valued. They need to be recognised for the work they have done. We take feedback very seriously from patients, any feedback is actioned swiftly."

A T Medics - Parkway, New Addington



Accuracy:

We feel as a practice that we don't want to put barriers up for patients, we want to make things as easy as possible for patients, so part of that was the registration process, so, patients who have just moved into a new home in the area will not necessarily have ID, or it is still packed away so then you know, the stress of moving without them having to find a local GP. So, we say to staff, get them registered. National Guidelines say we can register patients from anywhere.
We have signed up to be a 'Safe Surgery', where anyone can walk in and register without forms of ID. We don't put any barriers up at all. This helps our homeless and traveller community."

Attitude:

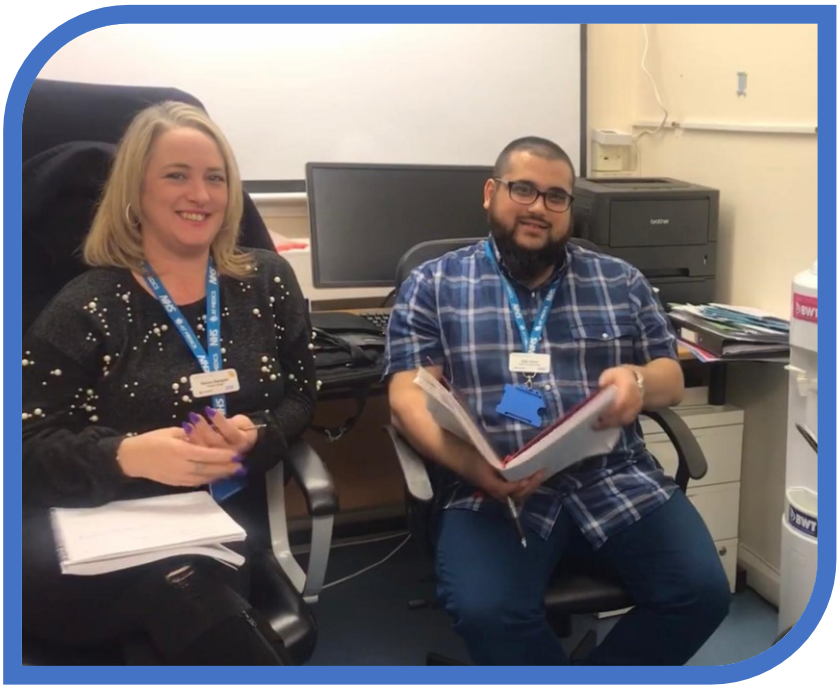
"We are very, very proud of that. Training, we regularly look at guidelines, we do role plays in team regular meetings where we all get together and do difficult situations and do a role play on that and ongoing training if we change processes or anything like that. Staff can bring suggestions or ideas to meetings they can bring up what they have difficulty with, patient experience."

Waiting times:

"We are fortunate here that we manage the three practices together, so we have a dedicated call hub based at one of the surgeries, so I have again, dedicated call handlers that are highly trained just to deal with the calls in a timely, effective manner which then again helps reception staff to be a bit more customer focused on the patients that attend at the reception window."

Overall comments

"First of all, so nice to be recognised for this. The key thing we do right is customer service focus, so we centre the customer first, and make it easy for the patient to register with us rather than easy for the surgery. Also, we don't know the circumstances of the patient, where they have come from and what problem they have had before. So, in that circumstances you want to be the best friend to the patient rather than make it hard for them. We are there to help them rather than push them away."



Dr Baskaran Surgery - New Addington

Helpfulness and attitude:

I have worked in a managerial position for high profile companies and our local authority, I have bought my 40 plus years of experience to this surgery, we have a customer focused approach. Most of the staff have worked at the practice for many years and have knowledge and experience of the patient population. The practice is like a family, and we have close relationships with the patients. We have a telephone overflow system, whereby if the phone is not answered immediately by the reception staff, people in the back office will pick up the phone to deal with patients, everyone works together. We deal with issues and complaints on the spot, very rarely does it go past the practice manager. We also offer care navigation and signposting to services, to support the patient experience. It is important to show empathy to patients with understanding and tolerance so that they feel valued and cared for.

Access:

The CQC commented that the access is good at this surgery. Our GPs meet and greet all new patients, sometimes if it is not too busy patients will be registered straight away on the computer and offered where possible appointment for a consultation. We also register people on a temporary basis, something that is appreciated by our patients.

3 Findings & Recommendations

3.1 Findings

Based on what we have heard these are our findings:

Waiting times: The average waiting time was 2 minutes and 34 seconds, with 36 surgeries below this time, and 21 above this time. However, there were two which we did not pick up after 11 minutes.

Staff attitude and helpfulness: 68% of practice's attitude was positive and just 8% of practices were negative, and with helpfulness 70% of practices were seen as helpful and 9% of practices were unhelpful.

Accuracy: 77% of practice's did not give the national standard information that they could just fill in a form without any identification. Just eight practices (15%) did give the correct information.

Websites: While 58% found themselves consistent with what they said on the phone, but only 7% had placed accurate information on their websites. 18% did not have a website or any information on registration that you can access.

3.2 Recommendations

These are our recommendations linked to provider and commissioner:

Based on our findings we make the following recommendations for the Croydon Clinical Commissioning Group (CCG) and GP Collaborative (GPC).

- **No ID needed:** GPs should meet national standard as defined in the Primary Care Contract in registering people without any ID.
- **Use NHS standard information:** GPs should make the process of registering easier, applying the well-written and clear information shown on NHS website to their own websites.
- **Use GMS1 as the standard form:** While they might want to know more, this consistency ensures all relevant data is received
- **Offer practice address:** GPs should clearly show that people with temporary or no fixed address can register under their GPs practice address.
- **Focus on the 'service' aspect:** It is after all the National Health Service. Practices that have applied customer service principles service industries register better patient experience.
- **Dedicated staff and phone lines:** By placing dedicated phone lines with staff specially trained for call answering, waiting times on the phone will be reduced and positive patient experience will increase. Staff will feel supported too.

Responses from NHS Croydon Clinical Commissioning Group and the GP Collaborative are shown in section 4.

4 Responses to our insights

Before publication, we shared this report and its full data with the relevant providers and commissioners of services to give a response to our recommendations and findings. This is their response:

NHS Croydon Clinical Commissioning Group

We are pleased to hear from this survey undertaken by that the majority of local people's experiences of Croydon's GP Practices were positive. At the same time, we would recognise that there are always some areas for improvement.

NHS Croydon CCG monitors patient experience at our Practices through our quality dashboard and ease of access for patients is part of the national survey of practices. However, as a result of this report we will;

- Recirculate information around registering patients, and ensure GP reception staff are aware of the correct process to improve consistency across the borough.
- Continue to support the training of practice staff on quality improvement and workflow optimisation, to help them improve access for patients.
- Promote the use of the additional appointments available at our extended access hubs and ensure that these are also available for homeless patients.

Dr Agnelo Fernandes, Clinical Chair of NHS Croydon CCG and local GP said: "We thank Healthwatch Croydon for their mystery shopper survey. It is pleasing to note that local people think that our general practice colleagues were mainly positive and helpful. It is also recognised, however, that there is always room for improvement and will work with our GP colleagues to address the gaps raised in the report."

5 Quality assurance

Design

Does the research ask questions that?

Are pertinent? Yes

Increase knowledge about health and social care service delivery? Yes

Is the research design appropriate for the question being asked? Yes

a) Proportionate: Yes; **b) Appropriate sample size:** Yes – we called all GP practices three times

Have ethical considerations been assessed and addressed appropriately? Yes, we reviewed other mystery shops undertaken by other Healthwatch organisations and also informed the Chair of NHS Croydon Clinical Commissioning Group before we began. No other GP was aware this was taking place to allow for authenticity in responses. We did not advertise this research to anyone else except our commissioner.

Has risk been assessed where relevant and does it include?

a) **Risk to well-being:** Yes
b) **Reputational risk:** Yes
c) **Legal risk:** Have appropriate resources been accessed and used to conduct the research? There was no need to refer to legal resources for this research.

Where relevant have all contractual and funding arrangements been adhered to? None to be considered.

Data Collection and Retention

Is the collection, analysis and management of data clearly articulated within the research design? Yes.

Has good practice guidance been followed? Yes.

Has data retention and security been addressed appropriately? Yes.

Have the GDPR and FOIA been considered and requirements met? Yes.

Have all relevant legal requirements been adhered to ensure that the well-being of participants has been accounted for? .i.e. the Mental Capacity Act. None required for this research.

Has appropriate care and consideration been given to the dignity, rights and safety of participants? This did not involve speaking to patients, but we presented ourselves as average patients seeking information on registration to practice staff.

Were participants clearly informed of how their information would be used and assurances made regarding confidentiality/anonymity? No participants.

Collaborative Working

Where work is being undertaken in collaboration with other organisations have protocols and policies been clearly understood and agreed, including the development of a clear contractual agreement prior to commencement? There was not contractual agreement for this research, but our working with partners was clearly agreed in advance of research taking place such as NHS Croydon Clinical Commissioning Group and our commissioner at Croydon Council.

Have any potential issues or risks that could arise been mitigated? These are shown below:

Risk factors	Level of risk	Contingency
Cannot access key people to research	low	We will record a non-answer. This still gives us information about systems.
Contact organisations let you down in terms of support	low	N/A, we are using public services
Question set does not work with group	low	Use question that is relevant to current legislation

Data is seen by providers as being out of date or not reflecting latest changes in service	low	Will be relevant if we publish in a timely way
Not enough respondents	low	N/A all GP surgeries will be contacted with three attempts made.

Has Healthwatch independence been maintained? Yes, this research is shared with partner organisations before publication for their comment, but only factual inaccuracy would be reviewed. This does not affect the comments of experiences we receive.

Quality Controls

Has a quality assurance process been incorporated into the design? There was a proper process of scoping.

Has quality assurance occurred prior to publication? Data collection was checked and re-checked.

Has peer review been undertaken? No peer review was undertaken. It was not required for this research project.

Conflicts of Interest

Have any conflicts of interest been accounted for? We do not feel there are any conflict of interests.

Does the research consider intellectual property rights, authorship and acknowledgements as per organisational requirements? The research is owned by Healthwatch Croydon, who are managed by Help and Care. Other organisations support has been recognised and suitably referenced.

Is the research accessible to the general public? It appears on our website as of 29 March 2019.

Are the research findings clearly articulated and accurate? To the best of our knowledge, we believe they are.

6 References

Healthwatch Croydon (2018) *Street Homeless Experience of Health Services in Croydon*

https://www.healthwatchcroydon.co.uk/wp-content/uploads/2018/07/Street-Homeless-experience-of-health-services-in-Croydon-June-2018.pdf

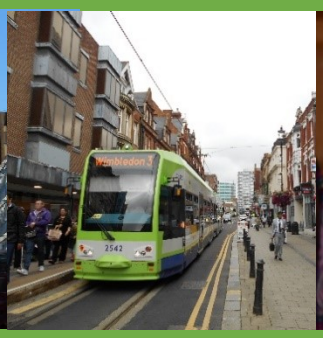
Healthwatch Croydon (2018) *The Experiences of Homeless People using Health Services in Croydon*

https://www.healthwatchcroydon.co.uk/wp-content/uploads/2018/06/Healthwatch-Croydon-The-Experiences-of-Homeless-People-using-Health-Services-in-Croydon-February-2018.pdf

NHS England (2018) *How to register with a GP*

https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/






Call 0300 012 0235

Email info@healthwatchcroydon.co.uk

www.healthwatchcroydon.co.uk

Be social with us on Facebook, Twitter, Instagram, Pinterest, LinkedIn and Google.

24 George Street Croydon CR0 1PB