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Chief Executive’s statement

Welcome to our third annual Quality Account, published shortly after we mark two years as Barts Health. 2013/14 has been a challenging year but one in which we have made great progress. We have taken decisive steps to improve our standards of care, and we were one of the first organisations to be inspected under the Care Quality Commission’s new inspection regime for acute hospitals. We have also built further on relationships with our local partners – commissioners, councils, Healthwatches and other NHS organisations - working together for people across east London and beyond.

As part of its response to the Francis Report into standards of care in the NHS, the Care Quality Commission (CQC) established a new inspection regime for acute hospital trusts. Barts Health was chosen as one of the first trusts to be inspected under the new system, and our inspection was carried out in November 2013. We welcomed this as an opportunity to gain an independent, dispassionate view of the organisation and the quality and safety of our services. I have described the resulting report as “tough but fair”. Overall, the inspection team found that our staff provide safe, clean care with compassion and that we treat patients with dignity and respect. The CQC report set out clearly where improvements were needed, for example in improving morale, in building a culture in which all staff feel that they are able to speak out freely and confidently, and tackling bullying and harassment. We prepared an action plan with staff and stakeholders following a series of quality summits to tackle all of the recommendations made by the CQC following the inspection. Earlier in the year, the CQC had issued us with three warning notices for failures at Whipps Cross University Hospital. We took swift action to address these shortcomings, and all three notices were lifted following the November 2013 inspection. You can read more about how we prepared for the inspection and its findings in the section starting on page 87.

At the heart of our own response to the Francis Report is our care campaign, launched in August 2013. It is a call to action to commit to improving compassionate care and patient experience, based around 13 key objectives. The campaign has engaged frontline staff at all levels, and has driven many of the actions we are taking to address the recommendations from the CQC inspection. The Board and I strongly support the campaign and the resulting improvements in our standards and processes. Linked to this is a major piece of work to improve standards of care for older people. Teams from 14 wards across Barts Health have completed a development programme, which was established to promote high standards of care, compassion and give patients more of a voice. The programme draws on wide expertise from across the Trust, as well as external evidence from patients and academic networks. We will widen this improvement support to other services in 2014/15.

Our mortality rate remains low and has continued to decrease over the last year. We are in a group of 13 hospital trusts nationally with a significantly lower than expected mortality rate, based on the numbers of patients and complexity of cases we see in our hospitals.

Our research activity continues to go from strength to strength. In 2013/14, around 22,000 Barts Health patients were recruited to take part in an approved research trial, spread across all our clinical specialties. We were successful in our bid to host a new integrated National Institute of Health Research (NIHR) Clinical Research Network, and we led the transition process to allow a new network to be established on 1 April 2014. In August 2013, the NIHR announced that Barts Health would host one of its prestigious new Collaborations for Leadership in Applied Health Research and Care (CLAHRC). These achievements underline our role as a key leader in research and development. Read more on our work in this area on page 81.
Working closely with our local partners has been a key theme of the year. In September 2013, we began planning in earnest for the winter with colleagues in local authorities and across the health and social care sector. Supported by additional funding, we were able to maintain a higher standard of performance and safety than in previous winters across all our hospitals, particularly the three sites where our Accident and Emergency departments are based. All three A&Es met the four-hour access target across January, February and March 2014, and Barts Health met the target for the whole of 2013/14.

During the year, we took positive and decisive action to improve our underlying financial position. We took the decision in June to put in place structures and support for financial turnaround - a whole organisation effort to improve the robustness and pace in the development and delivery of safe cost improvements and income recovery, whilst never losing focus on safety and quality. Every cost saving scheme is scrutinised for any adverse impact on quality and safety, and must then be signed off clinically through a process led by our medical director and chief nurse. One example of this work is a project which has enabled us to save over £800,000 a year by switching to a single supplier for replacement hip and knee joints.

We have continued to invest in our hospital sites. At Whipps Cross University Hospital, we opened a new acute assessment unit, replacing three outdated wards in different parts of the hospital and representing the final part of a £27million investment in emergency and acute care at the site. New facilities also opened in the maternity unit at Whipps Cross. In April, we opened the new dental hospital, new entrances and an education academy at The Royal London Hospital. During this year, work continues on the new heart centre at St Bartholomew’s Hospital, with services due to move in from early 2015.

A major focus for 2014/15 is to build on the work we are now doing with our local commissioners and other partners to develop the Transforming Services, Changing Lives programme. This is a shared programme of work which will involve clinicians, patients and other stakeholders in helping us decide how best we can provide services in the future, both to help us meet growing demand and also to raise standards across all our services. We already have excellent outcomes in areas such as stroke, heart attack, major trauma and renal medicine, but all our patients, no matter how and where they receive care from us, should expect equally high standards.

I hope you find our latest Quality Account informative. It is an accurate reflection of our performance against all our quality indicators. We are committed to continuous improvement and we welcome your feedback. To give us your comments, or to request the Account in different languages or formats, please use any of the contact details on the rear cover of the report.

Peter Morris
Chief Executive
Barts Health NHS Trust
About this Quality Account

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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

- The Quality Account presents a balanced picture of the Trust’s performance over the period covered
- 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 that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, 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 they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Peter Morris
Chief Executive

Sir Stephen O’Brien
Chairman
Introduction
About us

We are the largest NHS Trust in the UK, serving a population of over a million in east London and beyond.

Barts Health NHS Trust was established on 1 April 2012, and consists of six local hospital sites: The London Chest Hospital, Mile End Hospital, The Royal London Hospital, Newham University Hospital, St Bartholomew's Hospital and Whipps Cross University Hospital. The new merged operational management team for Barts Health has been working together since October 2012. Barts Health is also proud to be part of UCLPartners, Europe’s largest and strongest academic health science partnership. The objective of UCLPartners is to translate cutting edge research and innovation into measurable health gain for patients and populations through partnership across settings and sectors, and through excellence in education.

Our vision is to change lives

Our ambition is for east London to have health services in which we can all take pride. These services will reach beyond our hospitals and provide care where it is needed most – at home, in our communities, or in specialist facilities across the boroughs. Outstanding research, a commitment to learning and improvement, and a focus on partnership, will allow Barts Health to succeed. Success will see the health of the population transformed and inequalities in health reduced substantially. This commitment is what defines our organisation and our values.

Our values

Our core behaviours set out how we will work, regardless of the role we hold in the organisation. These behaviours, consistently carried out, will embed the Barts Health values in our everyday working lives, and support delivery of our vision to change lives and improve the quality of care that we provide for our patients. Barts Health has set five organisational values, which are:

- To be caring and compassionate, with patients, each other, and our partners
- To actively listen, understand and respond to patients, staff and our partners
- To relentlessly improve and innovate for patient safety
- To achieve ambitious results by working together
- To value every member of staff and their contribution to the care of our patients

Our activity

Across our six hospitals and our community services, we provided well over 2 million patient “contacts” in 2013/14 - the number of occasions when we saw or treated a patient. Our major areas of activity were:

<table>
<thead>
<tr>
<th>Area</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendances at one of our three A&amp;E departments and the minor injuries unit at St Bartholomew's Hospital</td>
<td>429,583</td>
</tr>
<tr>
<td>Number of inpatient stays</td>
<td>270,258</td>
</tr>
<tr>
<td>Number of outpatient appointments</td>
<td>1,460,721</td>
</tr>
<tr>
<td>Number of babies born</td>
<td>16,627</td>
</tr>
</tbody>
</table>
Our hospitals

The London Chest Hospital
The London Chest Hospital, situated in Bethnal Green, is a specialist hospital with around 110 beds, providing care for patients with cardiac, cardiovascular, respiratory and thoracic conditions. It is also home to the heart attack centre for North East London and further afield, caring for patients who are experiencing acute cardiac arrest symptoms. In early 2015, all services from the London Chest Hospital will move to a new, £250m state of the art cardiovascular centre at St Bartholomew’s Hospital.

Mile End Hospital
Mile End Hospital is a community hospital in the heart of Tower Hamlets, providing a range of inpatient and outpatient services, including physiotherapy and rehabilitation care. The hospital also houses services for mental health patients which are provided by East London NHS Foundation Trust.

Newham University Hospital
Newham Hospital is situated in Plaistow. It has around 350 beds and provides a range of district general hospital services, including maternity, emergency and urgent care, general surgery and stroke care.

The Royal London Hospital
The Royal London Hospital is a major acute and specialist hospital situated on Whitechapel Road, less than a mile from the City of London. With around 760 beds, It provides a full range of general and specialist care, including maternity, emergency and urgent care, surgery, neonatal intensive care and treatment for cancers and rarer conditions. The hospital has a major trauma unit, providing specialist care for the most seriously ill and injured patients from across London and the South East. It is also home to London’s Air Ambulance, whose medical crews work closely with and in the Emergency Department within the hospital.

St Bartholomew’s Hospital
St Bartholomew’s (Barts), is an internationally renowned teaching hospital situated the City of London with around 300 beds. It provides a wide range of local and specialist services, including centres for the treatment of cancer, heart conditions, fertility problems, endocrinology and sexual health conditions. During 2015, a new, £250m state of the art cardiovascular centre will open at St Bartholomew’s. It will be one of the most advanced centres of its kind in Europe.

Whipps Cross University Hospital
Whipps Cross Hospital is situated in Leytonstone, in the borough of Waltham Forest. It is a large district general hospital with around 500 beds, providing a range of services, including maternity, emergency and urgent care, general and specialist surgery, ophthalmology, respiratory care and acute stroke care.
What do our patients think?
We welcome feedback from patients, their relatives and carers on any aspect of our services. The section starting on page 81 has detailed information on survey results, complaints and our feedback mechanisms, and also explains how patients share their stories with our Board at every monthly Board meeting.

Patients also leave feedback on the NHS Choices and Patient Opinion websites. A selection of anonymised recent comments from these sites follows.

Maternity at Whipps Cross Hospital – from Patient Opinion
Our experience was great. All the staff were fantastic over 16 hours of labour and three shift changes. I had to deliver by c-section and the explanation, swiftness in decision making and expertise shown by the team is commendable.

Accident and Emergency at The Royal London Hospital – from NHS Choices
I visited the A&E with what I thought was a broken ankle (turns out it was just a bad sprain). I came in to the hospital at 3pm on a Monday, so I expected a bit of a wait. I was admitted within 10 minutes and seen within 20. The practitioner nurse who helped me was extremely pleasant and good-natured and made me feel really at ease. The admin staff were efficient and very professional. I cannot recommend this hospital more highly and I would absolutely visit again with any more health problems.

MRI and CT cancer screening at St Bartholomew’s Hospital – from NHS Choices
I had to attend the hospital for an MRI scan and CT scan. I’ve never had any of these before and of course was slightly anxious. I need not to have worried, the staff talked me through both procedures explaining everything and answering my questions. The procedures went without a hitch as explained to myself. The staff concerned were without a doubt very professional, polite and so helpful. Just to say thank you to all concerned for the time and effort put in by yourselves and all other colleagues. A pleasing experience, I just hope my results come out ok but with the team at St Bartholomew’s behind me it has surely eased my mind.

A&E and Maternity at Newham Hospital – from NHS Choices
I am 21 weeks pregnant, and I had read so many reviews of this hospital to the limit that I was considering to go back to my birth country to have my baby. Before I got to take that decision, I had to be rushed to the A&E last week with a kidney infection, and I stayed booked in the hospital for almost six days. My doubts about giving birth at Newham hospital are over. I was in A&E for a day, and then I was moved to the Larch Ward in the Maternity Area. Thank you so much for taking care of me, to every single member of the staff (midwives to the guy who cleaned my room every day, to the last person there.) I can’t understand how people can write so much “rubbish” about this hospital and staff. I have no complaints, I am just so thankful to everybody, because when you are in so much pain - they look after you. This is priceless.

Plastic surgery outpatients at The Royal London Hospital – from NHS Choices
I waited two hours to be seen for a dressing change today, in the end I was told by a nurse they were too busy to see me, despite I only having surgery a week ago. I was told to go home and book with my local doctor if I wanted dressing changed. I am absolutely disgusted by my treatment.

Ultrasound and eye treatment unit at Whipps Cross Hospital – from NHS Choices
I am so disappointed with the level of care and consideration I have received from both the ultrasound and eye treatment departments. My life is filled with stress due to misinformation, constant waiting, lost test results and rude and inconsiderate staff. I had no idea I could elect a hospital for treatment. I will be doing this and it will most definitely not be Whipps Cross. I cannot stress how much inconvenience and upset staff at Whipps Cross have caused me.

Maternity ward at Newham Hospital – from NHS Choices
I called today to speak to a lady in the maternity ward regarding my sister. The lady was busy so
I spoke to another woman who was extremely rude. I asked her for her name and she put the phone down on me. I thought staff are meant to be professional towards their patients! Clearly I didn’t see that. Rubbish service, really upset by this. Will remember not to send any of my family there again!

**HDU at the London Chest Hospital – from NHS Choices**

I was admitted for a double coronary artery bypass. I spent a week in the hospital (mainly in HDU). The staff were all, without exception, kind, courteous, and thoroughly professional. I really cannot praise them highly enough. So, thank you London Chest Hospital, and all who work there.
Part 1
Looking forward – our priorities for quality improvement
Part 1 - Looking forward – our priorities for quality improvement

Our quality priorities for 2014/15

Our six priorities for 2014/15 reflect our commitment to putting patients first and improving their care, experience and outcomes. The emphasis for 2014/15 will be to progress and sustain goals that were set last year. Key themes will be:

- Striving for excellence and innovation
- Delivering harm free care within all our wards and departments
- Empowering staff to use data to drive quality improvement
- Learning lessons and closing the loop
- Involving patients in improving our services

The six quality priorities outlined below have been included as part of the Trust’s draft Integrated Business Plan (IBP).

Priority 1 - Patient Safety - reduce avoidable harm
Aim – 94 per cent of patients receive harm free care, measured on the following indicators:

- Pressure ulcers
- Harm from falls
- Never events
- Specific hospital acquired infection
- Venous thromboembolism
- Managing the acutely unwell patient/failure to rescue

Priority 2 - Patient Safety – maintain SHMI rates
Aim - Maintain a position in the top ten per cent of NHS organisations with the lowest Standardised Hospital Mortality Indicator (SHMI)

Priority 3 - Clinical Effectiveness – reliable Care
Aim - patients are treated at the right time in the right place

Priority 4 – Patient Experience – improve overall patient experience
Aim – Achieve a position in the top 20 percent for the NHS national patient experience survey by 2017/18

Priority 5 – Staff Experience – improve staff engagement
Aim – Achieve a position in the top 20 per cent for the NHS national staff survey by 2017/18

Priority 6 – Patient Safety – sharing the learning to improve the safety of our patients
Aim – Improve systems for sharing learning from incidents and events amongst staff at all our hospitals and sites

Our improvement agenda through the Commissioning for Quality and Innovation payment framework in 2014/15

The Commissioning for Quality and Innovation (CQUIN) scheme for 2014/15 provides a national framework through which organisations providing healthcare services under the NHS Standard Contract can earn incentive payments of up to 2.5 per cent of their contract value by achieving agreed national and local goals for service quality improvement.

Each year, we identify a range of CQUIN priorities, projects and measured targets with our commissioners and our goal will be to work towards delivering these. We monitor progress each month at our CQUIN governance group and report progress to our commissioners. CQUINs are also reviewed at each of our Clinical Academic Group’s performance review meetings.
For 2014/15, CQUIN payments will be set at 2.5 per cent of the value of all services commissioned through the NHS Standard Contract, split as follows:

- 2 per cent for locally agreed CQUINs
- 0.5 per cent for nationally mandated CQUIN projects

The national CQUINs in 2014/15 are:

- Enhanced performance under the NHS Friends and Family Test
- Improvement against the NHS Safety Thermometer indicator for hospital-acquired pressure ulcers
- Improving dementia and delirium care, including the FAIR assessment - Finding people with dementia, Assessing and investigating their symptoms and Referring for support

In consultation with our commissioners, CQUINs are in the process of being agreed to cover our:

- Acute contract
- Community contract
- Specialised contract
- Dental, screening, health visiting and early years contracts

All acute contract CQUINs have been agreed in principle, with the final detailed templates being refined. The acute contract CQUINs are shown in the table on page 16. For the dental contract, a dashboards CQUIN has been agreed with NHS England. For the community, specialised, screening, health visiting and early years contract, as at June 2014 a number of CQUINs had been agreed in principle, although the full list of CQUINs is still in the process of being finalised.

**Monitoring our quality priorities and CQUIN targets**

Our quality priorities for 2014/15 will be monitored in the following ways:

- Via our Integrated Performance Framework and Report
- Via local review through the Clinical Academic Groups’ governance processes
- Assured by reporting to our Board, the Operational Management Group and Quality Assurance Committee
### Proposed 2014/15 acute contract CQUINs

<table>
<thead>
<tr>
<th>Acute contract</th>
<th>Site</th>
<th>CQUIN</th>
<th>% contract value</th>
<th>Estimated value (£m)</th>
<th>% of all acute CQUIN values</th>
</tr>
</thead>
<tbody>
<tr>
<td>National CQUINs</td>
<td>All</td>
<td>Friends and Family Test</td>
<td>0.125%</td>
<td>£0.675</td>
<td>5.00%</td>
</tr>
<tr>
<td>All</td>
<td>Dementia</td>
<td>0.125%</td>
<td>£0.675</td>
<td>5.00%</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>NHS Safety Thermometer</td>
<td>0.125%</td>
<td>£0.675</td>
<td>5.00%</td>
<td></td>
</tr>
<tr>
<td>Local CQUINs</td>
<td>All</td>
<td>Delivering and Enabling Integrated Care - 'Integrated Care'</td>
<td>0.625%</td>
<td>£3.375</td>
<td>25.00%</td>
</tr>
<tr>
<td>All</td>
<td>Delivering and Enabling Integrated Care - '7-day working'*</td>
<td>16.000%</td>
<td>£2.160</td>
<td>16.00%</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>COPD Care Plans</td>
<td>0.200%</td>
<td>£1.080</td>
<td>8.00%</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>Improving Patient Experience</td>
<td>0.300%</td>
<td>£1.620</td>
<td>12.00%</td>
<td></td>
</tr>
<tr>
<td>NUH</td>
<td>Improving Communications and Consultant Advice</td>
<td>0.100%</td>
<td>£0.540</td>
<td>4.00%</td>
<td></td>
</tr>
<tr>
<td>NUH</td>
<td>Improving the Quality of Maternity Services and Outcomes</td>
<td>0.100%</td>
<td>£0.540</td>
<td>4.00%</td>
<td></td>
</tr>
<tr>
<td>RLH</td>
<td>Improving Last Years of Life Care</td>
<td>0.067%</td>
<td>£0.360</td>
<td>2.67%</td>
<td></td>
</tr>
<tr>
<td>RLH</td>
<td>Improving the Quality of Maternity Services and Outcomes</td>
<td>0.067%</td>
<td>£0.360</td>
<td>2.67%</td>
<td></td>
</tr>
<tr>
<td>RLH</td>
<td>Diabetes Inpatient Care</td>
<td>0.067%</td>
<td>£0.360</td>
<td>2.67%</td>
<td></td>
</tr>
<tr>
<td>WX</td>
<td>Support for reducing harm in community settings (Falls and Pressure Ulcers)</td>
<td>0.100%</td>
<td>£0.540</td>
<td>4.00%</td>
<td></td>
</tr>
<tr>
<td>WX</td>
<td>Consultant advice and communications*</td>
<td>0.100%</td>
<td>£0.540</td>
<td>4.00%</td>
<td></td>
</tr>
</tbody>
</table>

* To be finalised with commissioners.

**Key:**
NUH – Newham University Hospital
RLH – Royal London Hospital
WX – Whipps Cross University Hospital
Part 2
Looking back – a review of quality performance and governance in 2013/14
Part 2 - Looking back – a review of quality performance and governance in 2013/14

Our response to the Francis Report

The Francis Report on the public inquiry into failings at Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. We carried out a detailed review of the 290 recommendations made and the subsequent Government response. We compared this information with our own existing developments and work streams and mapped them against each other.

Key developments which began in 2013/14 and will continue in 2014/15 include:

- Talent and performance reviews for staff linked to the Barts Health values
- On-going organisational development work to embed the Barts Health values and improve staff experience
- Expanding our Care Campaign to incorporate further staff groups. See page 70 for more information on the campaign
- Establishing a clinical standards forum led by medical director Dr Steve Ryan and chief nurse Professor Kay Riley to discuss how clinical safety concerns are monitored and acted upon and to promote shared learnings for relevant staff
- Continuing our programme of patient stories at each Trust Board meeting, and developing a similar programme of staff stories.
- Introducing a new staff reward and recognition scheme linked to performance
- Introducing a ward accreditation programme.
- Reviewing our Patient Advice and Liaison Service (PALs), complaints management and patient experience function.
- Joint working with UCLPartners on three themes for improvement:
  - The development of the NHS health check model
  - Understanding key drivers for staff experience that impact upon providing a consistent, caring service
  - A ward sister training and accreditation programme
- Devising a Board members’ development programme
- The ongoing older people’s service improvement programme
- Starting conversations with front line staff about the learning from the Francis Report and developing three things that teams will do differently as a result
- Use of the Skills for Care minimum training standards and code of conduct for new health care support workers and discussion with directors of nursing on how these can be rolled out for existing employees
- Development of an overarching quality strategy for Barts Health for 2014/15

Many of the actions detailed elsewhere in this Quality Account also form part of our on-going response to the Francis report, including:

- Our patient experience and engagement work – see page 95
- Reviewing how we respond to and learn from patient feedback
- Our on-going Quality Collaborative Initiative
- Our response to the findings of the CQC’s Chief Inspector of Hospitals inspection – see page 87
- Our work on improving the experience of our staff, our response to our staff survey, our staff engagement work and our organisational development programme – see page 72
Our Trust Board identified areas where we needed to strengthen our performance to ensure the culture at Barts Health is:

- patient centred
- has no tolerance of non-compliance with fundamental standards
- is open and transparent
- has strong leadership
- is caring and compassionate every time, with every patient

To address these areas, the Board agreed to hold quarterly Francis Independent Panels (Francis IPs) with our Clinical Academic Groups (CAGs) and corporate teams to gain assurance on the leadership approach to balancing and integrating quality with good financial performance and equal access to our services for all patients. The Francis IPs will include representation from the non-executive director lead for quality and a patient panel chair. It was agreed that they would require our leadership teams to demonstrate the following:

- How they are ‘putting patients first’, using and learning from staff and patient stories and complaints to improve quality, i.e. living the Trust values
- Showing that every member of staff has had the opportunity to have a ‘learning from Francis’ conversation
- How they are meeting the Trust’s quality priorities and contributing to the commitments in the Quality Account

The metrics agreed to monitor performance against the Francis recommendations are the same as those in our ward accreditation programme and include:

- Staff engagement score
- Number of staff recommending Barts Health as a place to work
- Number of staff recommending Barts Health as place for their friends and family to be cared for
- Friends and Family Test results

The Francis IPs for CAGs started in Quarter 1 of 2014/15, with IPs for corporate areas being held later in the year.

The Government’s final response to the Francis report, Hard Truths, was published in late 2013. We have undertaken a high level review to identify what gaps exist in our plans and where there is further work for us to do.

Effective and appropriate complaints management is a key component of responding to the Francis report. The work we are undertaking in this area is detailed in the complaints section on page 102, but key actions to note include:

- Signs/posters in wards and patient areas explaining how to raise a concern or complaint and the support available
- Developing an organisational culture and behaviour which welcomes positive and negative feedback to improve service delivery and action at the bedside by frontline staff to resolve people’s concerns as they arise
- Publishing quarterly complaints reports, including actions taken

Safe staffing levels are also a key aspect of the Francis report. At Barts Health we have responded to this by:

- Monitoring actual as well as intended staffing levels and sharing details with our commissioners and the public
- Holding six-monthly reviews of staffing levels, which are then signed off by the Trust Board and published
- Working towards supervisory status for all ward managers

As part of our response to the Francis report, we also reported to the Trust Board in December 2013 on our gap analysis of the Berwick and Keogh reviews and where we needed to undertake
further work. The recommendations in these two reports are re-iterated in Hard Truths. Key points for Barts Health related to this section were:

- Embedding a true learning culture across the organisation
- Consistent use of early warning systems and escalation across the Trust
- Embedding patients as equal partners in our work
- Raising concerns early
- Learning lessons from incident and SI reporting, demonstrating evidence of actions taken and closing the loop to prevent repeat errors – e.g. Never Events
- Ensuring we have a culture where our staff feel able to report any incident
- Using feedback from trainees/students to protect patients and ensure safety

More information on actions we are taking to address the recommendations can be found in other sections of this Quality Account, including:

- Managing deteriorating patients – page 29
- Our safety culture – page 26
- Listening to patients – page 96
- Listening to our staff – page 72
- Responding to the CQC’s Chief Inspector of Hospitals inspection – page 87

Safe staffing levels are a key aspect of the Francis report. At Barts Health we have responded to this by:

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- Working towards supervisory status for all ward managers

**Maintaining a safe and quality environment at Whipps Cross Hospital**

It is widely recognised that the buildings and the estate at Whipps Cross University Hospital require substantial investment to make necessary improvements. Work is already under way to reduce the risks associated with the estate and to make improvements to the environment. Work undertaken during 2013/14 totalled around £690,000 and included:

- Structural surveys to inform future upgrade programmes (exterior fabric)
- Upgrading ward heating systems
- Various environmental improvements in ward areas, including repairing floors, redecoration, kitchen improvements and new disposable curtains
- Installing opening restrictors on windows

During 2014/15, there will be a continued focus on the site’s infrastructure. We are committed to improving the environment at Whipps Cross, and a considerable programme of work is proposed, subject to capital funding allocations.
Our quality priority challenges in 2013/14

In our 2012/13 Quality Account, Barts Health Trust Board identified six distinctive quality priorities for 2013/14. In this section we provide an overview about how we did, some of our achievements and areas identified as needing further development or improvement. Page references are provided for the relevant section in the Quality Account where more detail is available.

Priority 1: Reducing avoidable harm

In 2013/14, we aimed to empower more staff to use evidence based practice and use proven improvement methodologies to reduce avoidable harm. Key focuses were:
- Reducing avoidable harm through our quality improvement collaborative
- Reducing the number of hospital acquired infections
- Managing deteriorating patients
- Avoiding pressure ulcers
- Avoiding patient falls
- Preventing surgical never events
- Reducing avoidable venous thromboembolism

Priority 2: Improving mortality rates and sharing the learning

Barts Health continued to have one of the lowest mortality rates of all NHS trusts in England. The section on page 37 describes our progress more fully.

Priority 3: Ensuring that the patient is treated in the right place at the right time

It is recognised that to maintain high levels of quality of care, every patient needs to be on the correct ward or pathway at the correct time to ensure they receive the care they need from the most appropriate clinical team. A key focus during 2013/14 has been ensuring that patients are cared for in the optimum timeframe, so that:
- Waiting time is minimised
- Cancelled operations are kept to a minimum
- Patients receive appropriate medical treatment so they are not readmitted
- Patients are not transferred between wards out of hours
- Care and standards are subject to regular audit and re-audit

The section beginning on page 43 details our progress against this priority.

Priority 4: Improving standards of care

In 2013/14 we focused on improving standards of care through four major improvement programmes:
- Our Quality Improvement Collaborative
- Our Great Expectations programme in maternity services
- Our older people’s service improvement programme
- Our Care Campaign

We also undertook work to improve standards of care in and for these specific areas and patient groups:
- Nutrition and hydration – page 61
- End of life care – page 62
- Care of people with learning disabilities – page 58
- Care of people with mental health needs – page 44
- Safeguarding adults and children – page 57
Priority 5: Listening and feeding back to staff

With over 14,000 staff, Barts Health is one of the largest single employers in east London. Listening to and involving our staff remains a key priority for the Trust Board. We acknowledge we have more to do going forward to meet our objectives for priority 5.

During 2013/14, our focus has been on embedding ways of improving engagement and dialogue with staff on the ground in local teams and departments, as well as building on our programme of internal communications activities and channels. A major element of the feedback provided to us by the Care Quality Commission following the inspection of our services in November 2013 was the need to improve our organisational culture and do more to ensure staff feel able to raise questions and concerns.

See the section on staff experience and engagement on page 72 for more information, including key results from the national NHS staff survey and our local staff surveys in 2013/14.

Priority 6: Ensuring all patients receive compassionate care

Our multi-profession Care Campaign and the other large scale improvement programmes outlined under Priority 4 all underpin our focus on care and compassion. To read more about the campaign, see page 70.

We were very pleased when, following their inspection of our hospitals in November 2013, the CQC reported that “The majority of patients and relatives we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect.” However, the CQC also spoke to people who described having a poor experience of our care at their listening events. We are taking steps through our CQC improvement agenda and patient experience and engagement strategy to ensure every patient has a good experience and that their needs are met at every contact while they are receiving care and services from us.

To read more about what our patients think and how we seek and listen to their views, see our patient experience section on page 95.

The Commissioning for Quality and Innovation payment scheme in 2013/14

In this section we highlight some of the CQUIN improvement and developments in 2013/14, including what we achieved and what challenged us.

There were four national CQUINs for 2013/14:

- Safety Thermometer - a focus on data collection and the reduction of pressure ulcers
- Friends and Family Test (FFT) - phased expansion, increased response rates and improved performance on the staff “net promoter” score – the number of staff who would recommend their own trust’s services to others
- Venous thromboembolism (VTE) – patient risk assessment and root cause analysis of diagnosed cases of VTE.
- Dementia - with a focus on Find, Assess, Investigate and Refer (FAIR), clinical leadership and support for carers of people with dementia

At the end of 2013/14, we reported our performance against the national CQUINs as follows:

- Safety Thermometer - the focus on data collections has been very successful and the target for this element of the CQUIN has been met. However, despite extensive work by clinical and tissue viability teams, Barts Health has not achieved the 30 per cent reduction in hospital acquired grade 2 to 4 pressure ulcers. The risk systems, tissue viability, business intelligence and patient safety teams have worked together successfully to devise a reporting process that will support the notifying of commissioners, partners and other
providers for patients who present with grade 2 to 4 pressure ulcers on admission. For more information on reducing pressure ulcers, see page 30

- **Friends and Family Test (FFT)** – the FFT for patients has been rolled out in our wards, A&E departments and most recently our maternity units. Barts Health has met the required year end 20 per cent response rate across emergency departments and inpatient wards. The views of staff are also sought monthly via our staff pulse survey and annually through the national NHS staff survey. We have more work to do to improve our performance against key staff experience indicators.

- **Venous thromboembolism (VTE)** – the VTE assessment rate has consistently remained above the required threshold this year. This is a significant achievement as it has proved difficult to sustain in previous years. Barts Health has designed and implemented a Trust-wide monitoring system and operating framework for root cause analysis of hospital-acquired VTEs.

- **Dementia** – Despite missing the 75% target for FAIR, we have made considerable progress towards it. A dementia training programme was agreed and delivered across the Trust. Clinical leadership has been strengthened and named leads have been identified and are supporting this work. A carer’s audit is now taking place each month to identify areas of improvement and good practice.

**Local CQUINs**
The local CQUINs for 2013/14 were grouped into two categories:

- Those that applied to the whole of Barts Health:
  - Staff and patient satisfaction, including A&E and cancer services.
  - Integrated care management, including long term conditions.
  - Integrated information systems and information sharing.

- Those that were site specific:
  - Whipps Cross University Hospital smoking cessation programme
  - Whipps Cross University Hospital cancer staging
  - Newham University Hospital consultant advice
  - Newham University Hospital improved quality of communication
  - The Royal London Hospital chronic obstructive pulmonary disease (COPD) care plans
  - The Royal London Hospital diabetes care plans

At the end of 2013/14, we reported our performance against the national CQUINs as follows:

- **Staff and patient satisfaction, including A&E and cancer services** - a system to collect real time feedback from patients is now in place on all our wards, maternity units and emergency departments, and a further rollout of this scheme is under way. In these areas, the system is now running well and is supported by Picker Institute Europe, a not for profit organisation that aims to champion patients’ views on healthcare. However, whilst there has been some improvement in the number of staff who would recommend Barts Health as a place to work, at the end of 2013/14 we continued to track below the national threshold on this measurement.

- **Integrated care management, including long term conditions** – together with our partners, we made good progress on delivering a significant number of initiatives to support integrated care.

- **Integrated information systems and information sharing** – despite some significant technological challenges, Barts Health has made good progress in the delivery of a number of integrated information initiatives, including moves toward integrating GPs within Tower Hamlets and Newham Clinical Commissioning Groups with the Trust’s Health Information Exchange, an electronic method of sharing healthcare information.

- **Whipps Cross University Hospital - smoking cessation and cancer staging** – we were very successful in delivering significant improvements in both referrals to smoking cessation services and in cancer staging for patients at Whipps Cross and meeting the CQUIN targets.

- **Newham University Hospital - consultant advice and improved quality of communication** - both of these CQUINs (and their multiple indicators) have proved very
challenging for us during 2013/14. While a proportion of the CQUIN target will not be delivered, these are some notable successes and improvements

- **The Royal London Hospital - COPD and diabetes care plans** - we have been able to deliver significant improvements in these areas. More than 60 per cent of eligible patients with COPD are provided with completed care bundles, and over 65 per cent of eligible patients with diabetes have a care plan completed while they are an inpatient. This has the potential to substantially improve their care.

**The specialist and highly specialist CQUINs**

These covered:

- **Clinical dashboards for specialised services** – clinical dashboards have been implemented by all relevant specialties and reported quarterly. Barts Health fully met the requirements for this CQUIN.

- **Bone marrow transplantation outcomes (post-transplantation and donor acquisition measures)** – Barts Health collected, collated and submitted data on post-transplant outcomes (after 100 days, one year and two years) on a quarterly basis. The indicators for donor acquisitions have recently been finalised, and reporting against these quality indicators took place in quarter 4 for the whole of 2013/14.

- **Renal Patient View** – the renal team has made good progress in ensuring patients are registered and are using Renal Patient View, a website that allows patients to manage and monitor their condition, meeting the targets for this CQUIN.

- **HIV: communication with GPs and cost effectiveness of treatment** – the HIV team has successfully worked with patients to gain their consent to share their information with their GP, and this is now happening for more than 75% of our HIV patients. We also focused on ensuring that GPs have had a letter from the service in the past 12 months, successfully achieving this for 98% of patients.

- **Highly specialised services** – three of Barts Health’s highly specialist services have participated in the QCUIN programme - The Behcet’s Centre of Excellence, the retinoblastoma service and the ocular oncology service. Together with colleagues from around the country, these teams have participated in a collaborative audit workshop, compiling a report outlining the clinical outcomes, implications and ways forward for improvements.
Our quality priorities in 2013/14 – what we achieved and what challenged us

Quality Priority 1 - Reducing avoidable harm

The Barts Health Quality Improvement Collaborative

In early 2013, Barts Health set up a Quality Improvement Collaborative (QIC) to bring together multi-professional teams of nurses, doctors, therapists, porters, cleaners and patients. The expectation is that the Collaborative will support bringing about cultural change and embedding a set of core organisational values and behaviour that will support the delivery of our quality and safety priorities, consistent with our overall vision of changing lives.

The QIC work is still at an early stage, but evaluation and feedback so far is that it is already proving useful. QIC is also closely aligned with the Barts Health Improvement Model that was rolled out in 2013/14. This is a system-wide approach to improving the safety, efficiency, effectiveness and quality of care that we provide, which is understood and utilised by frontline staff, leaders and executives. QIC will seek feedback from patients and review evidence-based practices that will empower frontline staff and help them to reduce avoidable harm.

Our work is based on the Institute for Healthcare Improvement (IHI) Model for Improvement, a powerful tool for promoting positive change. The aim is to strive for excellence in healthcare whilst offering harm free care. Front line staff are empowered to make use of improvement tools, such as Plan, Do, Study, Act cycles and ward accreditation, to help wards benchmark themselves against others and identify who is doing well. Successful wards are given a prestigious gold award, demonstrating that the ward is consistently achieving excellence in leadership and care.

In 2013, ten wards chose a harm area to focus on, and their success was shared at the Institute for Healthcare Improvement’s conference in April 2014. So far in 2014, a further 16 wards have joined the programme and are learning from their predecessors’ experiences. One very positive example of how our work is benefitting patients is the 50% reduction in falls achieved on Riviere ward at the London Chest Hospital.

So that results are sustained, we are working to ensure that necessary internal structures are in place to share best practice and encourage a culture of continuous quality improvement.

Reducing harm - hospital acquired infection

Preventing and controlling healthcare associated infections remains a top priority for the Trust. Our aim is to preclude avoidable harm by maintaining a clean and safe environment. Alongside the cleanliness of our wards, we also continue to focus on our programme of comprehensive training for staff, stringent hand hygiene and the monitoring of high impact intervention care bundles. We have strict antibiotic policies and closely monitor compliance against them, and infection control specialist nurses have participated in and supported wards participating in the Quality Improvement Collaborative to reduce healthcare associated infections. Several of our wards are participating in projects to reduce avoidable infections.

The Trust has a robust strategy to prevent the transmission of infection to patients. Our infection prevention and control team is involved in monitoring infections and providing ward staff with advice on how to prevent, treat and contain the spread of infection. The Trust also routinely screens all appropriate elective patients – those being admitted for routine, planned care - for MRSA in line with our MRSA screening policy.
Methicillin-resistant staphylococcus aureus (MRSA)

We reported 11 MRSA bloodstream infections in 2013/14, of which four were unavoidable. We subsequently breached our nationally agreed target, which was to have zero avoidable infections during the year. Our overall figure is comparable with our performance in 2012/13. The figures in the graph below show the MRSA cases attributed to the Trust, i.e. those detected 48 hours after a patient’s admission.

![MRSA post 48 hours of admission by month, site ward](image)

It was disappointing that, despite a good start to the year, there was a rise in the number of cases in November 2013. Each individual case was investigated to look for patterns. In three cases, intravenous line care and the blood culture technique were identified as contributory factors. We have since redoubled our focus on line care and the aseptic non touch technique to improve our performance.

The graph on page 28 shows the various sources of the MRSA bacteraemias detected in 2013/14. For two cases, it was difficult to identify the root cause, but it was agreed that the most likely source in the first case was a peripheral cannula (a tube in a vein) and for the second case it may have been a chest infection or fragile skin.
We have asked the **NHS Trust Development Authority** to undertake an evaluation of our post infection reviews to assess our current practice, and we have also reintroduced senior leadership ward rounds to ensure a real-time review of patients’ care and management, including cleaning standards.

Over the next year, we will ensure that avoiding health care associated infections remains our focus through:
- Sustained improvement with care bundles and robust monitoring of compliance
- Ensuring infection control risk assessments are undertaken for all admitted patients and acted upon
- Daily monitoring of MRSA admission screening of elective and emergency patients, with follow up isolation and decolonisation regimens as required
- Continued improvement of care for patients with chest infections/tracheostomies
- Developing the infection prevention and control link practitioner role
- Continue to support the Care Quality Collaborative
- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Continuation of weekly ward rounds for patients with Clostridium difficile (C.diff) infections
- Roll out of antibiotic stewardship (management) ward rounds across the Trust

**Working hard to combat Clostridium difficile infection**
We have seen significant reductions in Clostridium difficile (C diff) cases over the past few years and we will continue to focus on further improvements. The Department of Health set us a very challenging ceiling threshold or target of 75 cases or less in 2013/2014. This was a significant reduction on our previous threshold of 99 in 2012/13, when we reported 89 cases.

This year, regrettably, we breached our ceiling threshold with 84 cases recorded by the end of the year. Samples taken more than 72 hours after admission are considered to be healthcare acquired cases; those taken prior to 72 hours are reported as community acquired cases. The graph on page 29 focuses solely on the post 72 hours samples which have been allocated to the Trust.
The graph highlights a significant decrease in Trust apportioned cases in the first five months of the year. However, the reported monthly cases increased, peaking at 12 cases in January 2014. All cases are reviewed to ensure that any avoidable incidents are not repeated.

**How we test for and monitor C.diff**

Our testing method identifies potential carriers of C.diff, and all cases are reported to Public Health England (PHE) both pre and post 72 hours of admission. Testing consists of two stages, as not all carriers of C.diff are considered infectious. Non-infectious patients do not receive treatment but are isolated in single side rooms, as in some cases they later become positive for toxins, the poisons that can be produced by the C.diff bacteria. Cases are only counted when the toxin is detected, even if the organism was present on admission. This is important to bear in mind, as between 15 and 30 per cent of all patients admitted to hospital are estimated to be carriers with no symptoms, and antibiotic therapy is the major cause of subsequent symptomatic disease. Much of our efforts in recent years have therefore concentrated on antibiotic stewardship.

Whilst in-patient transmission can occur, our tests show that this is not the major factor behind "clusters" of symptomatic cases in our hospitals. This has been established through ribotyping, the identification of the particular C.diff strain a patient has. Cases are also reviewed by infection control nurses, pharmacists and microbiologists. In 2013/14, all samples have been different except for a single cross infection incident when two ribotypes were the same. Most of the incidents were not true ‘infection’, i.e. the condition was not passed from one individual to another, but were instead deemed to be ‘gut carriage’, and caused by bacteria in the gut which is present in many healthy adults.

Over the coming year, our plans will continue to focus on the following control measures:

- Isolating all patients with diarrhoea
- Complying with national guidance on testing
- Keeping records on isolation non-conformities - situations where we are unable to isolate a particular patient with an infection, for example because of a lack of suitable side rooms or if the patient requires close observation for another condition
- Ribotyping all positive samples to monitor for clusters and cross infection
- Monitoring and maintaining cleaning standards, including using hypochlorite (bleach) solutions in areas where infectious patients are cared for
We will also continue to work with our local Clinical Commissioning Groups to help prioritise responsible antibiotic stewardship in the wider community.

During 2014/15 we will strengthen our infection prevention procedures to further improve safety. Our goals are:
- To aim for zero cases of avoidable MRSA bloodstream infections
- To reduce the number of C.diff cases to a maximum of 71

These objectives are challenging, and it is critical that we continue to embed good infection prevention practices across Barts Health. To help us achieve our objectives, the Quality Improvement Collaborative will continue to focus on ways to reduce healthcare-associated infections over the coming year.

Managing deteriorating patients

We have continued to work hard to strengthen our procedures to identify and escalate deteriorating patients. Observations of factors including temperature, blood pressure and alertness can help staff to quickly identify patients whose condition is deteriorating and take appropriate action.

In November 2013, a multi-disciplinary peer review forum was re-established to promote good practice across the Trust. The Managing the Acutely Ill Patient Group (MAIPG) will provide a strategy for the care and management of acutely ill and deteriorating adult patients at Barts Health. There is a separate forum for children. The group aims to:
- Develop the overall strategy for the acutely ill adult patient with the emphasis on preventing deterioration
- Analyse moderate and severe incidents relating to ‘failure to rescue’ to determine trends, organisational learning and loop closure
- Review national policy and implement relevant guidance from key organisations e.g. the National Confidential Enquiry into Patient Outcome and Death
- Audit the effectiveness of the delivery of care and participate in relevant research projects
- Collaborate with other forums to resolve issues and work with Clinical Academic Group leads, governance teams and our patient safety team
- Determine competencies and education needs for staff working in our acute care services

We are currently working on the following actions to support these aims:
- A peer review of serious incidents and moderate incidents to promote cross CAG learning
- A review of site specific issues to promote resolution
- Developing and implementing the National Early Warning Score
- Developing a Faculty of Critical Care Education to harmonise training across the Trust
- Harmonising other key protocols for acutely ill adult patients, including tracheostomy management and oxygen delivery
- Developing key metrics to measure whether the care and management of the sick and deteriorating adult patient is appropriate, for example reviewing inpatient cardiac arrest rates

Avoiding pressure ulcers

Reducing harm from pressure ulcers is a key quality priority for Barts Health. Over the past year, we have been implementing systems and processes to prevent and manage pressure ulcers within our hospitals and community settings.

Pressure ulcers are mostly preventable, but if left to develop they can be extremely uncomfortable and lead to severe harm or even death. They are also expensive to treat - a recent estimate from UCLPartners suggests that each pressure ulcer adds £4,000 to the care costs for the patient affected.

Over the past year, our tissue viability service has been working across the Trust to reduce the
prevalence and incidence of pressure ulcers. This has included work on the following initiatives:

- Developing a new Trust-wide electronic clinical incident reporting system with revised codes to assist with more detailed monitoring
- Introducing a standard medical photography service for all patients with admitted and acquired grade 3 ulcers (moderate harm) and grade 4 ulcers (severe harm). This enables staff to accurately assess the severity of the condition and monitor progress
- Introducing an updated pathway for pressure ulcer reporting and investigation, including local action plans to improve the quality of care provided
- Developing a paper and electronic version of a five step model for pressure ulcer prevention, based around the SSKIN principles:
  - **Surface**: make sure your patients have the right support
  - **Skin inspection**: early inspection means early detection
  - **Keep your patients moving
  - **Incontinence/moisture**: keep patients clean and dry
  - **Nutrition/hydration**: patients need a good diet with plenty of fluids

This model is being tested on eight wards and plans are in place to roll it out across the Trust.

- Introducing non-concordance guidelines to help staff provide the best care for patients who are unable or unwilling to enter into a partnership for the prevention or management of pressure ulcers
- Developing an education and training programme that includes an e-learning module – this must be taken and passed by all new nurses, and by existing staff every two years
- Introducing a new role of pressure ulcer prevention practitioner to support our work in reducing pressure ulcers
- Outlining new competency-based roles and responsibilities for all band 2 to 8 nursing staff to focus on reducing avoidable pressure ulcers
- Producing updated leaflets for use in our hospitals and the local community to promote awareness of the prevention and management of pressure ulcers
- Setting up a pressure ulcer prevention steering group, chaired and led by the Clinical Academic Groups – their mission is to reduce avoidable pressure ulcers at CAG and ward level. This involves collaboration across the acute, rehabilitation and community sectors
- Developing a ward accreditation scheme to enable us to celebrate exemplary performance – for example a kite mark of quality might be for a ward to go for 100 days without any patient developing an avoidable hospital acquired pressure ulcer

We are starting to see some positive results from our endeavours. The Care Quality Commission (CQC) inspection report into Barts Health, published in January 2014, commended the Trust for reducing hospital acquired pressure ulcers. Although our rates were above the national average in December 2012, they are now average or below average. The year to year comparison in the table below illustrates that Grade 2 ulcers have remained static, but there has been a significant reduction in Grade 4 Ulcers. We will also focus on reducing Grade 3 Ulcers, where we have seen an increase in numbers. The table on page 32 compares the number of ulcers acquired in hospital and by grade for 2012/13 and 2013/14.
Number of hospital acquired pressure ulcers in 2012/13 and 2013/14

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Grade 2 Ulcers</th>
<th>Grade 3 Ulcers</th>
<th>Grade 4 Ulcers</th>
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<td>May 2012</td>
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<td>June 2012</td>
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<td>July 2012</td>
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<td>7</td>
<td>3</td>
</tr>
<tr>
<td>March 2013</td>
<td>95</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total for 12/13</strong></td>
<td><strong>770</strong></td>
<td><strong>109</strong></td>
<td><strong>39</strong></td>
</tr>
<tr>
<td>April 2013</td>
<td>63</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>May 2013</td>
<td>58</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>June 2013</td>
<td>59</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>July 2013</td>
<td>58</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>August 2013</td>
<td>67</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>September 2013</td>
<td>60</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>October 2013</td>
<td>65</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>November 2013</td>
<td>58</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>December 2013</td>
<td>71</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>January 2014</td>
<td>71</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>February 2014</td>
<td>68</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>March 2014</td>
<td>75</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total for 13/14</strong></td>
<td><strong>773</strong></td>
<td><strong>179</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

Reducing pressure ulcers will continue to be a quality priority in 2014/15 and will form part of our CQUIN improvement agenda. We are taking an active part in UCLPartners’ project to eliminate all avoidable pressure ulcers by December 2014.

**Avoiding harm from falls**

We continue to reduce patient falls across the Trust, and follow recommendations from the National Patient Safety Agency (NPSA) to record and monitor our falls rate per 1,000 occupied bed days. The rate can be used to make comparisons between hospitals of different sizes. The average is 4.8 falls per 1,000 bed days for an acute hospital. In 2012/13, our score was 4.1 and in 2013/14, we achieved a lower average of 4.02 falls per 1,000 bed days.

Our Quality Improvement Collaborative is supporting four inpatient wards with falls improvement projects, which are delivering excellent results. On Riviere Ward at The London Chest Hospital, our staff reduced falls by 50 per cent in eight months, against a target of 20 per cent. Specific changes included:

- Using a modified simpler falls risk assessment tool and care plan
- Introducing new systems to highlight at risk patients, marking them up on the patient board and providing them with yellow wristbands
- Advising carers and relatives to bring in non-slip footwear for patients
- Providing non-slip socks as required
- A pharmacist review of medications for at risk patients
- Using the Plan Do Study Act rapid cycle testing methodology to support this work
- Using new audit tools to assess these activities
The ward team presented their findings at the International Forum for Quality and Safety in Healthcare’s conference in April 2014.

Other activity across the Trust in 2013/14 included:
- Pharmacists piloted a formal ‘medication and risk of falls assessment’ in older patients who have had a fall. The results are communicated to the patient’s GP on discharge and include recommendations on reducing the risk of falls and any changes made to medication during admission
- Making significant improvements in compliance on mandatory falls training, rising from 33% in April 2013 to 95% by February 2014
- Launching a new Trust-wide slips, trips and falls policy
- Introducing a policy to ensure that patients are not at risk of being trapped in bed rails (guards on the sides of a bed to stop a patient falling out)
- Setting up a a falls steering group and recruiting four improvement facilitators, one of whom is dedicated to falls improvement work

Improvement work in 2014/15 will include:
- Trust-wide participation in the National Falls Audit
- Enabling staff to monitor falls data and assessments electronically
- Introducing a patient information leaflet on falls prevention
- Physiotherapists working to identify patients who need one to one support and analysing other contributing factors for falls

The following graph shows the downward trend in the number of reported falls between September 2013 and February 2014.
Avoidable harm – never events

In our 2012/13 Quality Account, we made a commitment to reduce the number of incidents that occur during surgical procedures, with particular emphasis on reducing the number of surgery related ‘never events’.

Never events are defined by the Department of Health as serious and largely preventable patient safety incidents. The occurrence of never events is potentially indicative that a hospital has not implemented the correct systems and processes required to protect patients. In 2013/14, Barts Health reported eight never events, having reported 14 in 2012/13. Three further never events were reported but have since been declassified following changes to the Never Event criteria.

The table below provides a breakdown of the never events reported at Barts Health between 1 April 2013 and 31 March 2014.

<table>
<thead>
<tr>
<th>Category of never event</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained swab/packs</td>
<td>3</td>
</tr>
<tr>
<td>Wrong site surgery</td>
<td>4</td>
</tr>
<tr>
<td>Misplaced nasogastric tube</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
</tr>
</tbody>
</table>

During 2013/14, we have focused our efforts on reducing the number of never events associated with retained packs or swabs, and have not reported an incident of this type during the last two quarters of the year. All of these incidents were thoroughly investigated and lessons learnt were shared with all theatre staff to help prevent future incidents.

A campaign on learning from all never events was launched in April 2014, based on eight key messages:

1. **Think loudly** - speak out when you think something is not right
2. **If in doubt, take it out** - remove incorrectly placed naso-gastric feeding tubes immediately
3. **5.5 is the limit** - don’t feed a patient after nasogastric tube insertion without doing a pH paper test (this test checks if stomach acid is present in aspirate)
4. **Surgical safety (who and we)** - are we sure this is the right patient? Have we as a team checked we know who this patient is and what their procedure is?
5. **Whose side are you on?** - check procedure is carried out on the correct side and site
6. **Pause for gauze** - document any swab left inside a patient
7. **In = out** - leave nothing behind unless retention is intentional
8. **Double doesn’t cause trouble** - check as many times as you need to, with as many people as you need to

We have significantly improved patient safety during surgical procedures in the last year. We have focused on implementing the recommendations made by a group from Plymouth Hospitals NHS Trust, who undertook a review of our theatre systems and processes in March 2013. Our progress to date includes:

- Consultant anaesthetist Dr Annie Hunningher led the development of the MATCH programme (Multidisciplinary Action Training in Crises and Human Factors) with the aim of improving local safety culture and enhancing the performance of multidisciplinary theatre teams. MATCH is running a research project to look at the effectiveness of intensive training programmes. Three theatre teams - orthopaedics, oral/maxillofacial and renal - have attended the training so far and the MATCH team is now monitoring progress through observational audits. We are doing this work collaboratively with our academic partners at Queen Mary University London, and we hope to report on the results later in 2014.
Team briefings before the start of each theatre list are now mandatory. Everyone working in an operating theatre meets at the start of each shift to discuss the planned operations and identify any possible issues.

Structured debriefs known as ‘after action reviews’ are being introduced after any incidents, with help from the MATCH team. These allow staff to analyse what happened, what could be improved and what can be done to prevent further incidents.

An educational plan has been developed to augment the formal training given to theatre staff.

The World Health Organisation’s Surgical Safety Checklist is now embedded in all our theatres.

An electronic tracking system, SurgiNet, has been introduced to help staff to monitor the use of the checklist. This system is in place in all our hospitals except Whipps Cross, where it will be implemented later in 2014.

**Reducing avoidable venous thromboembolism (VTE)**

Some conditions are more likely to occur in a healthcare setting, such as venous thromboembolism (VTE), a disease that includes both deep vein thrombosis and pulmonary embolism. Being ill, immobile and having major surgery can increase a person’s risk of VTE, but this can be mitigated through preventative measures.

We constantly strive to improve our safety levels on VTE. The Trust has consistently achieved the risk assessment CQUIN target in 2013/14, which means that at least 95 per cent of our eligible patients were risk assessed for VTE on admission.

**Comparing our performance on VTE risk assessment with other NHS trusts in England**

An acute organisation’s VTE risk assessment performance is measured and reported as a mandated Quality Account core indicator. We achieved the NHS target of 95 per cent (and above) for April to December in 2013/14. Provisional VTE data for the final quarter to the end of March 2014 at 96.08 per cent indicates we have achieved the target for the whole year.

To see Barts Health’s performance compared to the best and worst Trusts in England and the national average refer to the data tables at Appendix 2.

**Identification and investigation of all cases of VTE diagnosis**

Over the past year, we have developed a process to identify all hospital associated VTEs diagnosed at Barts Health. The process enables us to investigate these cases with a root cause analysis within 30 days (as required by the national CQUIN). We are pleased to have achieved the CQUIN target of 75 per cent of VTEs subject to root cause analysis in 2013/14.

Through the root cause analysis process, we seek to identify the number of patients who, according to all available guidelines, have received appropriate assessment and prophylaxis. For those who did not receive appropriate care, the process gives an opportunity for the admitting teams to learn and feed back locally, driving future improvements. Facilitating the auditing of data by individual teams such as orthopaedic surgery and older people’s services will encourage further clinical recommendations and potentially lead to changes in policy.

Data collected over the year indicated that:

- Between July 2013 and March 2014, 465 VTEs were diagnosed at Barts Health
- Of those, 54 (11.6 per cent) were diagnosed within 90 days of discharge
- Of the 49 root cause analyses undertaken by departmental clinicians, eight (16.3 per cent) identified omissions in care – four occurrences of missed drug doses during inpatient stays and four occurrences of delays in prescribing prophylaxis after a VTE was missed when a patient was admitted

Clinicians review every case so that learnings can be documented and any necessary changes to practice made. At the time of reporting, six cases still required further investigation.
Our aspiration for the future is to expand the project to identify and investigate all hospital VTEs that could be attributed to Barts Health, not just those diagnosed at the Trust. This will involve working with primary care colleagues, local coroners and other hospitals. Over the next two years, we will:

- Continue to investigate every VTE diagnosed following a recent inpatient episode in one of our hospitals, whether it occurs during a patient’s time in our care or elsewhere
- Share learning and improve care from instances where we could have done better
- Standardise practice and better understand the impact of risk assessment and proactive treatment

We will also work towards:

- Harmonisation of our drug charts and IT systems across our sites so that we have a single process for performing and recording VTE risk assessment
- Revision of the patient/carer information leaflet about VTE
- Implementation of the NICE VTE management guidelines and quality standard, including providing a seven day ultrasound service for DVT diagnosis
- Introduction of the new oral anticoagulant, rivaroxaban, as an alternative to heparin/warfarin for appropriate patients, in line with NICE guidance

We will measure our performance against these aims against the national target and CQUIN indicators, and also by benchmarking against other comparable trusts through the work of the All-Party Parliamentary Thrombosis Group.
Quality Priority 2- Improving mortality rates and sharing the learning

How we rate under the Standardised Hospital Mortality Indicator (SHMI)

The Standardised Hospital Mortality Indicator (SHMI) is a national measure of hospital-level mortality in each organisation. It shows whether the number of deaths linked to a particular organisation is more or less than would be expected, given the characteristics of the patients treated there and the average national mortality figures. It also shows whether that difference is statistically significant. Deaths in hospital, and deaths within 30 days of discharge, are included.

A score of 1 indicates that the observed rate of death is the same as the expected rate of death. A score below 1 indicates a lower death rate than expected. A score above 1 indicates a higher death rate than expected. We regularly use the indicator as a tool to monitor individual services, and if rates are higher than expected, we will then investigate on a case by case basis.

Along with many other similar organisations, Barts Health moved to using the Standard Hospital Mortality Indicator (SHMI) as the single mortality measure from April 2012. NHS trusts have been using this data and the associated reports to assure themselves and the public that care is safe and effective. It gives a broader picture of hospital mortality than the previous Hospital Standardised Mortality Ratio (HSMR) by:

- Including all deaths in all settings, not just those which occur in hospital
- Including deaths up to 30 days after discharge from hospital
- Covering all clinical codes (describing the diagnoses, procedures and treatments carried out for every patient) rather than just those codes relating to the 80 percent of the most common causes of death in hospital

The SHMI is reported quarterly, in arrears. Data from the period January 2013 to January 2014 shows Barts Health’s SHMI was below 1 and therefore in a group of 13 hospital trusts nationally with a significantly lower than expected SHMI rate. This should give patients and referring clinicians confidence in our clinical safety levels.

SHMI rates for Barts Health from January 2013 to January 2014

Source: Health and Social Care Information Centre

In the 2012/13 Dr Foster league tables, Barts Health had the seventh lowest SHMI, 0.81. In the 2013/14 tables, for the period July 2012 to 2013 our SHMI rate was even lower, 0.79, meaning that we have the fifth lowest SHMI in the country. This is a remarkable achievement for a newly merged organisation.
Specific initiatives which have contributed to our success include:

- Implementing a Trust wide mortality dashboard to enable clinical teams to examine statistical trends and benchmark against peer groups of their choice
- Rigorous examination of mortality outliers (statistically unusual occurrences) so that lessons learned can be identified and shared on all sites
- Trust wide initiatives to promote infection control and harm free care such as the Safety Thermometer, managing deteriorating patients and our Quality Improvement Collaborative
- Increased Consultant presence on wards with daily ward rounds (introduced by the Emergency and Acute Medicine CAG)
- Increased participation in national audits
- A Trust wide audit of participation in mortality review meetings with on-going management of areas that are non-compliant

Areas of focus for 2014/15 will include:

- Establishing a Trust wide mortality review group which will consider mortality data from other sources, including CHKS and the Health and Social Care Information Centre. This will enable us to identify teams with good practice that can be shared, and quickly identify any areas where mortality may be increasing
- Contributing to strategic developments which may sustain and improve mortality to above the benchmark
- Establishing the use of a Trust-wide unexpected death review proforma, and consider and disseminate lessons learnt from any serious incidents associated with patient deaths.
- Continuing to promote local mortality review by all our clinical teams in each service

An acute organisation’s SHMI performance is measured and must be reported as a mandated Quality Account core indicator. To see Barts Health’s SHMI performance compared to the best, average and worst trusts in England for the period July 2012 to June 2013, refer to the data tables in Appendix 2.

Demonstrating our learning safety culture through accurate reporting of incidents

A strong patient safety culture is typically indicated by a high rate of incident reporting, including the reporting of low harm and no harm (near miss) incidents. It is important for staff to report incidents so that everyone can learn from them. Remedial action can be put in place at a local level and across the wider organisation before any serious harm occurs.

In 2013/14, a total of 21,662 of patient safety incidents were reported by staff across Barts Health NHS Trust compared to 19,493 in 2012/13, a positive trend.

Comparing our rate of incident reporting to other trusts in England

In last year’s Quality Account we reported being in the bottom quartile of acute teaching Trusts for incident reporting, with an incident reporting rate (IRR) of 4.89 per 100 admissions. This was according to the National Reporting and Learning System (NRLS) which publishes comparative data and reports for the NHS.

Data published by the NRLS in April 2014 - relating to incidents reported between 1 April 2013 and 30 September 2013 – showed that our IRR had improved to 7.98 per 100 admissions, placing us in the upper middle group of reporters.

An acute organisation’s incident reporting rate per 100 admissions is measured and must be reported as a mandatory Quality Account core indicator. To see Barts Health’s performance compared to the best, average and worst Trusts in England, refer to the tables in Appendix 2.
We need to improve our timely incident review performance
We do not always meet the deadlines for incident review and final approval – the expected standard is 14 days - meaning that a proportion of patient safety incidents do not reach the NRLS system and so are not counted in the rate calculations. Based on current reporting rates, and if we consistently managed our incidents within the 14 day window, we could achieve a rate in excess of nine per 100 admissions by September 2014, which would place Barts Health in the top group of reporters. Work will continue with the Clinical Academic Groups (CAGs) and our Datix incident handlers in each CAG to improve our performance. Datix is the electronic risk management system we use to report and manage incidents.

Incident reporting trends at all hospitals
We know that that the majority of patient safety incidents – 74 percent from a total of 21,662 - were categorised as ‘no harm’. This means that no harm was caused to the patient as a result of the incident. During 2014/15, we will continue to encourage staff to report all incidents as fully and accurately as possible. We will also ask our managers to robustly analyse the data on an on-going basis so that we can learn from all incidents and reduce harm.

What categories of incidents are reported most frequently?
The following table shows the number of incidents staff reported using Datix in 2013/14 at each of our hospital sites, broken down by the level of severity.

<table>
<thead>
<tr>
<th>Level of harm and description</th>
<th>LCH</th>
<th>MEH</th>
<th>NUH</th>
<th>RLH</th>
<th>SBH</th>
<th>WXUH</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No harm</strong> caused to the person affected</td>
<td>333</td>
<td>373</td>
<td>2,872</td>
<td>5,506</td>
<td>1,026</td>
<td>5,089</td>
<td>792</td>
<td>15,991</td>
</tr>
<tr>
<td><strong>Low harm</strong> Extra observation and/or minor treatment required</td>
<td>145</td>
<td>134</td>
<td>640</td>
<td>1,783</td>
<td>276</td>
<td>1,682</td>
<td>198</td>
<td>4,858</td>
</tr>
<tr>
<td><strong>Moderate harm</strong> Moderate increase in treatment</td>
<td>8</td>
<td>15</td>
<td>137</td>
<td>315</td>
<td>28</td>
<td>211</td>
<td>56</td>
<td>770</td>
</tr>
<tr>
<td><strong>Severe harm</strong> Permanent or long term harm</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td><strong>Death</strong> Death occurred as a direct result of the incident</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>14</td>
<td>0</td>
<td>9</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td>522</td>
<td>3,661</td>
<td>7,624</td>
<td>1,330</td>
<td>6,992</td>
<td>1047</td>
<td>21,662</td>
</tr>
</tbody>
</table>

Key to hospital sites:
LCH – The London Chest Hospital
MEH – Mile End Hospital
NUH – Newham University Hospital
RLH – The Royal London Hospital
SBH – St Bartholomew’s Hospital
WXUH – Whipps Cross University Hospital

The top ten incident types accounted for over 77 percent of all incidents reported. Compared with 2012/13, there has been no change in the categories appearing in the top ten and virtually no movement in the respective order of categories within the top ten. There are more pressure ulcers and falls reported than any other type of incident, although it should be noted that 54 percent of pressure ulcers reported are already present when a patient is admitted to our care. The table on page 40 shows the number of incidents within each category.
Top ten categories of incident at Barts Health in 2013/14

<table>
<thead>
<tr>
<th>Category of incident</th>
<th>Number</th>
<th>Percentage of total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers</td>
<td>4,953</td>
<td>23%</td>
</tr>
<tr>
<td>Patient falls</td>
<td>2,891</td>
<td>13%</td>
</tr>
<tr>
<td>Delays in care</td>
<td>1,818</td>
<td>8%</td>
</tr>
<tr>
<td>Medication</td>
<td>1,684</td>
<td>7%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1,217</td>
<td>6%</td>
</tr>
<tr>
<td>Treatment</td>
<td>1,100</td>
<td>5%</td>
</tr>
<tr>
<td>Communication issues</td>
<td>1,084</td>
<td>5%</td>
</tr>
<tr>
<td>Pathology/specimen</td>
<td>827</td>
<td>4%</td>
</tr>
<tr>
<td>Skin trauma</td>
<td>625</td>
<td>3%</td>
</tr>
<tr>
<td>Patient action</td>
<td>532</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>16,731</td>
<td>77%</td>
</tr>
</tbody>
</table>

Accurate identification of patient harm

In our Quality Account for 2012/13, inconsistencies were noted between the published national NRLS data and the data held locally for levels of harm. Measures have been implemented and are being monitored to ensure consistency and reduce recurrence.

In order to be able to confirm and validate the level of harm for the patient, reviewers rely on internal Serious Incident reports. A backlog in completion of Serious Incident investigations adversely affected our performance during Quarters 1 and 2 of 2013/14, but this has since improved and we are aiming to achieve consistency in our locally held and nationally published data by September 2014. As part of this work, we have established a new Level of Harm Review Group, attended by patient safety and risk system staff and senior clinicians who review each death/severe harm incident to ensure the harm grading is accurate before it is reported to the NRLS.

Severe harm or death incidents as a percentage of all incidents

We deeply regret that a number of serious incidents in 2013/14 involved the death of a patient, either as a result of the incident or linked to it in some way. The table below shows specific numbers involved, including the difference between the Barts Health (Datix) and NRLS figures. This difference is accounted for by changes to the original level of harm which are sometimes required to be made to the Trust’s incident database (Datix) retrospectively and after previously having uploaded final approved incidents to the NRLS. Additionally, when a Serious Incident investigation is completed, only then can the Level of Harm Review Group use the report to finally validate the level of harm. As highlighted previously, the backlog of overdue Serious Incident reports in 2013/14 impacted on this process, resulting in a longer timescale for report completion and subsequent validation. Note that final NRLS data will not be published until September 2014, and that Datix figures may change after any on-going investigation is concluded and/or a revised level of harm rating is recommended.

<table>
<thead>
<tr>
<th>2013/14</th>
<th>NRLS data death</th>
<th>Datix data death</th>
<th>NRLS data severe harm incidents</th>
<th>Datix data severe harm incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 and Q2</td>
<td>18</td>
<td>15</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Q3 and Q4</td>
<td>As of May 2014 14 approved incidents had been submitted to NRLS</td>
<td>17</td>
<td>As of May 2014 6 approved incidents had been submitted to NRLS</td>
<td>6</td>
</tr>
</tbody>
</table>
**Percentage of severe harm and death out of all reported incidents**

An acute organisation’s percentage of severe harm and death incidents out of all incidents reported is measured and must be reported as a mandated Quality Account core indicator.

Based on the number of severe harm/death incidents reported in Datix (43) for the year 1 April 2013 to 31 March 2014, severe harm/death incidents represented 0.2 percent of the total number of incidents we reported in the period.

19,840 incidents occurring in 2013/14 have been given final approval and were uploaded to NRLS out of a total number of 21,662 recorded in Datix. A proportion of incidents were still awaiting final approval and uploading to NRLS at the time of publishing this Quality Account.

To see Barts Health’s percentage of severe harm or death performance for the period April 2013 and September 2013 compared to the best, average and worst Trusts in England, refer to the tables in Appendix 2.

**Incidents reported under the NHS Commissioning Board Serious Incident Framework**

During 2013/14, we reported 407 incidents under the NHS Commissioning Board Serious Incident Framework, an increase on the 2012/13 figure of 348. This is a wider dataset than those graded as severe harm and death, as there are a number of categories of incident that must be reported under this policy regardless of whether or not severe harm has occurred.

The leadership team of each Clinical Academic Group and the central patient safety team are notified of each incident to allow them to review the circumstances of each case and confirm whether they meet the criteria for being designated as ‘serious’. The medical director and chief nurse are also informed and then agree the designation of each incident.

**Number of serious incidents reported, including deaths**

All serious incidents are reported to NHS England, our commissioners and where required - for Grade 2 incidents - the Care Quality Commission and NHS Trust Development Authority.

**Improving on the timeliness of investigating and reporting serious incidents**

During 2013/14, we have continued to experience issues with the timely reporting and submission of serious incident investigations to our commissioners and NHS England. A systematic review has identified some key areas for change in the way incidents are reviewed and escalated. Each Clinical Academic Group is being tasked with a review of their serious incident processes and the development of their own standard operating procedures to ensure timely reporting - within two working days - and timely submission of investigation reports - with 45 working days - to ensure that our performance improves in 2014/15. We are already starting to see positive signs of change.

The following table shows categories and numbers of incidents reported in 2013/14.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers</td>
<td>152</td>
</tr>
<tr>
<td>Maternity incidents</td>
<td>86</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
</tr>
<tr>
<td>Unexpected death</td>
<td>23</td>
</tr>
<tr>
<td>Delayed diagnosis</td>
<td>20</td>
</tr>
<tr>
<td>Infection related incidents</td>
<td>12</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>12</td>
</tr>
<tr>
<td>Allegations against staff</td>
<td>10</td>
</tr>
<tr>
<td>Ambulance delays</td>
<td>9</td>
</tr>
<tr>
<td>Drug incidents</td>
<td>8</td>
</tr>
</tbody>
</table>
Failure to act on test results | 5
Safeguarding incidents | 5
Surgical error | 5
Child death | 4
Confidentiality leak | 4
Radiology incidents | 4
Wrong site surgery | 4
Communication issues | 3
Screening incidents | 3
Child injury | 2
Outpatient delays | 2
Falls | 2
Absconson | 1
Assault by a patient | 1
Health and safety incident | 1
Equipment failure | 1
Mental Health Act incidents | 1
Suicide | 1
Venous thromboembolism | 1
Ward/unit closure | 1
Transfusion | 1
Total | 407

| Quality Priority 3 - patients treated at the right time and in the right place |

**Improvements to ensure effective and responsive care**

During 2013/14, Barts Health implemented a number of workstreams to improve the effectiveness and responsiveness of the services we provide in our three A&E departments and for inpatient and outpatient care. Over the past year, our teams have collaborated on a number of trust-wide initiatives focused upon improving patient flow through the hospital.

Over the winter months, a number of service improvements to support care outside hospital were piloted in partnership with our commissioners and local authority colleagues. These included a focused approach to discharge planning, improved access to specialist advice and earlier intervention to avoid admission to hospital. Significant improvement has also been seen within our hospitals, particularly at Whipps Cross where a programme of improvements to the emergency pathway has helped ensure that many more patients were seen and treated within the four hour standard. As a result of this work, the Trust achieved the standard for the whole of 2013/14. In 2014/15, we will work to further embed these improvements across all our hospitals so that services are both effective and responsive to the needs of our patients.

We have also reviewed other specific services, including neurosurgery and orthopaedics, to ensure that we are aiming for or achieving best practice, especially for waiting times for both planned and unplanned care. Many of the improvements we made in 2013/14 have begun to help improve Trustwide performance in areas such as length of stay, waiting times in A&E departments, surgical waiting lists, cancelled operations and readmission rates. These are reviewed in more detail below.

**London Emergency Care Standards**

During 2013/14, we updated our compliance with the London Emergency Care Standards. NHS England’s audit, shared with our commissioners, shows that Barts Health made progress but
that we are still not achieving a number of standards. In addition, Professor Sir Bruce Keogh, the Medical Director for NHS England, has laid out a three-year time frame for trusts to meet the standards, which will form part of annual and longer-term planning. To address these requirements and make the necessary improvements, we have established a medical workforce group to oversee this programme, led by our medical director Dr Steve Ryan. Key areas of focus will be:

- Ensuring all patients admitted for urgent and emergency care are assessed by a consultant within a maximum of 12 hours, every day of the week
- Meeting the national standards for treating patients with fractured hips
- Extending the hours where a consultant is available on our labour wards

**Optimising length of stay – making sure patients are discharged from our care as soon as it is safe to do so**

Barts Health put in place a number of initiatives in 2013/14 to improve patient flow and reduce length of stay. We aim to ensure that we have the necessary capacity for each patient to be treated in the right place at the right time and receive the best possible care.

To support reductions in length of stay, a set of core processes and standards have been established on all inpatient wards. This includes ward rounds (usually with a consultant), board rounds (where staff meet to discuss all patients in their care), the use of multi-disciplinary teams and discharge planning, with all care underpinned by clear communication and team working.

A programme of ward support was launched at Whipps Cross University Hospital in November 2013, and then at the Royal London Hospital in March 2014. This programme involves working intensively with small groups of wards to identify issues which impede patient flow and to put in place structures and processes that will improve the way our wards function. Our Clinical Academic Groups are closely involved and provide local clinical support, which is a vital part of the programme.

The programme is underpinned by *The Barts Way* - our agreed standards for delivering high quality care at ward level. This sets out the key service improvements required and describes a Trust-wide approach to improving the delivery of care at ward level. For example, improvements to board and ward rounds are based on current national best practice and Royal College recommendations. This allows any delays in care to be flagged up within wards and quickly escalated to clinical leadership teams if required, to ensure patients receive prompt attention. The strategy has been fully endorsed and clinical teams are being actively supported to implement change at the ward level.

The standards we are currently working towards are set out in the table below:

<table>
<thead>
<tr>
<th>Operational area</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The daily ward routine</strong></td>
<td>All wards will have a set daily routine. Decisions and care will take place in a timely manner, information will be shared and patients and their carers involved in all aspects of their care as much as possible.</td>
</tr>
<tr>
<td></td>
<td>Junior doctors will be ward based.</td>
</tr>
<tr>
<td></td>
<td>Medical handover from the night team will take place at a set time.</td>
</tr>
<tr>
<td></td>
<td>There will be a ward round every morning at which all patients will be seen - usually this will be conducted by the consultant.</td>
</tr>
<tr>
<td></td>
<td>A board round will take place either immediately before or immediately after the ward round.</td>
</tr>
<tr>
<td></td>
<td>The doctor and nurse in charge of the ward, or a senior deputy, will attend the midday hospital site bed meeting. The site meeting is held daily, with representatives from each ward and a number of departments, to discuss daily capacity and demand as well as any other operational issues. The meeting ensures that patients are on the most appropriate ward, and if not, transfers are arranged via the clinical site managers.</td>
</tr>
</tbody>
</table>
## Operational area | Standards
---|---
**Ward rounds** | There will be an afternoon board round and/or ward round at which discharges for the next morning are identified and any medication or further support that the patient may need after discharge is arranged. All acute wards will operate a seven day model of care. Weekends will not be a barrier to the provision of timely care and expert opinion.

**Ward rounds** | Ward rounds will take place daily, ideally early, and are led by a senior doctor who is able to make management decisions so that no delays in care occur, including the planning of discharge from hospital.

**Ward rounds** | Ward rounds will take place at set times and will be attended by the consultant (or alternate), as well as the nurse in charge, relevant therapists and other allied health professionals.

**Ward rounds** | Every patient is seen and the actions recorded in the patient’s notes. Patients and their carers contribute to decision making.

**Ward rounds** | Business rounds will be conducted quickly and efficiently, but will also use opportunities for teaching and training when appropriate.

**Ward rounds** | Ward rounds will be subject to regular peer review and audit.

**Ward rounds** | Delays in care are identified in ward rounds and are addressed robustly.

**Ward rounds** | Visiting teams are welcomed and accompanied by a senior nurse when visiting patients.

**Board rounds** | Board rounds will take place daily in front of a whiteboard or electronic equivalent - eg BedWeb at Whipps Cross University Hospital - and are a key vehicle for co-ordinating care and planning discharge.

**Board rounds** | Board rounds will be attended by senior doctors, nurses, AHPs and social workers as appropriate.

**Board rounds** | In line with good practice, whiteboards will hold key facts and decisions, including expected date of discharge and any pending investigations or procedures.

**Board rounds** | Board rounds will be subject to regular peer review and audit.

**Delays in care** | Patients currently in the “wrong” ward - known as outliers - will be moved back to their base ward as soon as possible. The number of outliers and inpatients waiting to come to the ward will be measured.

**Delays in care** | No patient will wait for more than 24 hours for the hospital to do something on their behalf, unless there is a clinical reason for this. Examples include imaging, blood tests, opinions from other teams and surgery.

**Delays in care** | Any patient waiting longer than 24 hours will be reported centrally to allow the CAG team to expedite. If this does not resolve the problem, further escalation will take place on day two.

**Delays in care** | A rolling record of delays (and the reason for delays) will be kept, with clear expectations on all CAGs and teams to improve performance.

**Discharges** | It is vital that patients, when clinically appropriate, vacate beds as early in the day as possible. This requires planning for discharge to occur in advance and ward teams should have systems in place to achieve this. The number of morning discharges should be discussed daily at ward board rounds, and at least 35 percent of discharges should be achieved before midday. There should be early use of the discharge lounge.
Reducing delayed transfers of care
An effective discharge workstream is well established at our three acute hospitals – Newham, The Royal London and Whipps Cross. Working closely with commissioners and partner agencies, we have focused on:

- Streamlining discharge processes
- Implementing best practice for board rounds
- Implementing criteria-led discharge at The Royal London
- Improving the management of patients staying over five days (seven days at The Royal London) through long stayers’ meetings
- Reviewing the use of rehabilitation beds and pathways on to community services
- Developing tools to measure and improve patient and staff experience
- Developing robust management of information processes and metrics
- Reducing the number of delayed transfers of care (DTOC)
- Reducing frequent admissions

DTOCs have been variable but underlying trend suggests reduction of circa 20% 

DTOC vary significantly from day to day as a large number of patients can be declared medically fit in a batch after Monday ward rounds for example. A 14 day moving average reveals a downward trajectory through winter, equating to a 20% reduction, or 10 beds

Multiagency conference calls take place weekly to manage delayed discharges by identifying and resolving blockages. Continued delays in placing neuro-rehabilitation patients have been a feature throughout 2013/14, and concern about the London-wide shortage of neuro-rehabilitation beds has been escalated as a key contributor to high numbers of DTOCs within Barts Health.

Managing patient choice has been a particular concern for The Royal London and Whipps Cross hospitals. As a result of a detailed consultation, revised patient information has been developed, explaining the support available on discharge and why patients need to leave hospital once their treatment has been completed. Clear information, provided at the point of admission to hospital (or very soon after) is a key part of ensuring that patients are discharged in a timely manner when they are medically fit and ready for transfer.

Good communication has been a key training theme for nursing and clinical staff. Discharge handbooks have been developed to guide and assist ward staff at The Royal London and Whipps Cross hospitals. At Whipps Cross, it is also planned that junior doctors will undertake a series of interviews with frail older patients, to learn from their experience of discharge.

A managed volunteer service was commissioned from the British Red Cross at Whipps Cross hospital over the winter months to support discharge, reduce re-attendance and prevent subsequent emergency re-admissions. This has proved to be a very effective means of
providing patients with practical help, telephone support and visits for up to four weeks after discharge from the hospital. The scheme has considerably reduced the number of non-urgent and ‘social’ attendances at Whipps Cross by elderly patients who have used the service.

We have also reviewed the primary reasons for readmission. At Whipps Cross, local audit results indicate that falls are the single biggest cause of readmission to hospital. The Trust has shared its data with Waltham Forest Clinical Commissioning Group and social care colleagues with the aim of promoting and supporting a more strategic approach to falls prevention across health and social care settings.

Work is now underway across the Trust, in partnership with the Clinical Commissioning Groups, East London NHS Foundation Trust, North East London NHS Foundation Trust and the London Ambulance Service, to develop and implement an effective flagging system for high risk patients, so that key contacts, baseline information and pre-agreed plans can be accessed for the most vulnerable patients. This will complement the work of the London Ambulance Service’s Pathfinder initiative, launched during the latter part of 2013/14.

**Cancelled operations**
Another key area for improvement is reducing the number of patients whose operation is cancelled on the day it is booked for. We have recruited additional staff who are dedicated to ensuring operations start on time and that theatre teams are fully prepared for the day ahead. We are working to make the best use of our critical care beds and at how we can reduce recovery times for patients undergoing complex and major surgery, including introducing more enhanced recovery programmes.

Several other workstreams are in place to review how we can improve the patient journey. Two are described here.

**Readmissions within 28 days of discharge**
Any patient who is readmitted within 28 days of discharge from hospital is defined as a readmission. Many such readmissions are unavoidable, but others can be prevented through careful management. We are committed to continually reducing the number of avoidable readmissions. Doing so improves the patient experience, reduces costs and reduces the number of occupied bed days.

During 2013/14, 6.34 percent of adult patients and 1.5 percent of paediatric patients were readmitted within 28 days of discharge.

We have a readmissions reduction programme in place to improve data quality and clinical pathways to reduce our overall number of readmissions and also reduce our liability to fines for emergency readmissions. The programme is currently focused on three key patient groups – older people, patients with sickle cell conditions and patients with respiratory conditions. Interventions to reduce readmissions include:

- Dedicated admission avoidance teams in our A&E departments
- Support on discharge for vulnerable patients from the British Red Cross
- Increased access to specialist nurses
- Updated technology to speed up sickle cell transfusions

An acute organisation’s percentage of readmissions to hospital within 28 days is measured and reported as a mandated Quality Account core indicator. To see Barts Health’s performance compared to the best, worst and average trusts in England for 2012/13, see Appendix 2. Note that the latest comparable data which has been published is for 2012/13.
Improving care and services for people with mental health needs

Barts Health does not provide mental health services directly. However through our partner trusts - East London NHS Foundation Trust and North East London NHS Foundation Trust - we offer a multidisciplinary psychiatric liaison service for patients who have both mental health and physical healthcare needs. This service is designed to provide prompt assessments, urgent psychiatric treatment and onward referrals to specialist services. Our partners also give advice to Barts Health staff on the appropriate care of patients with combined physical and mental health needs.

Until January 2014, our hospitals in the Tower Hamlets area (Mile End, the London Chest and the Royal London) were covered by a number of different psychiatric liaison teams with varying specialities, only one of which was able to provide a 24 hour service. From January 2014, these services were integrated into a new, 24 hour service using the RAID (Rapid Access Intervention and Discharge) model, with multi-skilled practitioners who are able to deal with most issues or refer appropriately. This model was established and successfully evaluated at Birmingham City Hospital in 2009 and has been successfully implemented by a number of other trusts. The intention is to roll out similar integrated arrangements across all Barts Health hospitals.

Wherever necessary, specialist mental health nurses are employed as temporary staff to provide one to one care for inpatients with acute mental health needs. See the section on page 64 for more information on our work with patients with mental health needs.
Learning from Patient Reported Outcome Measures (PROMs)

PROMs results are used across the NHS to enable organisations to benchmark the effectiveness of operations from a patient's perspective. Clinical teams are encouraged to use PROMs data to inform their quality improvement programmes. Translation services are available to all patients to encourage as many responses as possible. We are required to achieve at least a 50 percent participation rate.

Patients having hip or knee replacements, varicose vein surgery or groin hernia surgery at Barts Health are given a questionnaire under the national PROMs scheme which asks about their health and quality of life before surgery. They are asked questions about the pain they are experiencing, mobility and how they are managing with everyday tasks such as shopping and personal hygiene. Patients who complete this questionnaire are later invited to fill in a second questionnaire about their health six months after their operation. Participation is voluntary, and some patients complete the first questionnaire but choose not to complete the second one.

Hip replacement surgery
According to the most recently released data, in 2012/13, 61.2 percent of patients who had hip replacements completed the first questionnaire. Post-operative questionnaires were sent to as many of those patients as possible, and of those, 71.9 percent returned them.

Based on 154 patients, 94.2 percent reported that their condition improved after hip replacement surgery, against an England average of 97.1 percent. 5.2 percent of patients' conditions had worsened, compared with 2.4 percent, in England. This suggests that the outcomes are worse than the national average, but they are comparable with some other major London trusts. The graph on page 49 shows our results for each question.

Knee replacement surgery
The health gain of total knee replacement surgery can be measured through the Oxford Knee Score, a 12 point patient reported scoring system.

In 2012/13, 51 percent of patients who had knee replacements completed the first questionnaire. Post-operative questionnaires were sent to as many of those patients as possible, and of those, 69.6 percent responded.

Our Oxford Knee Score was based on 194 records. Of those, 84 percent indicated a positive health gain against an England average of 93.3 percent, while 14.9 percent of patients' condition had worsened, compared with 5.6 percent in England. This also suggests that our outcomes are worse than the national average. The graph on page 50 shows our results for each question.

A case review is currently being undertaken to ascertain whether our outcomes for hip and knee replacements correspond with the case mix or health characteristics of patients treated at the hospital. Our orthopaedic service team also plans to verify national PROMs results with data collected locally in electronic health records.
<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the past 4 weeks, how would you describe the pain you usually had from your hip?</td>
<td>40%</td>
</tr>
<tr>
<td>2. During the past 4 weeks, have you had any sudden, severe pain - 'shooting', 'stabbing' or 'spasms' from the affected hip?</td>
<td>38%</td>
</tr>
<tr>
<td>3. During the past 4 weeks, have you been limping when walking, because of your hip?</td>
<td>37%</td>
</tr>
<tr>
<td>4. During the past 4 weeks, have you had any trouble getting in or out of your car or using public transport because of your hip?</td>
<td>36%</td>
</tr>
<tr>
<td>5. During the past 4 weeks, have you been able to climb a flight of stairs?</td>
<td>36%</td>
</tr>
<tr>
<td>6. During the past 4 weeks, have you been able to put on a pair of socks, stockings or tights?</td>
<td>32%</td>
</tr>
<tr>
<td>7. During the past 4 weeks, could you do the household shopping on your own?</td>
<td>31%</td>
</tr>
<tr>
<td>8. During the past 4 weeks, have you had trouble washing and drying yourself (all over) because of your hip?</td>
<td>31%</td>
</tr>
<tr>
<td>9. During the past 4 weeks, how much has pain from your hip interfered with your usual work (including housework)?</td>
<td>28%</td>
</tr>
<tr>
<td>10. During the past 4 weeks, have you been able to walk before pain from your hip becomes severe? (with or without a stick)</td>
<td>28%</td>
</tr>
</tbody>
</table>
Knee Replacement Oxford Score - % of patients who experienced improvement (n=256)

1. During the past 4 weeks, how much pain from your knee?
2. During the past 4 weeks, have you been troubled by pain from your knee?
3. During the past 4 weeks, have you been able to walk before pain from your knee becomes severe? (with or without a stick)
4. During the past 4 weeks, have you had any trouble getting in or out of your car or using public transport because of your knee?
5. During the past 4 weeks, for how long have you been able to stand up from a chair because of your knee?
6. During the past 4 weeks, after a meal (sat at a table), how much pain has it been for you to stand up from a chair because of your knee?
7. During the past 4 weeks, have you been limping when walking, because of your knee?
8. During the past 4 weeks, how would you describe the pain you usually had from your knee?
9. During the past 4 weeks, how much pain from your knee interfered with your usual work (including housework)?
10. During the past 4 weeks, have you felt that your knee might suddenly 'give way' or let you down?
11. During the past 4 weeks, could you walk down one flight of stairs?
12. During the past 4 weeks, could you do the household shopping on your own?

75% 75% 70% 69% 64% 61% 61% 59% 57% 52% 50% 42%
Varicose vein procedures
Provisional 2012/13 data show that fewer patients than expected returned pre-operative questionnaires before their procedures. Case mix adjusted figures enabling us to compare varicose vein surgery outcomes with other organisations were not available from the Health and Social Care Information Centre at the time of publishing this Quality Account.

Groin hernia procedures
Case mix adjusted data showing health gain after groin hernia procedures suggests that outcomes at Barts Health are comparable with other trusts in England.

Over the next year, we will continue to use patient feedback to improve our services, and assess how patients view the outcomes. To draw on their experiences, we will seek to improve participation levels in patient surveys in 2014/15.

An acute organisation’s PROMs outcome measures scores are measured and reported as a mandatory Quality Account core indicator. To see Barts Health’s performance compared to the best, worst and average trusts in England for 2012/13, see Appendix 2. Note that the latest comparable data which has been published is for 2012/13.

Faster access to emergency care
The Department of Health standard for access to emergency care is for 95% of patients who attend an NHS Accident and Emergency department to be assessed, treated, admitted or discharged within four hours. Barts Health achieved this standard in 2013/14 with an overall figure of 95.03%.

Nationally, a review by Professor Sir Bruce Keogh into urgent and emergency care was published in November 2013, and we are currently considering its implications for our services.

The diverse nature of our local population means we need to provide a generic, high-quality responsive service to cater for the general population, as well as local pathways and networks to meet the needs of our particular communities. In addition, The Royal London Hospital is home to one of the four major trauma centres for London. It is one of the highest performing trauma centres in the country, with an international reputation for treating patients with very complex injuries. The 2013/14 data shows that, although monthly attendance figures in our A&Es are comparable to 2012/13, acute hospital admissions have increased by ten per cent in some months, suggesting that we are dealing with more complex cases than before. Patient acuity, particularly over the winter months, is currently being reviewed.

London’s Air Ambulance, the helicopter emergency medical service, is based at The Royal London Hospital and delivers advanced services to critically injured people throughout the M25 area. The team’s work has featured in major television programmes over the year, including BBC2’s An Hour to Save Your Life and Channel 5’s Trauma Doctors.
How we plan to drive forward improvements
During 2013/14, we concentrated on standardising services in our three A&E departments and developing schemes in close partnership with local agencies. Emergency access is managed across Barts Health by the Emergency Care and Acute Medicine (ECAM) Clinical Academic Group who will continue to lead a number of initiatives to improve standards through collaboration and sharing best practices and resources.

To ensure that all patients are assessed and treated in a timely manner, ECAM will take the following steps in 2014/15:

- Work closely with partner organisations to design programmes to help reduce attendances, avoid admissions and promote early discharge
- Continue to develop effective streaming and ambulatory care pathways to avoid unnecessary admissions to hospital for less acute conditions
- Improve length of stay across all services, ensuring that patients do not stay in hospital any longer than is clinically necessary
- Ensure effective resourcing and alignment of processes in our three EDs to optimise patient experience and flow
- Identify opportunities for system-wide collaboration to develop pathways for complex conditions, particularly focusing upon older patients, using case management and best practice methods

Planned care – the 18 week pathway
When a patient is referred to hospital by their GP, they should have to wait no longer than 18 weeks for their first definitive treatment, whether this is as an outpatient or an inpatient. The Department of Health standard is for this to be achieved for at least 95% of patients requiring treatment as an outpatient and 90% of patients requiring admitted care.

The Trust’s overall performance against the 18 week targets has regrettably worsened in the last year. A number of factors have contributed to this situation, including our ability to provide sufficient clinical capacity to meet demand and sustain activity levels in order to carry on meeting the target. A review of our reporting systems also identified some fundamental underlying issues in the way that patients were being placed on lists and prioritised for treatment. As a result, our waiting lists grew in size and length.

To improve performance, the Trust launched a comprehensive recovery programme in November 2013, agreed with the Trust Development Authority and our commissioners. It is fundamentally made up of two phases of work:

- Clearing the backlog of patients waiting over 18 weeks - plans are in place to deliver increased activity in those areas where we are experiencing the greatest problems, and these plans are monitored weekly. Patients who have been waiting the longest, and especially those over 52 weeks, are being prioritised for treatment
- Sustainable improvement - work is under way to make the necessary changes to help us sustain shorter waiting times in future. This includes launching a new Trust-wide access policy (which sets out the criteria for patients to be admitted to our services), rolling out a Trust-wide training programme for staff who manage waiting lists, aligning capacity with demand, redesigning services, raising awareness and improving communications both internally and externally.

Barts Health has given a commitment that we will meet our 18 week performance standards by the end of June 2014, except for trauma and orthopaedics where the commitment is for compliance by the end of September 2014. Figures for February 2014 show that the number of patients waiting over 18 weeks for treatment dropped to 8,598 from 11,237 in November 2013. The number of patients waiting over 18 weeks for treatment is reducing and we are on track to deliver the commitment given.

Cancer care

Referral and treatment standards
We are measured on nine different waiting time standards for cancer patients, and we are on course to achieve six of them in 2013/14. Our performance against each standard is detailed in the table below. Note that the data is provisional at the time of publishing this Quality Account.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Target</th>
<th>2013/14 Provisional performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 day GP referral to date first seen</td>
<td>93%</td>
<td>92.1%</td>
</tr>
<tr>
<td>14 day GP referral for breast symptoms to date first seen</td>
<td>93%</td>
<td>93.8%</td>
</tr>
<tr>
<td>31 days from decision to treat to first treatment</td>
<td>96%</td>
<td>98.8%</td>
</tr>
<tr>
<td>62 day urgent GP referral to treatment</td>
<td>85%</td>
<td>84.6%</td>
</tr>
<tr>
<td>62 day GP referral for breast symptoms to first treatment</td>
<td>Locally monitored</td>
<td>90%</td>
</tr>
<tr>
<td>62 day from screening programme referral to treatment</td>
<td>90%</td>
<td>94.9%</td>
</tr>
<tr>
<td>62 day consultant upgrade to first treatment (where a consultant detects a cancer where one was not originally suspected on referral)</td>
<td>85%</td>
<td>84.6%</td>
</tr>
<tr>
<td>31 days from decision to treat to subsequent treatment – drugs</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>31 days from decision to treat to subsequent treatment – surgery</td>
<td>94%</td>
<td>95%</td>
</tr>
<tr>
<td>31 days from decision to treat to subsequent treatment – radiotherapy/other</td>
<td>94%</td>
<td>98%</td>
</tr>
</tbody>
</table>

In 2013/14, a great deal of work was put into meeting the target for at least 85% of patients to start their treatment within 62 days of an urgent GP referral for suspected cancer. This measure was not achieved in 2012/13, when we fell slightly short at 83.46%. Following a review of our systems and pathways, we improved our performance, although we still narrowly missed the target.

To ensure that we sustain and improve our performance in 2014/15, we are taking the following steps to improve our cancer pathways:

- Providing more specialist multi-disciplinary clinics where patients can see an onocologist, surgeon, radiotherapist and specialist nurse practitioner on the same day and discuss their diagnosis and treatment
- Streamlining the pathways between our hospitals and other providers so that patients can receive high quality care in the best place for their needs in a timely fashion
- Reviewing our systems to ensure that patients have access to specialist diagnostics as soon as possible, so that more people get specialist treatment at an early stage of their disease

**Cancer staging**

Cancer staging is the process of identifying the severity and treatability of each patient’s cancer. In our 2012/13 Quality Account, we reported with regret that Barts Health was one of the poorest performing trusts in London for the quality of cancer staging data collected - we only recorded consistent staging data for 30 percent of cancer patients. Over the past year, this has increased to over 80 percent, making us one of the highest performing trusts in the country.

Improving the consistency of staging data was also a local CQUIN project in 2013/14 at Whipps Cross, which we successfully delivered.

**Cancer patient experience – we still need to do better**

We were extremely disappointed by the results of last year’s NHS National Cancer Patient Experience Survey. Barts Health was also ranked the second worst trust in England in Macmillan Cancer Care’s league table, published in September 2013.

As a direct result, a weekly taskforce has been set up to help improve our position. The group is clinically led, with attendance from a variety of staff involved in providing cancer care. To respond to concerns, clinical care has been standardised across all cancer specialties to ensure we provide a consistently good patient experience and that high quality information is more readily available for patients.
We have also conducted our own local survey to prepare ourselves for the national survey which will take place later in 2014. For more information about the work we are doing and what has been achieved over a short period of time to change the experience of patients with cancer and their families, see page 97.

**Mixed-sex accommodation**

We continue to provide patients with privacy and dignity, but their clinical needs always come first. The NHS Trust Development Authority (TDA) and NHS England wrote to all acute trusts in August 2013 stating that they had identified variations from the national guidance in London trusts’ reporting of mixed sex accommodation (MSA) breaches.

Following a review, we found that we were not following national guidance in all instances for critical care. We have now resolved this issue by introducing a revised method of reporting in September 2013. However, there may be occasions when, on safety grounds, a breach of MSA guidelines may be necessary, so that the patients’ clinical needs can be prioritised. These instances will still be reported as a breach.

The following table shows the number of breaches month by month at each of our hospitals for the period April 2013 to January 2014.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>MEH</th>
<th>SBH</th>
<th>LCH</th>
<th>NUH</th>
<th>RLH</th>
<th>WXH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 2013</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>5</td>
<td>38</td>
<td>7</td>
<td>61</td>
</tr>
<tr>
<td>May 2013</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>6</td>
<td>12</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>June 2013</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>37</td>
<td>2</td>
<td>51</td>
</tr>
<tr>
<td>July 2013</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>39</td>
<td>4</td>
<td>55</td>
</tr>
<tr>
<td>August 2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>29</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>September 2013</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>11</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>October 2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>November 2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>December 2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>January 2014</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>45</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>42</td>
<td>257</td>
<td>32</td>
<td>355</td>
</tr>
</tbody>
</table>

Key to hospital sites:

- LCH – The London Chest Hospital
- MEH – Mile End Hospital
- NUH – Newham University Hospital
- RLH – The Royal London Hospital
- SBH – St Bartholomew’s Hospital
- WXUH – Whipps Cross University Hospital

**Meeting mixed-sex accommodation standards at The Royal London Hospital - challenges and solutions**

The level of mixed sex accommodation breaches at The Royal London has reduced during 2013/14 from an average of 80 a month to 30 or less. The majority of these breaches occur within the hospital’s adult critical care unit and are mainly due the difficulties we experience in discharging patients to specialist beds in a timely manner, particularly patients with tracheostomies who need specialist monitoring as part of their ongoing care.

Improvements have been made in anticipating discharges and communicating these at each bed meeting, held three times per day. This means that appropriate arrangements can be put in place to care for patients requiring one to one care. We recognise that more needs to be done to improve patient flow as well as specialist bed capacity, and we are currently conducting a review to enable us to improving access to care in the most appropriate environment for each patient.
Improving outpatient care and responding to feedback

The majority of the care we provide is through our outpatients departments, where we have over 1 million contacts with patients every year. Each contact represents an opportunity to improve the health of patients and ensure that their experience at our hospitals is the best it can possibly be. Outpatient departments are the first point of contact for most patients, and improving our outpatient services represents a major opportunity to improve overall standards of care. We are committed to working effectively with local GP practices and Clinical Commissioning Groups and the feedback that they provide is very valuable.

One of the major areas for improvement requested by GPs and patients was that outpatient letters should be completed more quickly and definitely within five days of the appointment. In 2013/14, our performance increased significantly. The average time for letters to be issued reduced from 22 days in May 2013 to 13 days in January 2014.

We have also focused on waiting times within clinics. In December 2013 we carried out a week long audit for over 1,000 outpatient settings to illustrate a snapshot of the waiting times. The following table outlines the findings.

<table>
<thead>
<tr>
<th>Barts Health totals</th>
<th>Number</th>
<th>Percentage of the total number of clinics audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clinics audited</td>
<td>1,004</td>
<td></td>
</tr>
<tr>
<td>Number of clinics with zero waiting</td>
<td>343</td>
<td>34%</td>
</tr>
<tr>
<td>Number of clinics with less than 30mins average waiting</td>
<td>500</td>
<td>50%</td>
</tr>
<tr>
<td>Number of clinics with more than 30mins average waiting</td>
<td>161</td>
<td>16%</td>
</tr>
</tbody>
</table>

The snapshot audit shows that 84 percent of outpatient clinics have less than 30 minutes’ waiting time. Our standard is 90 percent so we still have work to do, but we have already made good progress.
Loss of income due to non-achievement of operational and other performance targets

Whilst we have reported on some achievement and improvement against operational and clinical performance targets, the areas where we remained under challenge in 2013/14 resulted in loss of income totalling £57 million. The following table shows how this was allocated.

<table>
<thead>
<tr>
<th>Non-achievement of operational targets</th>
<th>Value of income deducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks referral-to-treatment</td>
<td>£5.6m</td>
</tr>
<tr>
<td>52 week waits for treatment</td>
<td>£3.7m</td>
</tr>
<tr>
<td>Emergency care (A&amp;E) four hour standard</td>
<td>£1.2m</td>
</tr>
<tr>
<td>Cancer</td>
<td>£1.1m</td>
</tr>
<tr>
<td>Other</td>
<td>£1.0m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£12.6m</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Productivity metrics</th>
<th>Value of income deducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant-to-consultant referrals</td>
<td>£0.4m</td>
</tr>
<tr>
<td>Day case to outpatient conversion rate</td>
<td>£2.0m</td>
</tr>
<tr>
<td>New-to-followup appointment ratio</td>
<td>£5.6m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£8.0m</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readmissions and threshold</th>
<th>Value of income deducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency threshold</td>
<td>£10.2m</td>
</tr>
<tr>
<td>Emergency readmissions</td>
<td>£10.8m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£21.0m</strong></td>
</tr>
</tbody>
</table>

| Commissioner challenges                                     | £11.3m                     |
| CQUINs                                                      | £4.0m                      |
| **Grand total**                                             | **£57.0m**                 |
Improving communication with GPs

During 2013/14, we have made a sustained effort to improve communication with our primary care colleagues, something which is central to the achievement of our quality priorities, especially in ensuring that the right patient is treated in the right place at the right time and improving standards of care. Our primary care team includes three local GPs who help our clinical teams work better with GP practices and advise the Trust Board on issues that have potential implications for primary care.

Our relationship with our local clinical commissioning groups (CCGs) and GPs has been strengthened over the past year through a range of initiatives:

- **Improving our patient administration systems** - In response to feedback from GPs, our outpatient improvement board led a programme to improve the turnaround time for letters we send to GPs. We will continue to improve our performance in this key area with an emphasis on the quality and timeliness of letters and discharge summaries.

- **Identification of clinical risks** – We have worked with Newham and Tower Hamlets CCGs to develop alert systems for GPs to highlight any problems, such as delays in providing diagnostic test results. This service will be expanded to Waltham Forest over the coming year. The data will feed into our monthly Trust Board complaints report.

- **Clinical engagement forums** - The Trust holds regular forums with primary care colleagues and CCGs at Newham, The Royal London and Whipps Cross hospitals to discuss strategic and operational issues, including integrated care, urgent care, service transformation and feedback about our services. We also offer tours of our services to our primary care colleagues.

- **ICT and innovation** - Our ICT team has worked with GP leads and our supplier Cerner to develop the Health Information Exchange (HIE) for East London. This innovative service provides clinicians with a summary view of patients' medical information via a secure system to protect confidential data. It is accessed via the Trust’s Electronic Health Record system and the local GPs’ electronic system (EMIS). 80 percent of GPs in Newham and Tower Hamlets have already signed up. This is the first stage of a two-year strategy, which will connect all GPs and our six hospital sites and will eventually include community and social care systems and the option for patients to access their own clinical information. We have also worked successfully with our CCG colleagues to develop innovative clinical care pathways, for example, the “straight to test” colorectal pathway at Whipps Cross University Hospital which avoids patients needing to attend an outpatient appointment before they can have a diagnostic test. This development was shortlisted for a British Medical Journal Excellence Award.

- **Education and training** - Our consultants provide educational sessions for practices across our hospital sites. Our ‘grand rounds’ - multi-professional educational sessions where clinicians meet to share and discuss case presentations, results from audits, best practice or information - are open to GPs. We will continue to collaborate with our CCGs, UCLPartners and Queen Mary University of London to develop education and research opportunities for primary care clinicians.

- **Recognising success** - Several outstanding teams and individuals were nominated by GPs for our 2014 Barts Health Heroes awards, including the adult respiratory care and rehabilitation team at the London Chest Hospital, The Royal London Hospital’s Stroke team and Andrew Wragg, Consultant Cardiologist, in recognition of the excellent patient outcomes delivered and their strong relationships with practices.
Our dementia strategy – improving screening and care in hospital

Across the UK, one in three people over the age of 65 suffers from dementia, a syndrome associated with the decline of the brain and its abilities. This can cause problems with memory loss, thinking speed, mental agility, language, understanding and judgement. The growing older population in London means that dementia is an increasing focus for health services across the capital. Estimates suggest that nearly one in 100 Londoners has dementia, and this is expected to rise by 16 percent over the next seven years.

At Barts Health, we are committed to meeting the needs of the population through our dementia strategy. It is based on seven key principles, identified by the NHS London Acute Hospital Network for Dementia. The seven principles are:

- Providing strong leadership for dementia throughout the Trust
- Offering care that is person-centred and individual
- Creating environments that are dementia friendly
- Assessing and identifying dementia at an early stage
- Supporting people with dementia to be discharged back home
- Ensuring that staff are skilled and have the time to care
- Forging strong working partnerships with patients, carers and other agencies

The national dementia CQUIN

All hospital trusts are required to meet targets for dementia care under the national CQUIN programme. We have made significant efforts to meet these targets, but we fell short in 2012/13. Estimates indicate that we will do so again in 2013/14. Every effort continues to be made and we are determined to improve further in 2014/15.

FAIR – Find, Assess, Investigate, Refer

There are three main areas of focus in the CQUIN, based around the FAIR model.

- **Find** - the target is to assess at least 75 percent of all patients over the age of 75 for dementia/delirium, following an emergency admission to hospital. This has to be completed within 72 hours of admission. It involves identifying whether the patient has an existing diagnosis of dementia, a diagnosis of delirium (a state of mental confusion), or if they have become more forgetful in the past 12 months.

- **Assess and Investigate** - the target is for at least 75 percent of the patients who are identified as being at risk of dementia/delirium to be assessed and referred on for specialist input as necessary. This is challenging, given the differing nature of recording assessments currently in use in each of our hospitals. We now have an electronic recording systems in place at our three main sites – Newham, The Royal London and Whipps Cross hospitals – and are hopeful that this will help us deliver a significant improvement.

- **Refer** – the target is for at least 75 percent of all clinically appropriate cases to be referred for specialist diagnosis and follow-up. Day patients, patients staying less than 72 hours, transfers and elective admissions are not included in this target.

**How we measured up to the FAIR challenge across Barts Health in 2013**

The figures below show compliance with the CQUIN target.

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find</td>
<td>50%</td>
<td>51%</td>
<td>41%</td>
<td>63%</td>
<td>64%</td>
<td>49%</td>
<td>75%</td>
</tr>
<tr>
<td>Assess &amp; Investigate</td>
<td>87%</td>
<td>70%</td>
<td>74%</td>
<td>91%</td>
<td>95%</td>
<td>93%</td>
<td>75%</td>
</tr>
<tr>
<td>Refer</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>18%</td>
<td>8%</td>
<td>12%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Overall, it is evident that we still have some way to go. Our electronic system to record the full CQUIN data set only went live at Whipps Cross Hospital in March 2014, before which referral data was collected manually. Considerable work is taking place to embed the CQUIN into all our departments to develop robust recording systems that are clinically appropriate and easy to use.

**Carer audits**
The carer audit is a new initiative introduced by the CQUIN in 2013/14. We have been carrying out audits since August 2013 following the development of an appropriate survey tool. Every month, we invite carers of people with dementia to complete a short survey when their relative or friend is admitted to hospital. This determines the caring responsibilities of the person completing the form and asks four questions:
1. Did staff ask you about details that would help them to care for your relative/friend such as their usual routine, preferences, or advice on anything that might cause distress or agitation?
2. Were you involved in the care of your relative/friend as much as you wanted to be?
3. Were you offered information about carer/family support services, for example from the Alzheimer’s Society or Crossroads?
4. Were you given information on how to get a carer’s assessment and what it involves?

The results are collated by our clinical effectiveness unit. In 2013/14, feedback suggested that we could do more to ask carers about details that would help us to care for their friend or relative. As a result we are piloting national Forget Me Not resources to record and display this information so that it is accessible to all members of staff who may find it helpful.

Training
At the start of 2013, we developed a Trust-wide training programme that will help us to create and maintain a dementia-friendly environment. Our ultimate aim is that:
- All staff working for Barts Health should be dementia aware
- Staff will have the knowledge and skills, appropriate to their roles, to support all people with dementia who are patients of or visitors to Barts Health
- We can tap into the expertise within the Trust to support the training and education of all staff

In addition, we now provide basic awareness sessions as part of Trust inductions, and offer bespoke dementia care programmes with modules that focus on communication, delirium, nutrition, pain management and challenging behaviour. Dementia awareness is included in our statutory and mandatory training booklet and all staff have access to a dementia e-learning programme. Over the coming year, we will continue to deliver our training plan, specifically aiming our dementia awareness sessions at areas and departments of the Trust that have not previously been targeted, such as reception staff, domestic/catering staff and clinical staff who do not routinely work with older people.

Tower Hamlets Community Health Services (CHS)
Barts Health provides a comprehensive range of community services in Tower Hamlets, covering all age ranges from before birth upwards. Services are delivered in people’s homes, or locally through community centres, health centres, children’s centres, schools and GP practices.

Our CHS team works in partnership with Tower Hamlets Clinical Commissioning Group, the London Borough of Tower Hamlets and other health and social care providers to develop integrated care across adult and children’s services.

From April 2014, community health service teams have been fully integrated into the Barts Health Clinical Academic Group (CAG) structure. Most CHS services now sit within either the Emergency Care and Acute Medicine (ECAM) or Women’s and Children’s CAGs.

Achievements during 2013/14
- Implementation of a new CHS management structure, developing clinical lead posts across all CHS services aligned to the GP Local Area Partnerships structure
- Integration and restructuring of the Community Virtual Ward, including case managers, the adult community nursing service, the community rehabilitation and support service and the palliative care centre to create locality community health teams. The teams include nurses, care navigators, therapists and social workers. Psychiatric nurses will join these teams in the future. The focus of the teams is to deliver care at home, promoting self care and preventing admission for the most vulnerable people
- Creating a hub of specialist support services which includes a single point of access and referral hub, an out of hours service and a night nursing service
• Engagement with the Department of Health’s Call to Action for Health Visitor Implementation Plan. Through this initiative there was a significant increase in the number of student health visitors appointed by the Trust, and we are on track to achieve 75 percent of the trajectory by January 2015
• Improvement in the recruitment and retention of the workforce across CHS with the development of new roles (such as care navigators) and working with the Barts Health Education Academy to support newly qualified nurses within community teams
• The CHS teams also continue to support the drive to improve integrated care across north east London. Successes in 2013/14 include the integration of the community and acute stroke teams, which has allowed the service to provide a co-ordinated approach to ongoing care for patients. Referral processes between the teams have been streamlined and the single team approach allows patients to be cared for by the appropriate healthcare professional in the most appropriate place, be that in their home or in hospital

Supporting people to achieve better health

A successful smoking cessation project at Whipps Cross University Hospital

One of our public health priorities is to help reduce the number of patients who smoke. For patients who stop smoking, the benefits can include fewer complications following operations, faster wound healing and a lower risk of infection. There may also be a reduced risk of smoking related diseases and premature death. Evidence shows that smokers are up to four times more likely to give up with support, and that patients admitted into hospital are more motivated to stop.

Last year, Barts Health agreed a local CQUIN with our local commissioners, under which frontline staff at Whipps Cross would refer 1,770 smokers to stop smoking services by March 2014 - 270 inpatients, 1,350 outpatients and 150 expectant mothers. The target also required 420 staff to be trained on how to make stop smoking referrals. The CQUIN included an £800,000 financial payment.

Staff training
Since April 2013, a total of 462 staff at Whipps Cross have been trained to offer stop smoking advice and referrals to the stop smoking service, exceeding our target of 420.

Stop smoking referrals at Whipps Cross University Hospital

The table below shows the number of referrals made from June 2013 to March 2014. Quarter 1 (April, May and June 2013) was a preparatory period and therefore referrals from that quarter are not included.

<table>
<thead>
<tr>
<th>Clinical area</th>
<th>Number of patients referred for smoking cessation</th>
<th>CQUIN target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>405</td>
<td>270</td>
</tr>
<tr>
<td>Outpatients (including pre-operative assessment)</td>
<td>1,482</td>
<td>1,350</td>
</tr>
<tr>
<td>Maternity</td>
<td>158</td>
<td>150</td>
</tr>
<tr>
<td>Total</td>
<td>2,081</td>
<td>1,770</td>
</tr>
</tbody>
</table>

In the whole of 2012/13, the Whipps Cross team referred 78 patients to the stop smoking service, according to North East London NHS Foundation Trust. In the shorter period from June 2013 to March 2014, the team referred 2,081 patients. Our targets for inpatients, outpatients and staff training have all been exceeded.

When we first set out to achieve our goal, there was no clear system in place for making smoking cessation referrals. We have since introduced a national electronic referral management system for staff to use. Between April 2013 and March 2014, 46 frontline staff at Whipps Cross have completed training on using the referral system, and numbers continue to rise. Staff were asked to complete ten minutes of online training to
build their confidence and understand the importance of recording the patient’s smoking status, advising the patient of the health benefits of stopping smoking and offering a referral to the stop smoking service.

Progress can also be attributed to staff commitment to achieving the targets, leadership from senior medical staff, the financial incentive, sponsorship of promotional materials, effective internal communication and continual progress updates for staff.

NICE featured our work in a video about smokefree hospitals in November 2013. We also generated positive media coverage for our efforts in publications including the local Waltham Forest Guardian newspaper in November 2013 and the Nursing Times in January 2014.

Next steps
Across the Trust, we have referred 2,568 patient smokers to stop smoking services since April 2013, with around 74 percent of these referrals being made at Whipps Cross Hospital, which is leading our referral and staff training rates. During 2014/15, we will build on our success so that the support we offer to patients who wish to stop smoking is consistently good on all our sites. We will also do more work to establish how long patients remain “smoke free” after quitting through the stop smoking service.

Members of our public health team promote No Smoking Day in March 2014
Quality priority 4 - Improving standards of care

Working with patients who may be vulnerable

Safeguarding children

Over the past year, we have been strengthening processes and policies across the Trust for safeguarding children. Overall, we have made good progress. We have taken our lead from the recommendations of the Munro Review of Child Protection - a review into frontline child protection practices - and Working Together to Safeguard Children 2013 - a national guide to inter-agency working.

Change is being driven by the new Barts Health safeguarding children supervision policy. This was ratified in July 2013 and is being implemented across the Trust. The approach is based on the Signs of Safety method originally developed in Australia. It offers staff a solution-focused and safety-based approach for child protection work.

Training provision for Trust staff has been increased with new training packages and easier access to training, including via bespoke sessions for ward teams and a new Trust-wide statutory and mandatory training booklet which was distributed to all Barts Health staff during the summer of 2013.

Since April 2013, Barts Health’s compliance with each level of child safeguarding training is as follows:
- Level 1 – 96 percent (up from 69 percent in the previous year)
- Level 2 – 93 percent (up from 50 percent in the previous year)
- Level 3 – 87 percent (up from 45 percent in the previous year)

We are pleased to have met our Care Quality Commission target of 80 percent compliance across every level. However, we have not met the more stringent target of 95 percent set by the NHS Litigation Authority for levels 2 and 3, and will address this during 2014/15 through further training. Combined level 2 and 3 classroom based sessions have been introduced to promote attendance and increase our compliance.

The implementation of the new supervision policy has been prioritised within specific areas of the Trust, including emergency departments, sexual health services and acute paediatric areas. This will take place over the coming year. The policy is already well established in other services for young people aged from birth to 19.

We also work closely with our partner agencies. Tower Hamlets’ multi-agency safeguarding hub (MASH) is now fully functional. Barts Health is represented by a health specialist, who contributes to the timely sharing of relevant information with other key agencies when children or young people are considered to be at risk of harm or in need of protection. In Newham and Waltham Forest, Barts Health contributes the work of the MASH by providing timely responses to requests for information pertaining to children who may be at risk.

Safeguarding adults

The past year has been a time of transition and development for the adult safeguarding team. A new team is now in post, including a safeguarding lead, a co-ordinator and a learning disabilities nurse. We have also made an interim appointment to lead on application of both the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards guidance to our work. They provide a legal framework to help ensure we do not inappropriately restrict the freedom of anyone in our care. The post holder will also be focusing on implementing the Prevent Strategy, a nationwide initiative that is designed to protect and support vulnerable individuals.

Our main achievements in 2013/14 were:
- Developing a safeguarding adults referral tracker, helping all reported incidents to be managed swiftly and effectively. The tracker provides summary information to the Clinical Academic Groups every fortnight, so that directors of nursing are aware of the alerts in their areas and any outstanding concerns. It also provides a point of reference for the safeguarding team so that progress can be measured.
Significantly improving our compliance with adult safeguarding training. In December 2013, compliance was 96 percent for mandatory level 1 awareness training and 94 percent for level 2, compared to 70 percent for level 1 and 60 percent for level 2 in May 2013.

Working closely within our three main boroughs – Newham, Tower Hamlets and Waltham Forest – to develop procedures to ensure timely and effective multi-agency working. This will be a key focus again in 2014/15.

**Plans for 2014/15**

Training for the Prevent Strategy will start in our A&E departments. The safeguarding children team will be involved in the organisational assessment process to ensure that we adopt an integrated approach. We will also adopt and undertake the national safeguarding adults risk audit, which will be monitored by NHS England. The audit will enable us to identify and share good practice and common areas of improvement across all agencies, as well as priorities for improvements specific to Barts Health.

**Improving standards of care for people with learning disabilities**

There is national concern about the care and treatment of people with learning disabilities and the provision of accessible healthcare services tailored to meet their needs. All NHS organisations must provide equitable access to health services. At Barts Health, we have developed a ‘hospital passport’ for people with learning disabilities that outlines each patient’s particular requirements. This enables us to provide reasonable adjustments so that staff can provide the best possible care and treatment. Reasonable adjustments include removing physical barriers to accessing health services and making whatever alterations are necessary to policies, procedures, staff training and service delivery, to ensure that they work equally well for people with learning disabilities.

**Progress this year**

To strengthen our protection of vulnerable patients we have appointed a lead nurse for learning disabilities whose role includes implementing our learning disability strategy, based on the recommendations for hospital settings in Healthcare for All, published by the Department of Health in 2008. Key priorities and achievements include:

- **Ensuring that there is a mechanism in place to identify and flag patients with a learning disability (LD)** - this is in place across The Royal London and Whipps Cross hospitals and we are working to embed it at Newham, so that ultimately we have a single integrated system. We have already been able to proactively flag up over 800 individuals known to the Tower Hamlets LD team, and will work to ensure the same facility is available for patients living in Newham and Waltham Forest.

- **Pathways of care should be reasonably adjusted to meet the care needs of people with LD** - we use initiatives including the hospital passport to allow staff to make reasonable adjustments. We have developed a pathway for our three A&E departments which is now being implemented.

- **Providing comprehensive information jointly designed and agreed with people with LD and/or local partnership agencies** - we produce ‘easy read’ information including leaflets about dental, orthotic and epilepsy services and complaints.

- **Training for frontline staff** - there is an e-learning programme in place and a focus on raising awareness of LD within frontline staff groups. Carers and service users are involved in the training.

- **Supporting patients and carers so that they can help to plan and develop services** - we have an LD steering group with representation from carers and local community LD teams. Our lead nurse for LD links with local partnership boards and user groups.

Our lead nurse also works closely with local LD teams to create a shared vision for health – specifically around the support for flagging, the use of the hospital passport, complex admissions and discharge, and hospital avoidance.

Our priorities for 2014/15 will include:

- Continuing to support people with LD, underpinned by data and analysis.

- Regularly auditing and monitoring outcomes, for example assessing the use of the hospital passport and responses to the Mental Capacity Act in our three A&E departments.
• Continue to make reasonable adjustments in our processes for people with LD, for example providing one to one support for inpatients delivered by patients’ own carers when needed, and introducing a reasonable adjustments/risk assessment tool for inpatients
• Developing a carers’ policy/guidance document
• Increasing the availability of ‘easy read’ information
• Continue to train more staff, including medical staff, and focus on specific issues such as communication, autism and the Mental Capacity Act

Improving standards of care for older people

This has been a major priority for Barts Health during 2013/14, in particular building on the success of our older people’s improvement project, which was designed specifically to drive up standards of safety and compassionate care for patients over the age of 65. Patients in this age group occupy up to two thirds of acute general hospital beds across the NHS.

Teams from 14 wards across Barts Health have now completed the development programme, which was established to promote high standards of care, compassion and give patients more of a voice. The programme draws on wide expertise from across the Trust, as well as external networks including academic and patient reference groups. It is based on the publication Best Practice for Older People in Acute Care Settings, the gold standard for nurses defined by City University London and patient representative groups, and guidance from the Nursing and Midwifery Council.

Each of the participating wards attended a week long learning hub between June and November 2013. During this time, the learning needs of staff were identified and sustainability plans were devised. A specially recruited older people’s shadow team was appointed to cover the wards involved, to allow regular staff to attend the training. The shadow team performed extremely well and a large proportion of these staff have been retained as part of the Barts Health workforce. We were delighted when the shadow team leader won an NHS Leadership Academy Award in the national ‘Emerging Leader 2013’ category. The programme team presented their work at the Royal College of Nursing’s Older People’s Nursing conference in March 2014.

Feedback from the exercise

All wards successfully completed the learning hubs. Feedback from a staff survey following the hubs showed greater levels of engagement and motivation amongst the staff who had participated, whilst patient safety and complaints data showed a significant improvement. All the staff who participated in the programme said that they were committed to making individual and team changes in their work with older people. 99 percent of participants ‘strongly agreed’ that the exercise had made a significant difference to the care that they provide, with one percent stating they ‘agreed’. One participant reported “We now know what A+ looks like and we are striving to get there.”

Future developments in 2014/15

Over the coming year, we will build on this success by:
• Further developing the knowledge and skills of staff in our older people’s service through workshops and other educational activities
• Working with London South Bank University on the introduction of three modules for staff working with older people to develop expertise in pain, discharge planning and rehabilitation
• Focusing on specific areas for improvement on our wards, including safeguarding, falls, pressure ulcers, the culture of care, ward communication and team engagement
• Building on the consultant nurse-led “Support and Sustain” team to lead quality improvements
• Regularly reviewing progress against action plans set by the Support and Sustain team
• Building on environmental improvements that will benefit older people
• Promoting opportunities for the dissemination of best practice, for example holding a mini conference for wards to share best practice
• Disseminating best practice through the wider development of ward senior sisters and charge nurses across the Trust as part of a leading care programme

In addition, patients’ views on service improvements are being sought through the patient representative mentor scheme. This is being piloted at Whipps Cross University Hospital, where 16 patients are working
together with senior sisters and charge nurses on shared goals and developments. Feedback to date from patients and relatives shows that improvements are bringing results. Comments include:
- “This nurse showed compassion … She weighed up the benefits of allowing relatives to stay and decided it was in the interest of the patient and relatives.”
- “The Nurses made time to talk to him about football and he was included in all the conversations going on. This was a very positive experience for him as he felt ‘part of it’ but also it seemed to save the nurses a lot of stress as he was settled and happy.”

**Improving care for patients detained under the Mental Health Act**

The Trust is registered with the Care Quality Commission to detain patients under the Mental Health Act. This may be necessary where a patient develops acute mental illness during the course of their admission, or where a patient already detained at a mental health hospital requires admission to Barts Health for physical health care.

During the year, the Trust detained 162 patients under the Act, either for assessment or for treatment. To meet the needs of these patients, we have established a new senior management post with specific responsibility for the Mental Health Act. We have recently strengthened our Mental Health Act framework by:
- Appointing specialist associate hospital managers who are trained to review the detention of patients held under the Mental Health Act
- Establishing a new service level agreement for Mental Health Act management with each of our partner trusts
- Establishing a Mental Health Act committee

Arrangements for the care and assessment of patients with mental illness in Tower Hamlets have been strengthened by the establishment of a new, integrated, psychiatric liaison service, hosted at The Royal London Hospital and provided by East London NHS Foundation Trust. This team is available 24 hours a day to assess patients with mental health issues, advise our staff on management, and make onward referrals where necessary.

Progress has also been made in consolidating the Trust's policy framework for the care of patients with mental health issues. This has included updating our Mental Health Act policy and our close observation and care of patients with behavioural disturbance policy. Occasionally, patients with mental health problems may need to be physically restrained or prevented from leaving hospital. To cover the safety, welfare and legal issues posed by such a situation, we have developed a new therapeutic restraint and containment policy. We have also agreed a new policy to cover the provision of the special one-to-one care that is sometimes required by patients with mental illness or behavioural disturbance.

In March 2014, the Care Quality Commission (CQC) carried out an un-announced inspection of Jubilee ward, an older people’s ward at Mile End Hospital, specifically to review standards of care for patients detained under section 3 of the Mental Health Act 1983. See the section on working with the CQC for further details.

**Improving standards of nutrition and hydration**

Over the past year, we have worked hard to integrate nutrition and hydration policies across Barts Health, with a special focus on patients who have complex needs. This was initially spearheaded by a Trust-wide nutrition and hydration committee, but it was felt that a more local approach would be the most effective way to engage with staff, and so the Committee was dissolved and replaced by nutrition action groups at each of our hospital sites. These groups have taken action on a range of local issues, including:
- Developing a new menu at Whipps Cross with snack choices for patients who require extra calories, and improving the Halal options
- Placing renewed emphasis on the “red tray” system at Newham, following incidents where patients were found not to have been given sufficient support with eating and drinking. Patients who need help at mealtimes are identified by a red tray, and staff working with older people have been trained in supporting elderly patients to eat without compromising their dignity
- Continuing to improve the quality of snacks at The Royal London, with better provision for patients requiring sustenance and food out of hours
There is also a Trust-wide drive to improve nutrition and hydration, led by our adult nutrition support team. A new policy is in place to promote high standards of care for patients with feeding tubes and an e-learning module has been developed to provide training for practitioners in confirming the correct positioning of these tubes using chest X-rays.

Another policy has been introduced for parenteral nutrition - nutrition introduced via a vein. Key staff have received training in artificial nutrition support. Databases across the Trust have been integrated to monitor patient numbers, and audit complications and outcomes for patients with complex nutritional needs.

Other Trust-wide initiatives included the development of the nutrition and hydration section in our new clinical statutory and mandatory training booklet which was given to all clinical staff in September 2013. This is supported by an e-learning module.

**Compliance with the CQC nutrition standard**
The CQC essential standard or Outcome 5 – Meeting Nutritional Needs - is regularly audited across the Trust. Results from our last audit cycle indicate that 91 percent of patients are being screened using a nutritional screening tool on admission. This tool helps to identify those patients who are at risk of malnutrition or who are already malnourished, and enables the development of a nutrition care plan based on individual client needs. Our audit results show that this occurs in 95 percent of relevant cases. For those who are identified as malnourished, 96 percent will be referred to a relevant healthcare professional, such as a dietician or speech and language therapist, who will assess a patient’s ability to swallow food safely. The results also show that 98 percent of patients are prepared for meals by getting them out of bed, positioning them correctly and enabling them to wash their hands. 98 percent of patients also receive the assistance they require at mealtimes and a red tray is used to ensure those who need additional help are identified.

In November 2013, all our policies and practices came under scrutiny in the Care Quality Commission’s inspection. We were advised to take action “to ensure that all patients receive nutritious food in sufficient quantities”. Some patients and staff commented that protected meal times were not adhered to. The inspectors witnessed nurses and medical staff continuing with their usual activities at mealtimes. Concerns were also raised about the training of catering staff in relation to the provision of special diets.

In response to the findings and recommendations, we will be prioritising the following over the coming year:

- Our nutrition and hydration committee will be re-instated. This will ensure that there is a Trust-wide nutrition strategy and a mechanism for centralising and escalating nutrition related incidents and learning across the Trust. This will require strong support from the Board and medical and nursing leadership
- An overarching Trust-wide nutrition policy will be developed. This will include all aspects of nutrition including food, catering and artificial nutrition support. Protected mealtimes will be reinforced

We are determined to continue improving standards of nutrition and hydration across the Trust. Our catering services at the majority of our sites are currently out to tender, giving us an ideal opportunity to make substantial changes over the coming year. Through careful selection of catering partners and on-going monitoring of the services provided, we will work hard to ensure that every patient receives the food and nutrition that best meets their needs.

**Improving end of life care**
A key action this year was our response to More Care, Less Pathway: A review of the Liverpool Care Pathway chaired by Baroness Julia Neuberger. Published in July 2013, the Government-commissioned investigation called for an overhaul in end of life care. As a result, throughout our hospital settings, we have decided to stop using the Liverpool Care Pathway, a technique used to relieve suffering in the final stages of life.

Immediate guidance was provided for all staff by our specialist palliative care team. More detailed care planning guidance has since been developed, including a Trust-wide teaching and education programme. Information is now available on our staff intranet on good practice for all health care professionals. This is also placed in patients’ notes, along with a recently developed nursing care plan and an initial assessment for dying patients with guidance on medication. Our specialist palliative care team provides an on-call consultant service 24 hours a day, in collaboration with colleagues across north east London.
Palliative care was identified as an area of good practice by the Care Quality Commission in their November 2013 inspection, which noted that "Palliative care was compassionate and held in high regard by staff, patients, friends and family."

In the Tower Hamlets area, the Trust has worked with Clinical Commissioning Group partners to integrate support and end of life services through our Community Health Services and local community health teams. Our aim is to make support more consistently available, linking in to care plans developed by primary care teams.
Our Care Campaign

Becausewe care

Our Care Campaign, launched by chief nurse Professor Kay Riley in August 2013, is the nursing, midwifery and allied health professionals’ response to the Francis Report. It is a call to action to commit to improving compassionate care and patient experience, and is aligned to the Chief Nursing Officer for England’s Nursing Strategy. The Campaign is strongly supported by the Trust Board, our medical staff, managers, corporate departments and volunteers.

Our front line staff devised the campaign known as #because we care, and identified 13 key objectives:

- Best Leadership
- Environment/cleanliness
- Complaints matter
- Accreditation
- Upholding our values
- Safety first – deteriorating patients and
- Eliminating falls and pressure ulcers
- Welcoming and listening to patient and staff feedback
- Everyone matters – team meetings, appraisal and supervision
- Caring with compassion
- Assurance – check outcomes and drive improvements
- Risks are well managed
- Economical – cost effectiveness and productivity

In 2013/14, we held three multi-professional interactive Care Campaign events and managers and patient representatives also attended. These were very popular and aimed to engage as many staff as possible in the Campaign. Social media has also been used to promote the campaign and has been successful in getting people talking about it and involved.

A big impact of the Campaign through its activities and new developments has been in enhancing team working and staff development at ward level. Regular team meetings are now universal, and staff briefings, appraisals and team communication have all improved. The Campaign supported and drove much of the improvement work we have carried out in response to the Care Quality Commission’s inspection of our services in November 2013.

The Care Campaign has also enhanced quality and safety, with the ward Safety Cross initiative being established to record quality of care and incidents in real time.
Les Bailes-Barrett, lead clinical site manager at Newham Hospital, promotes our Care Campaign
Quality priority 5 - listening and feeding back to staff

Recognising, appreciating and rewarding staff

We understand how important it is to thank people for a job well done. Barts Health Heroes was introduced in October 2012 as a way of rewarding and recognising those people who really live the Trust’s values, aiding recruitment and retention and helping to spread best practice. Anyone at Barts Health can be nominated, including volunteers and people directly employed by the Trust or our partner organisations. Nominations can be made by patients, staff, partner organisations and the general public for individuals and teams.

All nominees receive a certificate and are invited to one of a series of lunches hosted by our Chairman, Sir Stephen O’Brien. Last year a total of 408 nominations were received, 311 for individuals and 97 for teams. Entries were judged by a panel of staff, patients and partners, and shortlisted teams and individuals were invited to our second annual Barts Health Heroes ceremony, held in February 2014 at the Museum of London, which was attended by a number of external partners and colleagues. Awards were also presented to staff who have completed 25 years’ service with the Trust.

We said that we would increase the opportunities for staff to give their views - and this is what we have done

It is important that staff can feedback any concerns they may have so that we can continue to improve our service standard. We want to listen, learn and take action where necessary. To help us achieve this, our chief executive Peter Morris and the executive team have designated the first Friday of the month to be ‘meeting free’. All senior managers are encouraged to use this time to go ‘out and about’ in our wards and departments and talk to staff, patients and carers. This enables our leaders to see for themselves what we are doing well and what we can improve upon, using the opportunity to listen to concerns and provide support as required.

Learning from the annual NHS National Staff Survey 2013

We want our staff to recommend Barts Health as a good place to work

Every year, we ask our staff for feedback on how they rate us as an employer and healthcare provider in the annual NHS National Staff Survey. The 2013 survey was opened up to all staff across Barts Health. In 2013/14, 53.55 percent of staff said they would recommend the Trust to their friends and family. See appendix 2 for information on how we compare with other trusts in England.

Actions to increase staff engagement

Following the development of a clearly articulated set of values and underpinning behaviours, a programme of organisational development (OD) activity was established to help us embed our vision and values across the organisation. This has included:

- Recruiting and selecting staff based on our values and behaviours
- Engaging new staff in the values and behaviours through our induction programme.
- Designing values into performance, appraisal, talent management and succession planning
- Designing a consolidated programme of recognition, appreciation and reward for staff
- Obtaining feedback and measuring success on staff engagement
- Embedding a culture that promotes inclusion in employment practice and service delivery

We have gained knowledge of the experiences and perceptions of our staff through our monthly pulse surveys, run by Picker, which are sent to 4,000 randomly selected staff, and which enable us to take the “temperature” of the organisation on a regular basis. From both the annual staff survey and the pulse surveys, we have designed a programme of action and communication - 'you said we did’ - which focuses on demonstrating how feedback from staff has led to change.

Examples include:

- The introduction this year of monthly site briefings on each hospital site across Barts Health, led by our directors
- Building our programme of staff benefits, including many more discounted physical activities and a sports day hosted in the Olympic Park in the summer
• A weekly message from our chief executive, Peter Morris, which is now sent to all staff and encourages people to respond to and comment on his views

We engaged with the national NHS Change Day in March 2013 and again in 2014. Our organisational development (OD) specialists work directly with staff to develop local level OD interventions and actions. We are actively involved with the national Engage for Success movement and have embedded the four pillars - compelling strategic narrative, engaged leaders, staff voice and organisational integrity - into our culture and engagement work and strategy.

We know from international evidence that having engaged staff helps to deliver better outcomes for patients, and that engagement is largely dependent on good leadership. We have developed a suite of interventions to help our leadership team takes the necessary action to effect culture change. These include:
• A series of debates with senior leaders to capture the realities of the 'as is' and 'could be' of our culture
• Individual interviews with senior leaders, including gathering their views on our progress on improving staff engagement and culture, and ideas for areas of additional focus
• Themed team discussions
• A review of data and intelligence gathered from staff through a variety of means

We have improved our programme of visible leadership (First Fridays, Clinical Fridays, Nationwide Emergency Department visits) to include the presence of the On Call Director on site at weekends.

Responding to the CQC inspection in November 2013

Following the CQC’s inspection of our hospitals in November 2013, we are developing an approach to tackling bullying and harassment which aims to analyse and interpret staff experience and take appropriate actions based on the scenarios identified. We are commissioning an independent review of service areas that are significant outliers in the 2013 staff survey for bullying and harassment. We will deliver a communications campaign to raise awareness of the current policy and mechanisms in place to tackle bullying and harassment, and we are introducing the Speak in Confidence service which facilitates live, two-way and anonymous dialogue with a named director for any member of staff.

Progress in staff satisfaction and pulse surveys

Our return rate for the national staff survey increased in 2013 to 46.1 percent from 39 percent in 2012. Overall engagement levels have not improved, despite all the actions we have taken. However, we recognise that our major workforce review in 2013, which involved around 3,000 staff across management, nursing and administrative functions in all parts of the organisation, had an adverse impact on morale and levels of trust.

There has been improvement in the 2013 staff survey results on outcomes related to knowing who senior managers are, but there is more to do on building trust in the shared commitment to patient care. Clarity of feedback from line managers is improving, as is quality of appraisal. The number of staff reporting that they have experienced discrimination remains of concern. Staff also raised concerns around staffing levels, being equipped to do their jobs and having confidence in raising issues and knowing they will be dealt with. Effectiveness of communication between senior managers and staff continues to have room for improvement. There is also work to do on improving staff perceptions about the organisation – too many do not believe that care is the organisation’s top priority.

We have been running pulse surveys on a monthly basis, except during the period of the annual staff survey return. During the year, we increased the survey sample size from 2,000 to 4,000 each month and will be following up with areas where response rates are low. We have learned a great deal from these surveys, which help us understand how staff experience working at Barts Health. Feedback from staff has included:
• Patient and staff experiences are often seen as secondary to great clinical outcomes
• There is a limited infrastructure to support people to do their jobs effectively, leading to command and control leadership
• There is learned helplessness – staff are resigned to the fact that issues will not be dealt with and so they stop flagging them
- People are seen as replaceable and primarily as a cost
- Slow/resistance to change
- Blame culture
- Not a lot of fun at work

Whilst this feedback confirms that there is much to do to improve the culture at work, it also gives us a base point from which to start our journey to the culture that we aspire to – one where staff feel empowered, recognised and valued, are able to adapt to an ever changing environment and enjoy coming to work.

**Progress on appraisal and performance development plan (PDP) completion rates**

PDPs are included in our appraisal process. A new appraisal system for non-medical staff was launched in April 2013 which incorporates performance rating and talent management activities. Appraisal completion rates have been reported and monitored at CAG performance reviews since autumn 2013. Our completion rate for non-medical appraisals stands at 90 percent. With the launch of our new online e-appraisal system, completion, recording and monitoring of appraisal will be far more efficient. Medical appraisal rates were 79.27 percent at the end of March 2014.

For 2014/15, we will work to strengthen the link between workforce and patient experience. We therefore propose to measure the following key performance indicators:
- Staff satisfaction survey responses related to engagement – both in our own monthly pulse surveys and the annual national NHS survey
- Patient/service user satisfaction surveys

**Transformation through education and staff development**

Our vision is to provide the highest quality healthcare that meets the needs of our local population, and to be recognised locally, nationally and internationally for outstanding clinical services, research and education.

**Our Education Academy**

The Barts Health Education Academy has a vision of excellence in education for all our staff, students and trainees. The overall purpose of the academy is to ensure that we have a skilled and effective workforce who can deliver kind, compassionate and safe high quality care and services for our patients and local communities. This is achieved through:
- Providing high quality, evidence-based, value for money education focused on providing safe, positive experiences for learners
- Creating learners who are skilled, adaptable and innovative, who are engaged in their learning and demonstrate compassion and the values and behaviours that provide safe, effective and positive patient care experiences
- Visionary innovative educational leaders and the right number of practitioners, including educators and supervisors
- Trainers who are skilled, valued, developed, recognised and accredited as required

The Education Academy supports:
- 15,000 staff learners
- 800 undergraduate nursing and midwifery trainees
- 800 postgraduate nursing trainees
- 700 training doctors
- 529 medical students
- 150 allied health professional trainees

Our centralised teaching and training model allows us to accurately determine the costs of our investment, and will permit the business side of teaching and training to be developed in the future. Our aim is for all teaching and training to be self-funding, producing sufficient revenue for internal staff development and future investment.
Statutory and mandatory training requirements

During our second year as Barts Health NHS Trust, extensive work has been undertaken to review and refine the statutory and mandatory training requirements for all staff. New processes have been implemented, based on work undertaken nationally to streamline statutory and mandatory training. In the summer of 2013, we introduced a single statutory and mandatory training booklet for all staff, and an additional booklet for clinical staff. Both booklets contain all the information necessary to allow staff to complete their statutory and mandatory training.

As a result, in March 2014 we reported 91 percent compliance across all aspects of statutory and mandatory training, compared to 46 percent in May 2013. This is in line with our Care Quality Commission target of 90 percent. We will continue to develop our processes to ensure that compliance is sustained at this level.

Our statutory and mandatory training booklet was made available to every staff member in 2013
Part 3
Mandated quality assurance statements
Part 3 – Mandated quality assurance statements

In accordance with the Quality Account Regulations, Barts Health NHS Trust is required to include a set of prescribed assurance statements in the look back section of the Quality Account. These must cover:

- A review of services provided
- Details of participation in clinical audit and research
- Care Quality Commission regulation and registration status
- Income and performance through the Commissioning for Quality and Innovation payment scheme (CQUIN)
- Data quality and Information Governance assurance

Review of services

During 2013/14, Barts Health Trust Board reviewed all the data available to it on the quality of care in 100 percent of its NHS services, as measured by individual service lines.

These service lines cover the range of regulated activities (as specified in the Care Quality Commission’s registration statement of purpose) undertaken by the Trust in the period before 1 April 2014. The income generated by the services reviewed in 2013/14 represents 100 percent of the total income generated from the provision of NHS services by Barts Health NHS Trust for 2013/14.

Quality was reviewed by systematic data collection against a suite of quality and operational service line metrics which inform our performance management framework and Integrated Performance Report (IPR). The Trust operates a robust system of patient safety and risk management.

Quality governance is reviewed in depth through the Operational Management Group, Trust Management Board and the Quality Assurance Committee. The latter provides assurance to the Barts Health Trust Board.

Data quality

Since the creation of Barts Health in 2012, the Trust has sought to considerably improve data quality. This issue is relevant to all aspects of the delivery of patient care. It crosses both internal and external organisational boundaries and is the responsibility of everyone involved in delivering and supporting care. Ensuring that information is of the highest possible standard is crucial for:

- The effective delivery of patient-centred services
- Efficient service delivery, performance management and the planning of future services
- Compliance with Freedom of Information legislation, which substantially increases the public visibility of information quality issues

NHS number and General Medical Practice Code validity

Barts Health submitted records during 2012/13 and 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics. These records are included in the latest published SUS data.

There has been a significant improvement in the percentage of our records in the published data that included the patient’s valid NHS number, particularly for A&E records. The percentage of records that also included the patient’s valid General Medical Practice Code has also improved. The following table shows our results for both these measures for 2013/14 and 2012/13.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of records with the patient’s valid NHS number</th>
<th>Percentage of records with the patient’s valid General Medical Practice Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patient care</td>
<td>94.1% 93.56%</td>
<td>99.9% 94.64%</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>96.5% 96.4%</td>
<td>99.9% 95.29%</td>
</tr>
<tr>
<td>Accident and emergency care</td>
<td>84.7% 78.7%</td>
<td>99.4% 82.77%</td>
</tr>
</tbody>
</table>
Payment by Results audit – clinical coding errors

Barts Health was not subject to the Payment by Results clinical coding audit by the Audit Commission in 2013/14. The audit covers the ten worst performing trusts in England, along with 40 additional trusts who are selected at random. Barts Health did not fall into the worst performing category, and was not one of the trusts selected at random.

Each year, in order to comply with good clinical coding and information governance, NHS trusts must carry out coding audits. So far, a sample audit for surgical day cases undertaken in November 2013 has been completed. The error rates for that period for diagnoses and treatment coding (clinical) are:

- Primary diagnoses incorrect: 14 percent
- Secondary diagnoses incorrect: 21 percent
- Primary procedures incorrect: 7 percent
- Secondary procedures incorrect: 8 percent

The results are also shown in the graph below.

![Graph showing coding error rates](image)

The error rates reported in the surgical day-case audit are lower than those found in the Audit Commission coding audit last year. The rates for diagnoses remain above acceptable standards for primary diagnoses, although for secondary diagnoses our rate is one percentage point below the required standard. The rates for procedure coding have exceeded the expected targets.

There are a number of contributing factors that have led to a variation in the quality and completeness of our coding data. These include:

- Insufficient or incorrect information within the electronic patient record system, for example not recording or coding co-morbidities – conditions which a patient may have which are in addition to the main reason for their particular period of treatment or care
- Errors arising through use of U codes (unused codes) that are not recognised by the software used for clinical coding.

These issues are being addressed through closer collaboration with clinical and other corporate departments to strengthen the quality and completeness of coding data. We will also seek to improve our software system in order to reduce coding error rates.
We will further strengthen our commitment to improving data quality through the following actions:

- Monitor and maintain the professional standards and on-going training requirements of the clinical coding team
- Adopt and implement the Powerchart system within our electronic health record system – this allows quick access to the most relevant information to help clinicians make timely decisions – with support from our clinical coding quality leads to help clinicians use the system effectively
- Regularly circulate the list of co-morbidities and complications to clinical staff, and clinical coding target dates
- Educate our clinicians to become competent users of the SNOMED CT dictionary - an organised collection of standardised clinical phrases for use in patient records
- Carry out regular internal audit to assess the impact of the above actions and recommendations

Information Governance Toolkit attainment levels

The Trust is committed to ensuring that it manages all the information it holds and processes in an efficient, effective and secure manner. This is achieved through the application of robust information governance (IG) policies and procedures, in accordance with legislation and Department of Health guidelines. It is supported by a range of training and awareness activities.

Barts Health's Information Governance Toolkit score for 2012/13 was 57 percent, meaning that we were graded as red - not satisfactory. We have since made good progress on implementing a Trust-wide approach to information governance and introducing unified policies and procedures across all our sites. Our score for 2013/14 is 73 percent, giving a rating of green – satisfactory.

Our progress has been underpinned by an action plan, monitored by the Information Governance Committee which reports to the Trust Board. There is a detailed policy framework in place covering the management of healthcare records, confidentiality, information security, data protection and data quality, supported by detailed guidance material which is readily available to all staff.

Annual training on information governance (including records management) is mandatory for all staff. This is supplemented by targeted face-to-face training when incidents occur. In April 2013, the level of training compliance was 46 percent, but following the introduction of a new in-house e-learning solution and the distribution of a statutory and mandatory training booklet to every member of Barts Health staff, final compliance on 31st March 2014 was 90 percent, meeting the Trust's compliance standard of 90 percent.

Our information governance team also runs a programme of unannounced ward and department IG spot checks. In early April 2014, the Trust underwent a three-day detailed external data protection audit visit/inspection by the Information Commissioner's Office. Outcomes will be reported later in 2014/15.
Participation in national clinical audit and confidential enquiries

During 2013/14, 38 national clinical audits and four national confidential enquiries covered the NHS services provided by Barts Health NHS Trust. During that period, Barts Health participated in 100 percent (38 out of 38) national audits and 100 percent (four out of four) of the national confidential enquiries that we were eligible to participate in.

The national clinical audits and national confidential enquiries that Barts Health NHS Trust participated in, and for which data collection was completed during 2013/14, are listed in Appendix 1a, 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.

Learning from national clinical audit

National clinical audit is a system designed to improve patient outcomes by engaging all healthcare professionals in the systematic evaluation of their clinical practice against recognised standards, and to support and encourage improvements in the quality of treatment and care.

The reports of 38 national clinical audits were reviewed by the provider in 2013/14, and Barts Health intends to take the actions outlined in the examples of national audit summaries in the table at Appendix 1b, and to improve the quality of healthcare provided.

Learning from local clinical audit

Our clinicians are strongly encouraged to set up local in-depth audits to follow up on national audit findings, based on local quality and safety priorities. 764 projects were registered in 2013/14 and the reports of 237 local clinical audits were reviewed and actions agreed.

Local audit outcomes and recommendations for 2013-14 within the Emergency Care and Acute Medicine (ECAM) Clinical Academic Group

Local audits have resulted in a number of improvements within ECAM services across the Trust and at all stages of the patient pathway. Key themes for outcomes have included:

- Improvements in education
- Better awareness of local policies and procedures
- Use of resources
- Recording of information

Specific outcomes in individual services have included:

- Older people’s services - education on the management of acutely ill patients, ensuring assessments are completed frequently and, when necessary, patients are escalated appropriately and in a timely manner
- Hepatology - education to improve testing for co-infections at clinics for patients with Hepatitis B and C, while reducing the number of unnecessary tests being performed
- Dermatology - change in practice for the treatment of basal and squamous cell carcinomas to reduce the number of incomplete surgeries
- Rheumatology – improvements made to clinics letters and patient education leaflets; advanced planning introduced to reduce the number of cancelled clinics and to allow for the introduction of an urgent flare clinic as a rapid care alternative to A&E
- Gastroenterology - introduced a more detailed referral form for gastroscopy procedures, reducing the number of referrals for incorrect procedures and improving the quality of the patient information recorded
- Clinical Decision Units - highlighted and implemented better education on coding and the patient pathway and the need for increased medical out of hours and weekend staff cover on wards
- Respiratory Medicine - implemented a hospital wide oxygen prescribing initiative at Newham hospital following a project to improve training and access to local policies for all staff. The team also used audit results to develop a business case for a larger TB entrant and screening clinic
Research and development

The number of patients receiving NHS services provided or sub-contracted by Barts Health NHS Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee is estimated at 22,000.

Another successful year for research and development at Barts Health

2013/14 has been a productive year for research and development at Barts Health. Success has been evident across all our clinical specialties, highlighting the quality and depth of our research activity. Some examples are highlighted below. The Trust has exceeded what were challenging targets for increasing research and development income, participation in commercial clinical trials and National Institute of Health Research (NIHR) programmes. Working with our Local Comprehensive Research Network has resulted in a 10 percent increase in patient recruitment to clinical trials.

International Clinical Trials Day

In May 2013, the Trust participated in a range of events to mark International Clinical Trials Day. Events included interactive video workshops, poster presentations and information desks at all our hospitals, as well as Queen Mary University of London sites. Patients and staff from many of our research groups participated in the event, which was well received by patients and visitors. New patient and carer engagement initiatives this year included providing information on clinical trials to patients in clinic, under the national OK to ask about research patient engagement campaign. More events are being planned for 2014.

Leading a new Clinical Research Network

The National Institute of Health Research (NIHR) announced in July 2013 that Barts Health’s bid to host a new integrated NIHR Clinical Research Network was successful. The Trust led the transition process to allow a new network to be established on 1 April 2014. Responsibilities include managing the Network’s annual budget of £29.5m and ensuring that the partnership meets its main objective of making research accessible to our patients, widening participation in clinical trials and research studies. The new Network will be one of 15 nationally. There has been a considerable workload associated with the transition into the new structure, which merges two previous networks.

Hosting a new applied health research and care leadership collaboration

In August 2013, the NIHR announced that Barts Health would host one of its prestigious new Collaborations for Leadership in Applied Health Research and Care (CLAHRC). These academic and clinical collaborations are designed to conduct innovative research, evaluating translation into practice for patients. The CLAHRC will receive £9 million in funding over five years from January 2014. In addition, the CLAHRC has secured matched funding worth £34 million from a range of partner organisations, including Queen Mary University of London, Google and many others.

Highly commended in the 2013 Health Service Journal Awards

In November 2013 Barts Health received a ‘Highly Commended’ in the Clinical Research Impact category of the Health Service Journal Awards in a very strong field. This award recognises the significant impact that has been made in promoting a culture of clinical research at Barts Health, for our patients, staff and working environment. NHS organisations had to demonstrate the extent to which each trust as a whole has made clinical research part of its core business.

Working with UCLPartners

UCLPartners continues to provide a lead in sustaining and developing strength and depth in academic activity. The UCLPartners Research Programme aims to harness the immense research strength within its geography across the physical and social sciences in order to improve the health of the population. The partnership aims to maximise synergies between internal structures and external partners, thereby stimulating research pathways from basic innovation through to population health gain. During 2013, the partnership actively supported Barts Health in its successful bids to host the geographically related CRN and CLAHRC.

UCLPartners, working with Barts Health and other NHS trusts in the area, is committed to maximising the involvement of our population in clinical trials. In the last five years, 200,000 patients have participated in trials across the UCLPartners area. The combined geography opens 800 trials per year and approximately
25% of all commercial studies in England have a chief investigator from our area. In addition, UCLPartners has been actively involved in developing projects in applied health research that will be carried out by the NIHR CLAHRC. This will ensure that UCLPartners programmes continue to improve health and create wealth for local and national populations.

Cancer research initiatives
Barts Health was awarded Cancer Research UK Centre of Excellence status by an international review panel, cementing the partnership between the Trust, Queen Mary University of London and Cancer Research UK, with £3m of core funding. This complements our Experimental Cancer Medicine Centre status, which was recently renewed by the Department of Health and Cancer Research UK. In 2013/14, the Centre enabled over 700 patients to participate in clinical trials and access the very latest developments in cancer therapies. Research has already enabled Barts Health to deliver the country's best outcomes for bone marrow transplantation, and future work will also focus on kidney, lung and pancreatic cancers as well as research in radiotherapy using our state of the art facilities.

Commissioning for Quality Improvement and Innovation (CQUIN)
A proportion (£24.8 million across all commissioners including specialised commissioning) of Barts Health NHS Trust's income in 2013/14 was conditional on achieving multiple quality improvement and innovation goals agreed between Barts Health NHS Trust and our commissioners. Based on performance submissions to commissioners, Barts Health expects to receive £20.7 million, 83.5 percent of this amount, but this is still an estimation as final payments are not yet agreed.

For 2013/14, Barts Health agreed:
- Ten CQUINs (six national and four local) across the whole Trust
- Six further site specific CQUINs - two each for The Royal London, Newham University Hospital and Whipps Cross University Hospital
- Seven further specialist CQUINs
- Community CQUINs

The table below lists all the CQUIN projects and work streams in 2013/14.

<table>
<thead>
<tr>
<th>National CQUIN goal</th>
<th>Weighting</th>
<th>Percentage of CQUIN scheme available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Thermometer</td>
<td>0.125</td>
<td>5%</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>0.125</td>
<td>5%</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>0.125</td>
<td>5%</td>
</tr>
<tr>
<td>Dementia</td>
<td>0.125</td>
<td>5%</td>
</tr>
<tr>
<td>Staff and patient satisfaction, including A&amp;E and cancer services</td>
<td>0.2</td>
<td>8%</td>
</tr>
<tr>
<td>Integrated care management, including long term conditions</td>
<td>0.7</td>
<td>28%</td>
</tr>
<tr>
<td>Integrated information systems and information sharing</td>
<td>0.2</td>
<td>8%</td>
</tr>
<tr>
<td>Whipps Cross University Hospital specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>0.15</td>
<td>6%</td>
</tr>
<tr>
<td>Cancer staging</td>
<td>0.15</td>
<td>6%</td>
</tr>
<tr>
<td>Newham University Hospital specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant advice</td>
<td>0.15</td>
<td>6%</td>
</tr>
<tr>
<td>Improved quality of communication</td>
<td>0.15</td>
<td>6%</td>
</tr>
<tr>
<td>St Bartholomew’s and The Royal London hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>0.15</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes care plans</td>
<td>0.15</td>
<td>6%</td>
</tr>
<tr>
<td>Potential total</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

80
This totalled an estimated £16,894,013 of income, which was made up as follows:

<table>
<thead>
<tr>
<th>Trust wide</th>
<th>National</th>
<th>£3,378,803</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local</td>
<td>£7,433,366</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>£10,812,168</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site specific</th>
<th>Amount per site</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Newham University Hospital</td>
<td>£2,027,282</td>
</tr>
<tr>
<td></td>
<td>The Royal London Hospital</td>
<td>£2,027,282</td>
</tr>
<tr>
<td></td>
<td>Whipps Cross University Hospital</td>
<td>£2,027,282</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>£6,081,845</td>
</tr>
</tbody>
</table>

The above amounts also contain community CQUINs worth £1,100,078. Additional specialist and highly specialist CQUINs, totalling £8,865,717 are paid for by specialist commissioners.
Working with the Care Quality Commission (CQC)

CQC registration
Barts Health NHS Trust is required to register with the Care Quality Commission (CQC). Its current registration status at 1 April 2014 and in the reporting period for this Quality Account is full registration with no conditions.

During 2013/14, the CQC took enforcement action in the form of three warning notices issued against Barts Health NHS Trust. Barts Health NHS Trust has not participated in any special investigations by the CQC during the reporting period.

Enforcement action
Three warning notices were served in July 2013 for Whipps Cross University Hospital. Two were for breaches of Regulation 12 (Outcome 8 - cleanliness and infection control) and Regulation 16 (Outcome 11 - safety of equipment) in maternity services. The third was due to a breach of Regulation 23 (Outcome 14 – supporting staff) in two older people’s wards. The notices were imposed following routine unannounced inspections of Whipps Cross by the CQC in May and June 2013.

The CQC raised concerns about standards of cleaning, general housekeeping, maintenance and checking of equipment in the maternity unit. When inspecting two older people’s wards, they found inadequate clinical supervision arrangements for qualified and unqualified nursing staff, and that regular ward and staff feedback meetings were not held consistently. The CQC also found that previous recommendations to improve staff appraisal rates had not been sufficiently acted on.

We took rapid action in response
Following substantive and robust improvement action and the submission of evidence to the CQC in support of compliance, all three warning notices were lifted by the CQC in January 2014. The lifting followed the inspection under the CQC’s new surveillance and inspection regime in November 2013, during which we were able to demonstrate that these improvements had been sustained. In particular, we showed that we had:
- Increased the frequency, quality and monitoring of daily cleaning in the maternity unit
- Delivered new and refresher infection control training to staff in all professions in our maternity service to ensure more effective auditing of cleaning standards
- Funded an extensive programme of general maintenance and decoration
- Funded a disposable curtain replacement programme across the whole site
- Introduced new standardised procedures and enforced daily equipment safety checks
- Set and achieved a target of appraising 100 percent of our nursing staff
- Used our #becausewecare campaign to support the relaunch of regular ward and team meetings and one-to-one supervision in all care settings. See page 70 for more details of the campaign
- Introduced staff briefing sheets and regular open briefing meetings for staff in maternity services

Routine CQC inspections carried out in 2013/14
As a registered provider, Barts Health is subject to periodic inspection by the CQC as part of monitoring and surveillance against the 16 essential standards of quality and safety, also known as the Quality Outcomes.

Between 1 April and 31 October 2013, Barts Health NHS Trust participated in four unannounced compliance reviews. These were carried out at the hospitals and in the services highlighted in the table below, but exclude the inspection of Barts Health carried out in November 2013 as part of the CQC’s new inspection regime. A summary of this inspection is included on page 87.

The CQC is still consulting on and developing its new inspection framework ready for launch during 2014/15, including its proposals for awarding individual quality ratings for Trusts following inspection.

Routine CQC inspections in 2013/14 by site, service and outcome
<table>
<thead>
<tr>
<th>When</th>
<th>Site</th>
<th>Services inspected</th>
<th>Outcomes inspected</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-23 May 2013</td>
<td>Whipps Cross University Hospital</td>
<td>A&amp;E</td>
<td>Respecting and involving patients</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Older people’s services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Care and welfare of patients</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Meeting nutritional needs</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cooperating with other providers</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cleanliness and infection control</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicine management</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Safety, availability and suitability of equipment</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staffing levels and skill mix</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supporting staff</td>
<td>Not compliant (warning notice issued)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quality monitoring</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
<td>Surgery and operating theatres</td>
<td>Respecting and involving patients</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consent to care and treatment</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Care and welfare of patients</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cleanliness and infection control</td>
<td>Not compliant (warning notice issued)</td>
</tr>
<tr>
<td>17-18 June 2013</td>
<td>Whipps Cross University Hospital</td>
<td>Maternity</td>
<td>Respecting and involving patients</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgery and operating theatres</td>
<td>Consent to care and treatment</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Care and welfare of patients</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cleanliness and infection control</td>
<td>Not compliant (warning notice issued)</td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
<td></td>
<td>Safety, availability and suitability of premises</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td>Surgery and operating theatres</td>
<td></td>
<td>Safety, availability and suitability of equipment</td>
<td>Not compliant (warning notice issued)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staffing levels and skill mix</td>
<td>Not compliant</td>
</tr>
<tr>
<td>When</td>
<td>Site</td>
<td>Services inspected</td>
<td>Outcomes inspected</td>
<td>Findings</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------</td>
<td>-----------------------------</td>
<td>------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>4-5 June 2013</td>
<td>The Royal London Hospital</td>
<td>Maternity</td>
<td>Respecting and involving patients</td>
<td>Not compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Older people’s services</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Care and welfare of patients</td>
<td>Not compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cooperating with other providers</td>
<td>Not compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staffing levels and skill mix</td>
<td>Not compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supporting staff</td>
<td>Not compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality monitoring</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints</td>
<td>Compliant</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When</th>
<th>Site</th>
<th>Services inspected</th>
<th>Outcomes inspected</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 June 2014</td>
<td>Newham University Hospital</td>
<td>Stroke and Older People’s Services</td>
<td>Respecting and involving patients</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care and welfare of patients</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meeting nutritional needs</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safeguarding people from abuse</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staffing levels and skill mix</td>
<td>Not compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supporting staff</td>
<td>Not compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Records</td>
<td>Compliant</td>
<td></td>
</tr>
</tbody>
</table>

Following every CQC inspection, we develop and deliver action plans to address the standards that inspectors judged were not met.

As well as the improvements outlined above, in 2013/14 we have also delivered change to support compliance with essential standards through:

- Our Quality Improvement Collaborative
- Our Great Expectations project in maternity services
- Our Older People’s Services Programme

We have also made changes within our nursing and midwifery teams to improve leadership roles and ensure that the right nursing skills are available and deployed appropriately. Recruitment has been increased to ensure vacancies are filled more quickly.
In addition, we have developed a new ward accreditation scheme to roll out across the Trust in 2014, and we continue to undertake monthly internal CQC ward audits and spot checks of essential care and standards through the clinical walk round process, as well as ‘mock’ peer reviews and inspections using the CQC’s inspections methodology and standards.

**Inspection under the CQC’s new surveillance and inspection regime in November 2013**

In 2013, the CQC began consulting on and piloting planned changes to the way healthcare organisations are regulated and inspected. This included appointing Professor Sir Mike Richards as Chief Inspector of Hospitals and introducing a [new inspection regime for hospital trusts](#). It was part of the CQC’s response to the Francis report into failings at Mid Staffordshire Hospitals NHS Foundation Trust, which made recommendations for the NHS, local authorities and regulators around ensuring that standards across the NHS are improved and maintained.

The new inspection regime involves larger teams of inspectors spending more time at individual hospitals and speaking to staff, patients and the general public to gather a more rounded and in-depth view of services and standards. Each inspection centres on five key themes, looking at whether services and hospitals are:

- safe
- effective
- caring
- responsive to people’s needs
- well-led

The CQC has also defined the eight ‘core’ services of an acute healthcare organisation as:

- Accident and Emergency
- Medical care, including older people’s care
- Surgery, including operating theatres
- Intensive/critical care
- Maternity and family planning
- Children’s care
- End of life care
- Outpatients

Barts Health was included with 17 other trusts in the first wave of these inspections. In November 2013, a major inspection of our six hospitals and the Barking Birth Centre was carried out over several days by a team of 90 inspectors. The inspection required a considerable amount of preparation and planning. All areas
of the organisation were involved. Large numbers of staff and patients participated in listening events and other forums provided by the CQC for people to share views and feedback.

**Summary of key findings and recommendations**

In December 2013, the Trust received eight final compliance reports covering the seven locations inspected and an overall quality summary report for the whole Trust. Each report included findings for the eight core services, where provided, and addressed the five essential question areas. No serious failings were identified neither was any enforcement action issued. However, for 15 regulations and the associated outcomes, our standards were judged as requiring improvement. The table below provides further information.

The three warning notices issued previously at Whipps Cross University Hospital in July 2013 were lifted as inspectors were satisfied that sufficient improvements in safety and staff experience had been made to warrant this.

The CQC reported that in general they judged services at Barts Health to be safe, clean and well maintained with the risk of patients acquiring infection minimised. The majority of patients and relatives they spoke to described staff as caring and compassionate, and they also observed staff treating patients with dignity and respect.

However, the inspection team did report and highlight a number of concerns under the theme of staff experience and engagement. The CQC has made recommendations to the Trust Board to ensure there is a supportive staff culture at Barts Health, including visible leadership, zero tolerance on bullying, effective communication and mechanisms to support staff who wish to raise concerns. Details of our plans for organisational development and staff engagement in 2014/15, in response to the CQC reports, can be found in the staff experience section on page 72.

**Compliance actions by hospital site, outcome and key issues**

<table>
<thead>
<tr>
<th>Site</th>
<th>Outcome and regulations</th>
<th>Concerns and issues highlighted</th>
</tr>
</thead>
</table>
| The London Chest Hospital     | Outcome 4, Regulation 9 – care and welfare of people who use services | People who use services are not protected against the risks of receiving care or treatment that is inappropriate or unsafe.  
Staff ability to respond in a timely manner to meet patients’ needs at night, and ensure their safety and welfare, must improve. |
| Newham University Hospital    | Outcome 4, Regulation 9 – care and welfare of people who use services | Patients are not protected from the risks of receiving care or treatment that is inappropriate or unsafe in such a way as to reflect published good practice guidance from professional and expert bodies.  
The Trust must ensure that members of staff follow national guidance for the management of children undergoing surgery and that they do this sufficiently to maintain their expertise. |
|                               | Outcome 9, Regulation 13 – medicine management | Patients and others are not protected against the risks of unsafe use and management of medicines (medication was not in secured locations and could be accessed by unauthorised persons).  
The Trust must ensure that medicines and fluids for infusion are stored securely. |
|                               | Outcome 16, Regulation   | Patients and others are not protected against                                                                                                                   |
| 10 - assessing and monitoring the quality of service provision | the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems relating to the health and welfare of patients and others.

The Trust must promote a safety culture. The hospital must improve the visibility of management and embed clinical academic group structures and processes. |
|---------------------------------------------------------------|
| The Royal London Hospital | Outcome 4, Regulation 9 – care and welfare of people who use services | Patients are not protected from the risks of receiving care or treatment that is inappropriate or unsafe in such a way as to reflect published good practice guidance from professional and expert bodies.

The Trust must ensure that adolescents are treated appropriately and not within the general paediatric wards. |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 11, Regulation 16 - safety, availability and suitability of equipment.</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Outcome 13, Regulation 22 - staffing</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Outcome 16, Regulation 10 – assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Outcome 21, Regulation 20 - records</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>St Bartholomew's Hospital</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
</tr>
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</tbody>
</table>

In March 2014, the Trust Board approved six compliance action plans, one covering Trust wide themes and the other five covering specific actions for five of our six hospital sites – all except Mile End where no improvements were found to be necessary. The plans focus on the findings in the table above.

Each action is assigned an executive lead, action owner and expected completion date. We will regularly track and report on progress through our internal governance and performance management processes and Clinical Commissioning Group (CCG) quality reviews. The full action plans can be found at Appendix 3.

In addition to the staff and organisational development priorities outlined, other improvement commitments we have made as part of our CQC and quality priority areas agenda in 2014/15 include:
- Commissioning and acting on an external review of the nursing workforce structure and skill mix
- Implementing the Allocate e-rostering system to improve nurse rostering and reduce reliance on bank and agency staff
• Delivering our recruitment programme to recruit to 95 percent of our staffing establishment by September 2014 and further reduce reliance on bank and agency staff
• Continuing to strengthen our risk register processes so that identified risks are mitigated, acted upon and progress tracked
• Delivering a number of information technology improvement plans and projects to ensure better access and reliability across all sites
• Reviewing and improving capital investment, procurement and governance processes for clinical equipment to ensure availability, access and safety across all sites
• Continuing with our transformation of clinical services to reduce delays and meet quality and safety standards for emergency, surgical and medical care

Patients detained under section 3 of the Mental Health Act 1983 - unannounced inspection at Mile End Hospital

The Care Quality Commission also carried out an unannounced Mental Health Act 1983 monitoring visit to Barts Health NHS Trust on 6 March 2014. The Commission visited Jubilee ward, an older people’s rehabilitation ward at Mile End Hospital. On the day of the visit, a patient on the ward was detained under section 3 of the Mental Health Act.

We received the CQC’s report in late May 2014. Overall, the report and its findings were positive. Inspectors commented that the care provided was good, and that patients on the ward felt staff were very caring and looked after them well. Some areas requiring improvements were identified, for example ensuring that care plans are comprehensive, reflect any safeguarding risks, and include recorded evidence of assessment of capacity and consent. The CQC also recommended that we review therapy and group activities available to patients to support well-being and engagement.

At the time of publishing this Quality Account, we were still finalising our response to the CQC, which details how we will address the issues identified, and includes an action plan to monitor and report our progress. We will report on this inspection in the 2014/15 Quality Account.

Care Quality Commission essential standards ward audit

In April 2013, we introduced a programme of Care Quality Commission ward audits to measure and report on staff compliance with the CQC’s 16 essential standards. The aim is to strengthen staff awareness and compliance with these standards, promoting a greater understanding of how they should be put into practice and what they mean for patients.

Our compliance unit worked with heads of nursing and matrons to develop an electronic audit tool based on observation of practice, feedback from patients and staff and care records.

The first round of audits took place from April to August 2013 and included services within the Cancer, Cardiovascular, ECAM, Surgery and Women’s and Children’s Clinical Academic Groups.

The second round from October 2013 to February 2014 included all other clinical areas within the Trust, including Clinical Support Services and Community Health Services. The audits were led by the heads of nursing and analysed by the compliance unit.

Learning from results
• Participation by wards and clinical areas increased from 566 audits in the first round to 633 audits in the second round. This was principally due to the participation of Clinical Support Services and Community Health Services in the second round
• In the first round, we achieved an average score of 88 percent compliance, which improved to an average of 95 percent compliance in the second round
• One of the main issues identified in the first round was the Trust’s overall low compliance on staff completing statutory and mandatory training - the maximum score achieved by CAGs was just 50 per cent. Wards also achieved a very low score of 35 percent compliance in staff having their appraisals in the past 12 months. These scores reflect issues the CQC identified from their inspections
By the second round, we had made significant improvements. Wards achieved compliance with all statutory and mandatory training requirements except medical equipment. However, the second cycle identified low compliance with meeting nutritional needs of patients in some areas of the Trust and suitability and availability of equipment.

The table below shows the comparison of scores from the two audit cycles for each outcome.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>First audit cycle compliance for each outcome</th>
<th>Second audit cycle compliance for each outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1: Respecting and involving service users</td>
<td>93%</td>
<td>97%</td>
</tr>
<tr>
<td>Outcome 2: Consent</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td>Outcome 4: Care and welfare of people who use services</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>Outcome 5: Meeting nutritional needs</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>Outcome 6: Co-operating with other providers</td>
<td>75%</td>
<td>Not included</td>
</tr>
<tr>
<td>Outcome 7: Safeguarding patients from abuse</td>
<td>82%</td>
<td>96%</td>
</tr>
<tr>
<td>Outcome 8: Cleanliness and infection control</td>
<td>89%</td>
<td>96%</td>
</tr>
<tr>
<td>Outcome 9: Management of medicines</td>
<td>90%</td>
<td>98%</td>
</tr>
<tr>
<td>Outcome 10: Safety and suitability of premises</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>Outcome 11: Safety, availability and suitability of equipment</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Outcome 12: Suitability of staffing</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Outcome 13: Staffing</td>
<td>78%</td>
<td>85%</td>
</tr>
<tr>
<td>Outcome 14: Supporting workers</td>
<td>Not included</td>
<td>96%</td>
</tr>
<tr>
<td>Outcome 16: Assessing and monitoring service provision</td>
<td>83%</td>
<td>97%</td>
</tr>
<tr>
<td>Outcome 17: Complaints</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Outcome 21: Records</td>
<td>84%</td>
<td>92%</td>
</tr>
<tr>
<td>Average for all audits</td>
<td>88%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Key:
Green – greater than 80 percent
Amber – greater than 70 percent
Red – less than 70 percent

**Awareness and the way forward**
Another cycle of CQC ward audits will start soon and continue throughout 2014/15. It will reflect any changes the CQC makes to its regulations, which are currently out for consultation. The audits will help wards to effectively manage and monitor their performance as well as progress against our objective to deliver an exceptional quality of care for all patients.
Part 4
Listening and responding to patient feedback
Part 4 - Listening and responding to patient feedback

We continue to be committed to improving all communication with patients and carers, and we are well on the way to reaching our aim that all patients should feel safe, involved and able to make informed choices.

Our Patient Experience and Engagement Strategy

Our patient experience and engagement strategy helps to deliver three priority objectives:

- To ensure that patients are involved with service improvements, development and design work
- To build positive relationships with patients, in particular improving trust and confidence
- To improve access to health services and promote healthy living for local people

Delivering compassionate care

Across Barts Health, we have developed a strategy to improve our patients’ experience. A framework has been put in place to support the provision of an exemplary patient experience, while maintaining and building on what is both excellent and unique in each of our hospitals. We have introduced a number of initiatives that demonstrate our commitment to an open, patient-centred culture.

In our 2012/13 Quality Account, we promised to improve the patient experience, strengthen communication with family and carers, and treat every patient with respect and dignity whilst they are in our care. We have used our Trust-wide care campaign, #becausewecare, as one of the vehicles to promote compassionate care. The care campaign reaches out to all staff and also supports our approach to implementing the recommendations in the Francis report. The aim is to improve standards of care and patient experience, and encourage a culture where we welcome and listen to feedback from patients and staff. See page 70 for more information on the campaign.

We know through our Friends and Family Test results that many patients are very satisfied with their care. The Care Quality Commission also noted that, generally, patients at Barts Health feel that they are treated with dignity and respect. This is confirmed by our real time feedback. When patients are discharged from hospital, they are asked for their views. 70 percent say that they have been involved in decisions about their discharge, and around 65 percent of patients say that they had someone to speak to about their worries and fears.

Communication remains a challenge across the Trust and this is an issue that we will continue to address. We are working hard on supporting staff so that they can quickly and efficiently deal with any concerns at a local level before they become complaints.

Patient stories at our Trust Board meetings

We continue to open every public Trust Board meeting with a story from a patient, with increased engagement from our Clinical Academic Groups. This year, two key themes have emerged from the stories:

- The impact that expert patients can have on innovation and quality of care, and how important it is to listen to our patients
- How accurate and timely information can make a positive difference to patient experience

Ideas to improve patient information have been discussed by the Board in response to these and other themes, including better use of information technology such as virtual patient forums where people can exchange information and improved links with national societies. Our chairman, Sir Stephen O’Brien, has also encouraged Board members to visit patient support groups as part of their visit programmes. During 2014/15, patient stories will continue to form a key part of every Board meeting. Suitable stories will be identified and supported through the Clinical Academic Groups to ensure that the Board hears from patients who use a wide range of our services. We expect that all teams will learn from the themes that are raised and apply them to improvements in their own areas.
Capturing patient feedback in real time – our local survey mechanism

We now ask patients and relatives a number of questions on the reverse of the current Friends and Family Test (FFT) cards that are in use across the Trust. The questions are taken from the national inpatient survey and our patient experience CQUIN and cover areas where patients have told us there is room for improvement. Since October 2013, we have been gathering this feedback in inpatient areas, and it will be rolled out to our A&E departments and maternity units once we consistently achieve the 15 percent response rate month on month.

The results from the previous twelve month period – July 2013 to June 2014 - indicate that, on the whole, high numbers of our patients and service users who complete a Real Time Feedback (RTF) card think we provide high quality care and meet their needs in showing respect, communication and information.

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage of patients who agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you have confidence and trust in the doctors treating you?</td>
<td>90%</td>
</tr>
<tr>
<td>Did you have confidence and trust in the nurses treating you?</td>
<td>90%</td>
</tr>
<tr>
<td>Did you find someone on the hospital staff to talk to about your worries and fears?</td>
<td>75%</td>
</tr>
<tr>
<td>Did you feel you were involved in decisions about your discharge from hospital?</td>
<td>85%</td>
</tr>
<tr>
<td>Overall, did you feel you were treated with respect and dignity while you were in the hospital?</td>
<td>90%</td>
</tr>
</tbody>
</table>

Friends and Family Test - patients

All NHS acute inpatient and A&E services have now introduced the national NHS Friends and Family Test. The answers patients give are used to compare hospitals throughout the country. Patients can also add comments to explain the score they give and to provide each ward and department with specific feedback. At Barts Health, patients are given postcards to complete and post into a box on the ward or in the department they are seen in. There is also a Quick Response facility on each card so that patients using smartphones can scan the code and complete the survey online.

We have experienced more difficulty in collecting responses from patients in our three A&E departments than on our inpatient wards, due mainly to the nature of emergency care services where patients are present in the department for very little time. In January 2014, we introduced a new system for collecting FFT responses in the departments. Each patient is now given a plastic token on discharge and asked to drop the token into one of six collection boxes, one for each level of response from “extremely likely to recommend” to “extremely unlikely to recommend”. In the acute assessment unit at the Royal London Hospital, our staff have identified three particular groups of staff to help encourage patients to complete a response card when they leave:

- Acute physicians – we have asked all acute physicians to ask every patient they discharge if they were happy with the care they received, and remind them to complete a response card
- Nursing staff – when nursing staff hand a patient their medication to take home with them, they are reminded to give the patient a response card
- Ward clerks – when clerks print off discharge paperwork, they contact the discharge lounge to check that the patient has been given a response card

We continue to work closely with our A&E teams to increase the number of patients who are providing feedback. Every month, results are fed back to the specific ward or department, relevant Clinical Academic Group and the Trust Board through our integrated performance framework. We use the information to ensure that any improvements made are aligned to feedback from patients. We have also introduced the Friends and Family Test to some of our outpatient clinics, and have a plan to roll it out to all outpatient areas by October 2014. Work is also underway to introduce real time feedback in our diagnostic areas, such as x-ray and CT scan departments.
Along with all acute hospital trusts, Barts Health’s combined FTT patient score showing the percentage of patients who would recommend our services to their friends and family is measured and reported as a mandated Quality Account core indicator. To see our performance compared to the best, average and worst trusts in England, see Appendix 2.

**Patient experience net promoter score (NPS)**
Calculating and presenting the results of the Friends and Family test in a consistent and transparent way is crucial for the robustness and comparability of the data, so that patients and public can use the results to make informed choices. Trusts can also use the FFT to drive cultural change and continuous improvements in the quality of care. Barts Health has seen fluctuations in its Net Promoter Score since April 2013, as the core indicator table in Appendix 2 indicates.

**Participation in the national patient survey programme**
We use results from all national patient surveys to continually benchmark our performance against that of our peers and to ensure that our own feedback mechanisms continually reflect the standards and areas being monitored through the national surveys. The Care Quality Commission (CQC) also uses the data from the national inpatient survey to compare results for all acute hospital trusts. The CQC groups the results under ten headings and presents it as scores out of ten, rating each trust as better, worse or about the same as other trusts.

**National inpatient survey**
The results from the 2013 national inpatient survey show that, overall, Barts Health’s scored had improved significantly in the following areas over the 2012 survey:

- Providing patients with an explanation of the risks and benefits of an operation or procedure in a way they could understand, along with a clear explanation of what would be done during their surgery
- Ensuring patients receive copies of letters sent from the Trust to their GP
- Ensuring patients receive clear answers from our doctors to their questions

There were 28 areas where patients reported lower levels of satisfaction than in the 2012 survey, and 13 where levels were the same. The three main areas where patients are significantly less satisfied than the survey average are:

- Noise at night from staff
- Cleanliness of hospital rooms and wards
- Feeling that there were sometimes, rarely or never enough nurses on duty

Within key categories of the survey, the following areas were of most concern:

- **The hospital and ward**
  - Noise at night from both staff and other patients
  - Room or ward not very or not at all clean
  - Hospital food being described as fair or poor

- **Nursing staff**
  - Speaking in front of patients as if they are not there
  - Patients feeling there are not enough nurses to look after them

- **Doctors**
  - Speaking in front of patients as if they are not there
  - Patients reporting that they do not always have trust and confidence in their doctors

- **Admission to hospital**
  - Patients admitted via one of our A&E departments not being given enough privacy when being examined or treated
  - Patients admitted for a planned procedure not being offered a choice of hospital
  - Admission dates being changed by the Trust

- **Operations and procedures**
  - Staff not fully explaining how a patient would be put to sleep or how their pain would be controlled
  - Results not explained in a clear way

- **Leaving hospital**
  - Patients not feeling involved in decisions about their discharge
  - Poor notice of discharge
Not being told who to contact if worried
Family not given enough information to help
Needs for additional equipment or home adaptation not discussed

Overall
Patients not receiving any information explaining how to complain

National outpatient survey
Although this survey is not running as a nationally mandated survey this year, we will be running our own outpatient survey with support from the Picker Institute.

National A&E users survey
This survey did not take place in 2013, but is expected to run in 2014.

National maternity users survey
The national maternity survey is undertaken every three years. Following the 2010 survey, our former trusts (Barts and The London, Newham University Hospital and Whipps Cross University Hospital NHS Trusts) prioritised specific aspects of women’s experience and care on which to focus their improvement work. As there are many aspects of care which contribute to a woman’s overall experience of pregnancy and birth, it is important that trusts identify and make sustainable improvements in all areas and ensure that improvements are built on every year.

Barts Health’s scores for the 2013 survey were average when compared to other trusts for most questions. However, we scored below average in these areas:

- Moving around and choosing the most comfortable position during labour
- Skin to skin contact with the baby shortly after birth
- Staff introducing themselves
- Being left alone by midwives or doctors at a time when the woman was most worried
- Responses to call buttons
- Feeling involved in decisions about care during labour and birth
- Respect and dignity
- Women having confidence and trust in the staff caring for them during labour and birth

Three themes have been chosen as areas for improvement, taken both from the national survey and other feedback received directly from women and their partners:

- Women reporting that they were treated with kindness and understanding by staff after the birth
- Women feeling they were given the information and explanations they needed after the birth
- Women feeling that the length of time they stayed in hospital following the birth was right

Although not reported in the maternity survey, Barts Health has a better than expected maternal and neonatal mortality rate.

Our Great Expectations programme
There is a well documented link between effective leadership, staff engagement and consistently excellent patient experience, safety and improved outcomes. During 2013, we launched a programme known as Great Expectations to help us shape our culture of care. This programme supports our mission to provide a high quality service, responding to feedback from staff and patients and learning from joint working with local women, as well as standardising and improving the clinical skills of our staff. Feedback from women using our maternity services is collected through a mix of questions and discussion groups. It is also supported by the Department of Health’s Making Every Contact Count initiative through an 18 month programme of education and assessment for maternity staff. Comments made through our PALS service, websites and any complaints are also taken into account. Improvements are being made in response, including a review of the information provided and the choices on offer.

Working with our local Maternity Services Liaison Committees
Maternity Services Liaison Committees (MSLCs) are local forums for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families. Barts Health works with three Maternity Services Liaison Committees (MSLCs)
covering Tower Hamlets, Newham and Waltham Forest. All three MSLCs are in differing stages of development, and our Director of Midwifery is supporting them and working with them to agree a standardised way of working.

**Using the Friends and Family Test for maternity services**

The maternity Friends and Family Test was launched across the NHS on 1 October 2013. The test assesses women’s experience at three specific points in their pregnancy and immediately afterwards:

- **Antenatal care** – women are surveyed at their 36 week antenatal appointment
- **Birth and care on the postnatal ward** – two surveys are available at discharge or following a home birth
- **Postnatal community care** – women are surveyed after discharge from the care of the community midwifery team to the care of the health visitor/GP, usually ten days after their baby is born

Preliminary feedback for the first three months shows a high percentage of women, 61%, saying that they would be extremely likely to recommend the care they had received at Barts Health, with a further 30% saying that they would be likely to recommend the service.

**Maternity Services response by category**

![Maternity Services response by category](image)

### Responding to feedback from women, their partners and families

We are taking a number of actions in response to feedback on our maternity services, including:

- **Our Great Expectations programme**
- Introducing ‘one stop’ booking clinics and a direct referral system, allowing women to book into our antenatal services directly without going via their GP
- Introducing a new section on our website with comprehensive information to support women in the early stages of their pregnancy
- Developing new promotional leaflets to explain the full range of birth choices we provide, including consultant-led units, midwifery-led co-located units (based within or alongside our consultant-led maternity units) and our two freestanding midwifery-led birth centres
- Developing new pathways of care for women with more complex pregnancies to ensure they have the support they need to achieve the best possible outcomes for them and their baby

**National cancer patient experience survey**

Improving patient experience is a key part of our cancer strategy. Following disappointing results for Barts Health in both the 2013 national cancer patient experience survey and the adjacent survey run by Macmillan Cancer Support, we set up a steering group co-ordinate our response. We have already made substantial improvements, and we have begun a collaborative partnership with Macmillan Cancer Support to test new initiatives that will help us further improve standards of care. Our steering group is concentrating on the following areas:
• Ensuring consistency of service for cancer patients in all our hospitals
• Improving information for patients from the point of diagnosis through to post-treatment follow-up
• Discussing the results of the survey with all staff involved in delivering cancer care to promote understanding of where we have scored lower than other organisations and why
• Reviewing specific areas of pain control and side effects
• Reviewing discharge arrangements for patients
• Improving social support for patients
• Ensuring that the principles of excellent care are adhered to consistently

As a result, we have already made the following improvements:
• Substantially improved the provision of patient information across every hospital site and for every type of cancer
• Redesigned information for two week wait appointments, diagnostic services, research and clinical trials, tests and symptoms
• Developed checklists/guides for each area to ensure that we are giving consistent care to all patients, reiterating the core behaviours we expect from our staff, which are used in outpatient clinics, on wards and in diagnostic services
• Introduced weekly meetings with ward and outpatient staff to discuss areas for improvement and ensure that teams understand their roles
• Joined with Macmillan at an early stage to learn from national best practice
• Implemented care rounds for patients to pick up on any welfare and social care needs
• Introduced post discharge phone calls to check that patients are supported in their community
• Reviewed our pain management processes
• Undertaken a real time survey to see where we have improved and what we need to target next
• Put in place an information repository so that information is easy to access and is standardised across all our hospitals
• Introduced responsibilities for patient experience into job descriptions
• Put in place an on-going operational plan to ensure that actions are continuously picked up

A tremendous amount of activity is also underway to improve on the key areas of concern highlighted in the 2013 national survey. The plan has concentrated on areas that we can change quickly with the aim of improving scores in the 2014 survey. It typically takes six months to a year to see substantial improvements in scores, so we anticipate that our 2014 scores will still be lower than we would wish as the changes we have made feed through into improved patient experience. The next phase of the improvements programme will be to develop a two year plan to improve the patient experience by piloting new areas of good practice with support from Macmillan, focusing on the following improvements:
• Piloting an electronic holistic needs assessment for breast cancer with Macmillan. This will be rolled out in paper form for patients with other types of cancer, with the aim of securing the electronic version for all patients in the future
• Participate in phase one of the national roll out of ‘Schwartz rounds’ with Macmillan – monthly meetings which support all health practitioners working with cancer patients with the emotional and psychosocial issues that arise from their work
• Continuing discussions around collaboration on further early diagnosis work with our Clinical Commissioning Groups, London Cancer and Macmillan
• Developing a comprehensive education programme to train individuals and teams, including ‘Lunch and Learn’ programmes funded by Macmillan and more programmes to reach out into general wards where cancer care is provided
• Participating in the values based standard approach with Macmillan which protects patients’ rights across the care pathway – this will complement the checklists we already have in place
• Refining our techniques for breaking bad news, as this has been highlighted as a particular area for improvement - we are bidding for funding to further improve information and training
Listening to people’s concerns and resolving their problems

Our Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison and central complaints teams continued to work with our Clinical Academic Group (CAG) governance teams to encourage and facilitate patients to raise and report problems and concerns. We aim to improve our services by responding to the feedback gained, taking appropriate action and sharing learning across the Trust.

PALS can usually resolve concerns quickly, before they become complaints. During 2013/14, 5,748 people contacted the PALS service. 1,098 people were seeking general information and advice and 4,655 people raised issues or concerns which PALS helped to resolve. When it is not possible to resolve issues and concerns informally, PALS will support patients in making a formal complaint if that is what they wish.

During 2013/14, we also worked to respond to service issues and dissatisfaction about the PALS service itself. Following the creation of Barts Health in 2012, it became evident that the PALS function was not working consistently across all our hospital sites, due to a lack of cross site cover and an increase in telephone contacts being made (the most common way that people access and use the service). We identified a need to centralise the service’s telephone and email systems.

In July 2013, we introduced a centralised telephone call hub, so that calls can be managed in the most efficient way across our sites. There is now one phone number and one email address, and all PALS staff are in one location. This brings unity and consistency to the service and helps us ensure that all enquiries and casework are managed in line with Trust policies. It also enables us to clearly identify how we can best support patients in answering their queries and dealing with their formal and informal complaints. The drop-in services at The Royal London, Whipps Cross and Newham Hospitals was replaced by a bookable appointment system, to avoid keeping patients waiting.

Following feedback from stakeholders and our CQC inspection in November 2013, which highlighted that people want to see increased visibility of PALS and more information available, the service is being developed further. We are working on the CQC’s recommendation for an onsite PALS presence to help support local resolution of issues and we are working with our volunteers, staff and stakeholders to develop this model. Workshops were held in February and March 2014 to review how best the PALS service can support local resolution and better patient experience.

Case studies – how PALS helps to solve problems

Facilitating care pathway plans for patients

A patient was referred to PALS via Healthwatch, the body in each council area which acts as an independent “champion” for local patients. The patient’s admission date for planned surgery had been cancelled on several occasions due a shortage of high dependency beds. This had become very distressing for her family and PALS was asked to intervene. PALS liaised with the service management and clinical teams. A new surgery date was organised and a care pathway plan was agreed with the patient. The manager explained that, although we are unable to reserve high dependency beds for elective patients because of emergency admissions, we would keep her updated. The patient’s surgery did then go ahead, a full formal investigation was undertaken into the previous cancellations and a written response was provided to the patient.

Ensuring patients receive results in a sensitive and timely way

A patient had a mammogram and was informed that she would receive the results within three weeks. An appointment was booked for the following month for the results to be discussed with her, but the appointment was subsequently cancelled and rebooked for two months later. Understandably the patient was very anxious, particularly as she had a family history of breast cancer. She asked if PALS could help. PALS liaised with the breast unit team, and a breast nurse specialist called the patient and provided her results over the phone.
Performance, learning and improvement from complaints handling

In accordance with the NHS Complaints Regulations 2009, our performance standards stipulate that all reportable complaints should be acknowledged within three working days. Reportable complaints tend to be more formal and complex, requiring an investigation and written response. The response is provided within a timescale agreed between the Trust and the complainant. As an internal benchmark, we aim to resolve reportable complaints within 25 days and measure ourselves accordingly.

During 2013/14:
- A total of 2,451 reportable complaints were received by Barts Health, a 23 percent increase on the previous year
- We closed 2,468 complaints
- 81 percent were acknowledged within three working days
- 53 percent were responded to within 25 days or the agreed timescale

We acknowledge that during 2013/14 we did not always respond to all complaints quickly enough and our performance varied. In August 2013, after a robust remedial action plan was implemented by each Clinical Academic Group, we were able to close all overdue complaint responses. However, this position was not sustained and the number of complaints exceeding the agreed timeframe had risen to 90 in December 2013. Special measures were taken to make improvements, and by the beginning of March 2014 the number had reduced to 44 overdue cases out of a total of 464 open complaints.

The issues people raised with us
Of the 2,468 complaints closed in 2013/14, the three most reported themes were:
- Aspects of their diagnosis, care or treatment
- Problems with aspects of communication, including verbal communication with staff and written/email communication
- Problems experienced with appointments, including cancellations and/or clinic attendance

The pie chart below provides a further break down of complaint themes at Barts Health in 2013/14.
How we are taking steps to improve
The complaint themes have shaped our quality priorities for improvement in 2014/15. We are already making changes to our services. Two examples are outlined here.

Improving access to appointments for orthopaedic services - Many patients were concerned about the waiting times for our orthopaedic services, particularly pain clinics. We responded as follows:

- Held extra clinics to clear the backlog
- Set up extra consultant clinics for all areas of orthopaedic care
- Appointed a locum consultant for spinal appointments, a particular area of concern
- Booked patients with spinal conditions who had been subject to delays for their follow up appointments into extra clinics
- Developed systems to further reduce waiting times for spinal appointments
- Recruited additional staff to provide extra clinics in paediatric neuro-muscular services
- Developed systems to improve communication with patients about the length of waiting times and cancellations

Improving access to advice for GPs - Several Tower Hamlets GPs raised concerns about not receiving responses to emails they sent to generic email addresses for some of our clinical services. An investigation found that this was caused by a delay in updating email addresses following the creation of Barts Health. Email addresses have since been changed and are listed in the dedicated section of our website for GPs and health partners. In addition, each clinical team now has a named lead to support GPs with accessing information.

Managing complaints from GPs
During 2013-14, Barts Health agreed a formal process with our commissioners for managing non-urgent complaints made by GPs in Tower Hamlets, Newham and Waltham Forest about care provided to their patients. Prior to our merger in 2012, each of our legacy organisations had different systems for monitoring and recording GP complaints, which included a combination of manual and electronic systems. With the new process, Barts Health now records and monitors GP complaints via Datix, our risk management system.

During the year, a total of 349 GP complaints from across our hospital sites were submitted. Some of these complaints were raised before our new process was fully embedded, meaning that whilst responses were produced for all of them, not all of them were logged on Datix. Strengthening this aspect of the process is a continued focus for 2014/15, along with other priorities including:

- Monthly reporting of GP complaints to our Board
- Developing a single template for reporting back to GPs, ensuring that we feed back the outcome of complaints consistently
- Joint reporting of GP complaints and responses with the North East London Commissioning Support Unit

Of the complaints logged on Datix in 2013/14, the table below shows the breakdown of complaints by hospital site.

<table>
<thead>
<tr>
<th>Hospital site</th>
<th>Number of GP complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Chest Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Mile End Hospital</td>
<td>7</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>10</td>
</tr>
<tr>
<td>Royal London Hospital</td>
<td>126</td>
</tr>
<tr>
<td>St. Bartholomew's Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>163</strong></td>
</tr>
</tbody>
</table>
The issues GPs reported to us
Many of the issues raised by GPs through the complaints system were similar to those for patients. The three most reported themes from GPs were:
- Aspects of diagnosis, care or treatment
- Problems with communication - verbal, written and electronic
- Problems with appointments and/or clinic attendance

The chart below provides a further break down of all the themes identified in GP complaints

The Parliamentary Health Service Ombudsman stage two complaint handling process
The role of the Parliamentary Health Service Ombudsman (PHSO) is to independently review organisations’ handling of complaints and make recommendations for change where necessary. The PHSO reviews all cases referred to them and will either:
- Investigate such complaints and uphold, partially uphold or not uphold them
- Decline to investigate cases any further, either where a complaint falls outside the PHSO’s remit or they believe actions taken at a local level do not warrant any further investigation

In 2013/14, the PHSO requested information about 42 complaints managed by Barts Health. Up until the end of February 2014, the PHSO:
- Declined to investigate five cases, as the actions already taken by the Trust were considered appropriate
- Referred one case back to us for further local resolution
- Upheld or partially upheld eight cases and made recommendations that we agreed to implement

28 open complaints were still being reviewed at the end of 2013/14.

Upheld or partially upheld complaints
These are complaints where the PHSO considered that the quality of complaints handling, or the service or care provided, was below the appropriate standard that should have been reasonably expected. In a number of these cases, inadequate handling of the complaint had negatively affected complainants’ experience of the complaint process. We know from the inspection and listening events carried out by the Care Quality
Commission in November 2013 that some complainants reported being unhappy with the way their complaints were handled and/or were dissatisfied with our response.

Alongside making recommendations for change and providing a written apology for the poor experience, the PHSO always asks the Trust to demonstrate that lessons have been learnt. As a result, we made a number of changes in 2013/14, including:

- Providing more complaints and local resolution training - mandatory for managers and staff involved in complaints resolution - including an e-learning module
- Setting up a central complaints team in May 2013 to oversee the management of complaints across the Trust and to provide support and guidance for complainants and staff
- Agreeing a number of standard operating procedures for the management of different types of complaints to make our internal processes more efficient
- Reviewing and updating our complaints policy, taking into account the findings in the recent Ann Clwyd report into the NHS complaints system and the Francis Report
- Reviewing and updating our patient information so people know who to contact with a problem and if they wish to give us feedback or make a complaint

In 2014/15, we will:

- Continue to review patient experience across the Trust, including PALS and complaints services and arrangements for local resolution
- Consult internally and externally on how we manage patient feedback

In response to specific PHSO concerns about poor nutritional care, the following action has been taken:

- Patients are now weighed within 24 hours of admission, then weekly and/or if there are changes in their condition
- If a patient is unable to sit on weighing scales, a hoist with a weight measuring device is used
- Electronic and paper nursing records are monitored more closely
- The quality of documentation completed by nursing staff is closely assessed and support and training is provided if required
- Training in nutritional care is available for staff via e-learning
- Dieticians have been working with staff to reinforce the need for nutritional assessments and prompt escalation of concerns

The PHSO also raised the issue of inadequate clinical information being provided for a patient who attended a hysterectomy appointment. The service has since reviewed their information leaflet and it has been rewritten.

Further detailed analysis about PALS and complaint themes, performance and learning will be included in the Barts Health PALS and Complaints Annual Report, which will be published in July 2014.

**Involving patient representatives in the Trust**

Patients are at the heart of everything we do at Barts Health, and a new initiative to recruit patient representatives is being explored so that patients can be more actively involved in the Trust’s improvement work.

Across our Clinical Academic Groups, patient representatives have been recruited following a competitive shortlisting and interview process. Each of our hospital sites now has a patient panel chair, and work continues to develop panels on each of the sites using the Whipps Cross patients’ panel as a model. The Whipps Cross panel was established over ten years ago and is widely recognised as an example of good practice.

Local maternity services liaison committees are now set up on all sites, including multi-professional staff from our maternity service, local CCGs, local women’s groups, service users and invited members. The meetings look at local experiences for women and review areas for change or development to ensure we respond to women’s and families’ views.
Part 5
Responding to contractual remedies and benefits realisation set out by the Competition and Cooperation Panel
Part 5 - Responding to contractual remedies and benefits realisation set out by the Cooperation and Competition Panel

Why the remedies are in place

The merger to form Barts Health was approved by the Secretary of State for Health, subject to a set of behavioural safeguards recommended by the Cooperation and Competition Panel (CCP). This later became Monitor’s Cooperation and Competition Directorate.

Behavioural safeguards (contractual remedies) were agreed between our commissioners and the CCP, and these are subject to on-going monitoring. The aim is to ensure that the quality of care provided by the merged organisation for the residents of Newham remains at least as high as it would have been in the absence of a merger.

The CCP recommended that the merger should also deliver a set of measurable benefits for all patients and residents served by Barts Health. We have tracked our progress against these indicators in 2013/14 and fed back on our progress to commissioners.

Progress against the remedies in 2013/14

Overall, our performance has been mixed. We maintained or improved performance in the following areas:

- Agreeing to quality visits
- Providing proof of learning from the merged organisation
- Incident reporting rates
- Mortality rates
- Waiting times - although a deterioration in the third quarter of the year was noted
- New-to-follow-up ratios - a measure of the follow-up appointments a patient receives for the same condition - are improving, with a one percent increase in new patients and a two percent decrease in follow up patients. This is as a result of a redesign of patient pathways to ensure faster access to diagnosis and treatment
- Our performance on consultant-to-consultant referrals has been exceptional. Our two recent audits conducted with GPs found that 99 percent of referrals could only be dealt with by secondary care – previous audits indicated a level of between 90 percent and 95 percent

However in these areas, our performance appears to be declining:

- Site specific quality indicators
- Patient safety measures, especially numbers of never events
- Staff and patient satisfaction measures

Efficiency and productivity indicators also need to be improved, in particular:

- The length of stay for both elective (planned) and non-elective (emergency) procedures
- Rates of admissions and length of stay for patients with chronic obstructive pulmonary disease
- The number of inappropriate consultant-to-consultant referrals - for example, for unrelated conditions which should be referred back to the patient’s GP
- New-to-follow-up ratios for outpatients
- Avoidable emergency readmissions within 30 days
- Pre-procedure elective and non-elective bed days
- The numbers of patients who do not attend their first outpatient appointment
- Increasing day surgery rates
Progress towards benefits realisation in 2013/14

Transforming outpatients
Our outpatient transformation programme has had an outstanding year. We have taken 25 teams through our Trust-wide programme to improve pathways. This has resulted in a large number of substantial improvements for patients, and the results have been published in the Health Service Journal.

Changes include:
- Improving specialist colorectal continence pathways from 15 months to 2 months
- Introducing one stop haematuria (blood in urine) pathways that ensure all diagnostics are completed on the day with a full report back to the GP within five days
- Moving straight to diagnostic tests for most gynaecological pathways, ensuring diagnostics and treatment are provided more quickly whilst reducing new-to-follow-up ratios
- Introducing ‘see and treat’ clinics for gynaecology to shorten the time to treatment and move patients from day-case to an outpatient setting
- Changing cardiac pathways to provide consistent discharging and increasing the capacity for new patients
- Improving rheumatology patient pathways, moving to one stop clinics delivered within two weeks of referral
- Delivering one stop maternity services to ensure faster care for patients and increasing capacity for the growing number of births.
- Introducing telephone follow up appointments for testis cancer patients, allowing patients to be followed up in their homes rather than in a clinic
- Improving access to care through the introduction of four outreach vascular clinics across east London
- Redesigning sexual health services, including introducing self-testing options which have improved access to services
- Streamlining referral and booking pathway for paediatric orthopaedic services

The outpatient transformation programme has also implemented systems for advice and guidance for GPs, with 34 dedicated email mailboxes that GPs continue to use and value.

We are also transforming outpatient settings and the types of services we offer. In 2013/14, we moved to ‘straight to test’ services for gastro-intestinal patients and opened telephone clinics for patients in oncology and colorectal services.

Reducing length of stay for patients
We have made the following progress in 2013/14:
- An improvement workstream has been devised
- Work is underway to embed the Barts Health Way across the Trust. This is helping to establish good practice for inpatient care across our hospitals, standardising the daily ward routine, ward rounds, board rounds and discharges
- Wards are being assessed against the Barts Health Way standards
- A patient flow board has been established to oversee the work on improving patient flow, discharge and patient pathways
- A discharge dashboard is now in place to monitor performance improvements

Improving pathology services
We have made the following progress in 2013/14:
- A new laboratory system is in place at Whipps Cross University Hospital
- All pathology data is being integrated into a single reporting system
- A programme is underway to replace and standardise equipment across pathology services
- Trainees have completed a training programme and have been awarded registration portfolios
- Preparing to provide electronic access to pathology results for all GP practices in the Barts Health area
- We sent out a GP satisfaction survey to local doctors in early 2014 and will act on the feedback
Improving cancer care
We have made the following progress:

- We have introduced action plans to improve cancer performance and patient safety
- The ARIA chemotherapy prescribing system has been rolled out to Newham and Whipps Cross hospitals
- Newham’s chemotherapy day unit has re-opened following a period of closure due to unplanned consultant shortages. The service uses the hub and spoke model from the Barts Cancer Centre with nursing staff who also work on the medical oncology day unit.
- All solid tumour oncology patients are now offered treatment on the Newham site, if appropriate
- We now have three acute oncology service clinical nurse specialists, an initiative which was commended at an external peer review
- ‘Straight to test’ and one stop clinics have been introduced in a greater range of specialities

Improving paediatric consultant rotas
We have made the following progress:

- Senior consultants now work on all sites with an increase in their presence in the evenings
- There have been session exchanges between senior staff across the Trust’s sites to share good practice
Part 6
External feedback and reports
Feedback and reports from our stakeholders

In early May 2014, we sent a draft version of the Quality Account to a number of local stakeholders for their scrutiny, input and comment. The Account was sent to:

- City and Hackney Clinical Commissioning Group
- Newham Clinical Commissioning Group
- Tower Hamlets Clinical Commissioning Group
- Waltham Forest Clinical Commissioning Group
- Healthwatch City of London
- Healthwatch Newham
- Healthwatch Tower Hamlets
- Healthwatch Waltham Forest
- Senior council officers at:
  - City of London Corporation
  - Newham Council
  - Tower Hamlets Council
  - Waltham Forest Council

In previous years, the draft Account has been sent to the chair of each local council's health scrutiny committee, and senior representatives from Barts Health have presented to committees on the draft Account during regular scheduled meetings. For the 2013/14 Account, the schedule mandated by the Department of Health coincided with local elections for all London councils (except the City of London Corporation). National requirements for publicly funded bodies during the period leading up to elections require us to abide by specific guidelines, which state that we cannot directly approach existing elected members or candidates seeking election to ask them to comment on or speak about issues relating to our operations. Therefore, this year's Account was sent instead to senior council officers with a request that they provide feedback in the most appropriate way. As a result, we received feedback directly from the outgoing chair of the Inner North East London Joint Overview and Scrutiny Committee, representing the health scrutiny committees of the London Boroughs of Tower Hamlets, Newham and Waltham Forest and the City of London Corporation.

Formal responses received

Written responses were received from:

- Tower Hamlets Clinical Commissioning Group, on behalf of the collaborative commissioning arrangements for Barts Health NHS Trust, which included comments from commissioners on the content of the Account
- Healthwatch Tower Hamlets, on behalf of the Healthwatches for the City of London, Newham and Waltham Forest
- The Inner North East London Joint Overview and Scrutiny Committee

These responses are included at Appendix 2.

Internally, the draft Quality Account was presented to the Trust's Quality Assurance Committee, a sub-committee of the Board, the Trust Board and the Trust executive team.

Responding to our stakeholders' scrutiny and comments

We made a number of changes to the Quality Account as a result of feedback from our stakeholders, the Quality Assurance Committee, Trust Board, Trust executive team, and our auditors, Grant Thornton UK LLP. The main changes include:

- Adding a section to summarise activity and achievements within Tower Hamlets Community Health Services, which have now been integrated into the Barts Health Clinical Academic Group structure
- Adding information about an inspection by the Care Quality Commission in March 2014 of services under the Mental Health Act
- Adding references to our response to the Berwick and Keogh reviews, which reported during the year
- Updating the section on our response to the Francis Report
- Updating and adding to performance data where later figures became available since the draft Account was circulated for comment
- Responded in detail to a comprehensive set of requests for clarification and further information from our commissioners
Independent auditors’ limited assurance report to the directors of Barts Health NHS Trust on the annual Quality Account

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Barts Health NHS Trust’s Quality Account for the year ended 31 March 2014 (“the Quality Account”) and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (“the Act”). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:
- The percentage of patient safety incidents resulting in severe harm or death
- The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of Directors and auditors
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 annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).
In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:
- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- 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 that they are working effectively in practice;
- the data underpinning the measures 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 are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account. 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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions. We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:
- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 23/05/2014;
- feedback from Local Healthwatch dated 30/05/2014
the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated April 2014;
feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
the latest national patient survey dated February 2014;
the latest national staff survey dated December 2013;
the Head of Internal Audit's annual opinion over the Trust's control environment dated 25/05/2014;
the annual governance statement dated 04/06/2014; and
Care Quality Commission Intelligent Monitoring Report dated 13 March 2013;

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.

This report, including the conclusion, is made solely to the Board of Directors of Barts Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Barts Health NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:
- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquires of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; 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 which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Barts Health NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:
- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
• the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
• the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

30 June 2014
Appendices
### Appendix 1a - Participation in mandatory national clinical audit projects in 2013/14

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>National Clinical Audit supplier</th>
<th>CAG</th>
<th>Inclusion criteria - data submitted in 2013/14</th>
<th>Number of participating sites/number of eligible sites</th>
<th>Site coverage - number of cases submitted in 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult critical care</td>
<td>ICHARC Case mix programme</td>
<td>Surgery</td>
<td>All critical care patients in 2013/14 financial year. Audit of patient outcomes from adult general critical care units (intensive care and combined intensive care/high dependency units)</td>
<td>3/3</td>
<td>100% 426 patient records 100% 685 patient records 100% ICU 1243 patient records HDU: 1457 patient records Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>British Thoracic Society</td>
<td>ECAM</td>
<td>All patients on oxygen therapy on a ward from 15 August 2013 to 1 November 2013. Audit includes the first 10 patients in any one ward provided there is no bias in the selection of patients.</td>
<td>2/3</td>
<td>All wards contributed to local audit presented at Grand Round and in medical journal but data were not submitted to the national audit.</td>
</tr>
<tr>
<td>National Audit of Seizure Management (NASM)</td>
<td>NASM</td>
<td>ECAM</td>
<td>All cases of patient aged over 16 years presenting at the Emergency Department from 1 January 2013 with an episode thought to have been a seizure and seizure was the primary reason for presentation.</td>
<td>3/3</td>
<td>100% (30/30) 100% (30/30) 100% (30/30) Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>The Royal College of Anaesthetists</td>
<td>Surgery</td>
<td>All patients over the age of 18 year having a general surgical emergency laparotomy from 1 January 2014 to 31 November 2015.</td>
<td>3/3</td>
<td>Ongoing participation (participation figures will be finalised in 2014/15) Ongoing participation (participation figures will be finalised in 2014/15) Ongoing participation (participation figures will be finalised in 2014/15) Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Hip, knee and ankle replacements</td>
<td>National Joint Registry</td>
<td>Surgery</td>
<td>All hip, knee and ankle replacements from 1 April 2013 to 31 March 2014.</td>
<td>3/3</td>
<td>62 procedures by operation date 262 procedures by operation date 326 procedures by operation date Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Paracetamol overdose (care provided in Emergency Departments)</td>
<td>College of Emergency Medicine</td>
<td>ECAM</td>
<td>All patients (min. 50 cases) presenting to the Emergency Department with a paracetamol overdose from 16 October 2013 to 31 March 2014.</td>
<td>3/3</td>
<td>100% (55/55) 100% (55/55) 100% (55/55) Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Severe sepsis &amp; septic shock</td>
<td>College of Emergency Medicine</td>
<td>ECAM</td>
<td>Maximum 30 cases of adults (19 years of age or older) diagnosed with either severe sepsis or septic shock at the Emergency Department from 16 October 2013 to 31 March 2014.</td>
<td>3/3</td>
<td>100% (55/55) 100% (55/55) 100% (55/55) Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Severe trauma</td>
<td>TARHN</td>
<td>ECAM</td>
<td>All trauma patients in 2013 calendar year.</td>
<td>3/3</td>
<td>32 cases submitted 77 cases submitted 1040 cases submitted (Good data completeness) Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion: Use of Anti-D Prophylaxis</td>
<td>NHS Blood and Transplant</td>
<td>CSS</td>
<td>All women booked for delivery in September 2012 in every antenatal unit served by the laboratory including maternity units</td>
<td>2/2</td>
<td>23 cases submitted 100% Not eligible 40 cases submitted 100% Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>National Comparative Audit: Patient Information and Consent</td>
<td>NHS Blood and Transplant</td>
<td>CSS</td>
<td>Patients who have been electrolytically transfused with red blood cells (2 patients a week for a 12 week period starting 13 January 2014)</td>
<td>2/3</td>
<td>19 cases submitted Did not participate one off audit 19 cases submitted Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Bowel cancer</td>
<td>Health and Social Care Information Centre</td>
<td>Surgery and Cancer</td>
<td>All patients diagnosed from 1 April 2012 - 31 March 2013 undergoing major surgery.</td>
<td>3/3</td>
<td>100% expected (42 surgical cases submitted in total) 100% expected (126 surgical cases submitted in total) 100% expected (70 surgical cases submitted in total) Not eligible Not eligible Not eligible</td>
</tr>
<tr>
<td>Head &amp; neck cancer</td>
<td>Health and Social Care Information Centre</td>
<td>Surgery and Cancer</td>
<td>Patients diagnosed from 1 November 2012 to 31 October 2013.</td>
<td>2/2</td>
<td>Not eligible R1H as 'created by' organisation = 137 R1H as 'diagnosis organisation' = 158 Not eligible R1H as 'created by' organisation = 137 R1H as 'diagnosis organisation' = 158 Not eligible Not eligible</td>
</tr>
<tr>
<td>Disease Description</td>
<td>Healthcare Provider</td>
<td>Clinical Specialty</td>
<td>Condition Details</td>
<td>Participants</td>
<td>Completed</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Health and Social Care Information Centre</td>
<td>Cancer</td>
<td>Patients first seen from 1 January 2012 to 31 December 2012</td>
<td>4/4</td>
<td>102/112</td>
</tr>
<tr>
<td>Oesophageal-gastric cancer</td>
<td>Health and Social Care Information Centre</td>
<td>Cancer</td>
<td>Patients diagnosed in the first and second years of the continuing audit (01 April 2012 to 31 March 2013) including patients with oesophageal high-grade glandular dysplasia (HGD)</td>
<td>4/4</td>
<td>119/140</td>
</tr>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction</td>
<td>MNAP</td>
<td>Cardiovascular</td>
<td>All consecutive patients with suspected heart attack from April 2013 to March 2014</td>
<td>3/4</td>
<td></td>
</tr>
<tr>
<td>Congenital heart disease (Paediatric cardiac surgery)</td>
<td>CHD</td>
<td>Cardiovascular</td>
<td>All cardiac or intrathoracic great vessel procedures carried out in patients under the age of 16 years, and all adult congenital cardiac procedures performed for a cardiac defect present from birth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary angioplasty otherwise known as Audit of Percutaneous Coronary Interventional Procedures (PCI)</td>
<td>NICOR: National Institute of Cardiovascular Outcomes Research (also BCSI)</td>
<td>Cardiovascular</td>
<td>All PCI patients in the 2012 calendar year for report published in January 2014.</td>
<td>2/2</td>
<td></td>
</tr>
<tr>
<td>Adult cardiac surgery audit (ACS)</td>
<td>ACS (Society of Cardiothoracic Surgeons)</td>
<td>Cardiovascular</td>
<td>Patients undergoing two major types of cardiac surgery aortic valve surgery and coronary bypass surgery from 1 April 2012 to 31 March 2013</td>
<td>1/1</td>
<td></td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>ICNARC</td>
<td>ECAM</td>
<td>All individuals (excluding neonates) receiving chest compressions and/or defibrillation and attended by the hospital-based resuscitation team (or equivalent) in response to the 2222 from 1 April 2013 to 31 March 2013</td>
<td>4/4</td>
<td>Quarter 1: 43 cases</td>
</tr>
<tr>
<td>Heart failure (HF)</td>
<td>NICOR: National Institute of Cardiovascular Outcomes Research</td>
<td>Cardiovascular</td>
<td>All heart failure patients from 1 April 2012 to 31 March 2013</td>
<td>4/4</td>
<td>380 records submitted</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>Royal College of Surgeons</td>
<td>Surgery</td>
<td>Patients undergoing vascular procedures including aortic revascularisation, carotid revascularisation, lower limb revascularisation from 1 October 2012 to 30 September 2013</td>
<td>1/1</td>
<td></td>
</tr>
<tr>
<td>Pulmonary hypertension audit</td>
<td>HSCI/C</td>
<td>Not applicable</td>
<td>Pulmonary hypertension centres only. Barts Health is not a pulmonary hypertension centre.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes (Adult) ND(A)</td>
<td>NDA</td>
<td>ECAM</td>
<td>All patients diagnosed with diabetes and seen in and outpatient care from 1 October 2013 to 31 December 2013. (Please note: the number of cases reported in the 2013 Quality Account was incorrect.)</td>
<td>2/3</td>
<td>100% (1621 cases)</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit (NADIA)</td>
<td>NDA</td>
<td>ECAM</td>
<td>All admission with diabetes throughout a specified day from 16 September 2013 to 20 September 2013, Both Bedside Audits completed by clinicians and Patient Experience Surveys submitted</td>
<td>5/5</td>
<td>Bedside Audit: 59 forms Patient Experience: 23 questionnaires</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPD)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Children's</td>
<td>Patients that have been seen at paediatric diabetes clinics from 1 April 2012 to 31 March 2013 up to and including 24 years of age.</td>
<td>3/3</td>
<td>555 visits submitted</td>
</tr>
</tbody>
</table>

**Notes:**
- Not eligible: Indicates that the program is not eligible for participation.
- Data submitted: Indicates that data has been submitted.
- Good data completeness: Indicates that the data completeness is satisfactory.
- Full participation: Indicates that all patients were included in the study.
- Not participating: Indicates that the audit was not participating in the study.
- Full participation 997 devices procedures (663 Pacemakers, 334 ICD) 626 EP ablation procedures: Indicates that full participation was achieved with 997 devices procedures.
- Not Participating as sample too small to be included (<2 per annum): Indicates that participation was not achieved due to sample size being too small.
- Not eligible - no A&E department: Indicates that participation was not achieved due to lack of data from A&E department.

**Data Sources:**
- 102/112: Not eligible: Indicates that the program is not eligible for participation.
- 119/140: Not eligible: Indicates that the program is not eligible for participation.
- 3/4: Not eligible: Indicates that the program is not eligible for participation.
- 100% participation: Indicates that all patients were included in the study.
- 100% (1621 cases): Indicates that 100% of cases were accounted for.
- 380 records submitted: Indicates that 380 records were submitted.
- LCH and RLH data submitted as one 240 records submitted: Indicates that all records were submitted as one set.
- 787 OPD visits submitted: Indicates that 787 OPD visits were submitted.
<table>
<thead>
<tr>
<th><strong>Inflammatory bowel disease (IBD) includes Paediatric Inflammatory Bowel Disease Services</strong></th>
<th>Royal College of Physicians</th>
<th>ECAM and Children’s</th>
<th>50 consecutive prospectively identified admissions for ulcerative colitis from 1 January to 31 December.</th>
<th>4/4</th>
<th>Inpatient Audit: Adults: 19 cases Biology: Adults: 26 cases</th>
<th>Inpatient Audit: Adults: 9 cases Biology: Adults: 1 case</th>
<th>Inpatient Audit: Adults: 26 cases Paeds: 15 cases Biologics: Adults: 15 cases Paeds: 37 cases</th>
<th>Not eligible</th>
<th>Not eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronic Obstructive Pulmonary Disease (COPD)</strong></td>
<td>Royal College of Physicians</td>
<td>ECAM</td>
<td>Snapshot audits of admission to hospital from 1 February to 30 April 2014 with COPD exacerbation and outcomes at 30 and 90 days.</td>
<td>3/3</td>
<td>Organisational audit complete 50 cases submitted</td>
<td>Organisational audit complete 32 cases submitted</td>
<td>Organisational audit complete 89 cases submitted</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>Paediatric bronchiectasis</strong></td>
<td>British Thoracic Society</td>
<td>Children’s</td>
<td>Patients who attend an outpatient clinic for a review or follow-up appointment for bronchiectasis from 1 October 2013 to 30 November 2013. Patients seen in A&amp;E are not included.</td>
<td>1/1</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>21 eligible cases submitted (minimum of 20 consecutive patients)</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>Renal replacement therapy</strong></td>
<td>Renal Registry</td>
<td>ECAM</td>
<td>All patients starting renal replacement therapy (RRT) in 2013</td>
<td>1/1</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Quarter 1: 2343 (100%) Quarter 2: 2299 (100%)</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>Rheumatoid and early inflammatory arthritis</strong></td>
<td>British Rheumatology Society</td>
<td>ECAM</td>
<td>All patients with rheumatoid and early inflammatory arthritis from 1 February 2014. Data entry includes 3 months follow-up.</td>
<td>3/3</td>
<td>Organisational questionnaires submitted 3/2</td>
<td>Not eligible</td>
<td>Organisational Audit submitted with Mile End Data collection continuous until 28/02/2015</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)</strong></td>
<td>Centre for Mental Health and Risk, University of Manchester</td>
<td>Not applicable</td>
<td>Mental health services are provided by East London NHS Foundation Trust and North East London NHS Trust, not Barts Health.</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td></td>
</tr>
<tr>
<td><strong>National audit of schizophrenia</strong></td>
<td>Royal College of Psychiatrists</td>
<td>Not applicable</td>
<td>Mental health services are provided by East London NHS Foundation Trust and North East London NHS Trust, not Barts Health.</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td></td>
</tr>
<tr>
<td><strong>Prescribing Observatory for Mental Health (POMH)</strong></td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Mental health services are provided by East London NHS Foundation Trust and North East London NHS Trust, not Barts Health.</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Stroke National Audit Programme</strong></td>
<td>Royal College of Physicians</td>
<td>ECAM</td>
<td>All stroke patients from April 2013 to March 2014 in their first three days in hospital.</td>
<td>3/3</td>
<td>Quarter 1: 55 cases Quarter 2: 34 cases</td>
<td>Quarter 1: 47 cases Quarter 2: 25 cases</td>
<td>Hyper Acute Stroke Unit: Quarter 1: 213 (80%) Hyper Acute Stroke Unit: Quarter 2: 163 (82%)</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>Elective surgery (National PROMs Programme)</strong></td>
<td>NHSIAC</td>
<td>Surgery</td>
<td>All groin hernia, varicose veins, hip fracture and knee fracture patients.</td>
<td>3/3</td>
<td>Continuous participation - please see data provided in the PROMs section</td>
<td>Continuous participation - please see data provided in the PROMs section</td>
<td>Continuous participation - please see data provided in the PROMs section</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>Child health clinical outcome review programme</strong></td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Children’s</td>
<td>Did not take place in 2013/14 - confirmed by RCPCH April 2014.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Study Title</td>
<td>Reference</td>
<td>Population</td>
<td>Eligibility Criteria</td>
<td>n</td>
<td>7 eligible cases submitted</td>
<td>13 eligible cases submitted</td>
<td>13 eligible cases submitted</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Epilepsy12 audit (Round 2) - organisational Questionnaire.</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Childrens</td>
<td>Round 2: Children and young people between 1 month and 16 years who have a first EEG between 1 January and 31 October 2013 and then have a first paediatric assessment for the first paroxysmal episode or episodes between 1 January and 30 April 2014. Data is collected on 12 months of subsequent care. Patient Reported Experience Measure (PREM) questionnaires handed to families in clinics in February/March 2014.</td>
<td>3/3</td>
<td>7 eligible cases submitted</td>
<td>13 eligible cases submitted</td>
<td>13 eligible cases submitted</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Moderate of severe asthma in children</td>
<td>College of Emergency Medicine</td>
<td>ECAM</td>
<td>Maximum 6 cases of children aged between 2 years old and under 16 years old who presented to the Emergency Department with moderate or severe asthma from 16 October 2013 to 31 March 2014. Excludes patients presenting with life-threatening symptoms, or mild cases of asthma with peak flow on arrival &lt; 80% of the expected value.</td>
<td>3/3</td>
<td>100% (50/50)</td>
<td>100% (50/50)</td>
<td>100% (50/50)</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Childrens</td>
<td>All babies admitted to the neonatal unit in 2013, including term babies.</td>
<td>3/3</td>
<td>462 babies with a final discharge submitted</td>
<td>334 babies with a final discharge submitted</td>
<td>411 babies with a final discharge submitted</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>British Thoracic Society</td>
<td>Childrens</td>
<td>All children over 1 year of age admitted with a primary diagnosis of wheezy/acute asthma into a paediatric unit and under paediatric care in November 2013.</td>
<td>3/3</td>
<td>44 (minimum of 20 consecutive patients)</td>
<td>41 (minimum of 20 consecutive patients)</td>
<td>30 (minimum of 20 consecutive patients) + organisational survey</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Paediatric Intensive care</td>
<td>PICANet</td>
<td>Childrens</td>
<td>All children and young people admitted to the paediatric intensive care unit from 1 January 2012 to 31 December 2014.</td>
<td>1/1</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>373 eligible admissions submitted</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
<tr>
<td>National confidential enquiries: Tracheostomy Care, Lower Limb Amputation and Gastrointestinal Haemorrhage</td>
<td>NCEPOD</td>
<td>Surgery and ECAM</td>
<td>Organisational and clinician questionnaires accompanied by a snapshot of cases notes as selected by NCEPOD.</td>
<td>3/3</td>
<td>Participated</td>
<td>Participated</td>
<td>Participated</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
</tbody>
</table>
### Appendix 1b – national clinical audit summaries

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Synopsis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>All children over one year of age admitted with a final diagnostic coding label of pneumonia into a paediatric unit and under paediatric care from November 1 2012 to January 31 2013.</td>
</tr>
<tr>
<td><strong>Paediatric pneumonia</strong></td>
<td>The Whips Cross team found that too many children started intravenous (IV) antibiotics unnecessarily. In addition, routine chest X-rays, C-reactive protein (CRP) tests and blood cultures were too frequent and too many routine hospital follow-ups had been arranged for the sample of 60 children.</td>
</tr>
<tr>
<td>British Thoracic Society</td>
<td>At Newham University Hospital, children had a greater number of microbiological investigations than the national average. Newham had a better than average use of nasogastric (NG) feeding, but also higher than average use of IV fluids. The team have pledged to continue to follow current prescribing practice as their results show better adherence than nationally to antibiotics chosen and the duration of IV treatment. No complications were seen during the audit period, but the number of patients having hospital follow up appointments was higher than the national average at 75 percent.</td>
</tr>
<tr>
<td>Published May 2013</td>
<td>The Royal London Hospital action plan is yet to be received. The results show that microbiological tests were undertaken in 61.1 percent of cases compared with 28.9 percent nationally.</td>
</tr>
<tr>
<td></td>
<td>We have pledged to follow national guidance to rely on clinical diagnosis and minimise reliance on investigation-influenced management. Newham is considering the possibility of reducing the number of patients with outpatient follow up.</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>All children over one year of age admitted with a primary diagnosis of wheezing/acute asthma into a paediatric unit and under paediatric care in November 2013.</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>British Thoracic</td>
<td>Advice leaflets were handed out on discharge to four percent of families at the Royal London Hospital, 20 percent of families at Newham and 21 percent of families at Whipps Cross. Teams have been encouraged to budget for and order asthma advice leaflets and personalised management plans from Asthma UK.</td>
</tr>
<tr>
<td>Society</td>
<td>The Newham team reported that they had compared favourably with national data as only 14 percent of patients were given antibiotics compared with 27 percent nationally. The team aim to reduce this to less than 10 percent. The Royal London gave antibiotics in 17 percent of cases, while at Whipps Cross the figure was 26 percent. The team at Whipps Cross has not expressed an intention to reduce antibiotic prescribing, stating that this is not in the guidelines.</td>
</tr>
<tr>
<td>Published May 2013</td>
<td>Newham also committed to increase the use of peak flow in every child over six years old. Only 6 percent had peak flow attempted, with 17 percent potentially able, but this is comparable to national data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paediatric fever</th>
<th>50 or more children under the age of five presenting consecutively with a medical condition from 1 August to 30 November 2012.</th>
</tr>
</thead>
<tbody>
<tr>
<td>College of Emergency Medicine – managed by the Emergency and Acute Medicine CAG.</td>
<td>The feverish child audit highlighted that on the whole there is timely documentation of vital signs at triage at Newham University Hospital. Documentation at The Royal London Hospital and Whipps Cross University Hospital highlighted room for improvement.</td>
</tr>
<tr>
<td>Published February 2013</td>
<td>The College of Emergency Medicine recommends that departments with a prescription rate of greater than the median of 18 percent should review their practice and consider changes to reduce the antibiotic prescribing rate. The Royal London and Newham hospitals prescribed antibiotics in 30 percent or more cases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Patients seen at paediatric diabetes clinics from 1 April 2011 to 31 March 2012 up to and including 24 years of age.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal College of Paediatrics and Child Health National Paediatric Diabetes Audit</td>
<td>The Royal London Hospital team achieved excellent results with 30.1 percent of their 156 eligible patients gaining an HbA1c of &lt;58 mmol/mol (7.5 percent), and a good median HbA1c of 8.2 percent. Newham University Hospital achieved a median HbA1c of 9.0 percent based on 98 patients while Whipps Cross achieved a median of 8.2 percent with 104 patients. This compares with a London median of 8.6 percent. Data completeness was good at all Barts Health sites.</td>
</tr>
<tr>
<td>Published December 2013</td>
<td>A Patient Reported Experience Measures report was also published in 2013.</td>
</tr>
<tr>
<td><strong>Neonatal intensive and special care</strong></td>
<td>Data completeness outliers were sent to all Barts Health sites in 2012 relating to 2011 neonatal data. This was reported in the report published in 2013. Despite action plans having been completed, data completeness at Newham, The Royal London and Whipps Cross hospitals remains below the national average in a number of audit questions in data submitted for babies with a 'final' discharge between 1 July 2013 and 30 September 2013. The data published in 2013 for the calendar year 2012 suggests that the time of temperature from birth measurement, within an hour, did not take place in all cases at Newham and the Royal London Hospital. Very few eligible babies at The Royal London and Whipps Cross hospitals were screened for retinopathy of prematurity on time. Newham University Hospital recorded a slightly better rate, but still fell short of national guidance. Documented consultation with parents by a senior member of the neonatal team should take place within 24 hours of admission according to national standards. This happened in only 32 percent (143 of 445) eligible episodes at The Royal London, 64 percent (226 of 353) at Whipps Cross and 91 percent (384 of 423) at Newham.</td>
</tr>
<tr>
<td><strong>Epilepsy12</strong></td>
<td>The last report was published in September 2012. The Trust is currently participating in the next round of data collection. It is not clear at this stage whether the Trust is compliant with the recommendations in the September 2012 report by the Royal College of Paediatrics and Child Health:</td>
</tr>
<tr>
<td>Audit Title</td>
<td>Synopsis</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| Emergency Oxygen Audit 2013 | The British Thoracic Society’s guideline for emergency oxygen use in adult patients includes the following key recommendations:  
  • Oxygen therapy should be adjusted to achieve target saturations rather than giving a fixed dose to all patients with the same disease  
  • Oxygen will require a prescription in all situations except for the immediate management of critical illness  
  
  The local audit results are not yet available but the Trust has noted the national position that many patients were still being given oxygen with no prescription in late 2013. Nationally, there is some evidence that clinical staff may not always respond appropriately to patients with high or low oxygen saturation levels.  
  
  In January 2014, Newham University Hospital’s performance in the audit was presented at the grand round with a yearly comparison of compliance from 2010 to date. An article was also published in the journal Thorax. The team had instigated all the operational and education recommendations in the BTS guideline, yet the results across the three years were mixed, with both decline and improvement. The team therefore conducted a staff survey to find out about the barriers to success using Pathman’s four stages of guidelines compliance (awareness, agreement, adoption and adherence). As a result of the audit and survey, more ward based teaching will be provided by the pharmacy team. |
| British Thoracic Society (BTS) | Published national summary in February 2014 |
| National Audit of Seizure Management in Hospitals Report 2013 | The audit looked at 30 patients presenting with seizures to our three A&E departments to:  
  • Describe and understand the organisation of care available for people presenting to Emergency Departments with seizures  
  • Describe the variations in care actually delivered  
  • Set out options and opportunities for improving care and to share those with the hospitals, patient organisations and NHS managers in the hope that together they can act to effect improvement  
  
  Barts Health observed a higher than average number of repeat attendances which may mean that we could do more to resolve problems for our patients. The audit highlighted variations in practice at all sites.  
  
  This year, we will aim to standardise practice to ensure good recording of patient data as well as prompt clinical assessment. |
| National Audit of Seizure Management in Hospitals (NASH) | Published on January 31 2014 |
Appendix 2 - Quality Account 2013/14 Mandated Core Indicators

Standard Hospital Mortality Indicator (SHMI)

Definition
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to (a) the value and banding of the summary hospital-level mortality indicator (“SHMI”) for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.

Data period 1 July 2012 – 30 June 2013

<table>
<thead>
<tr>
<th>SHMI</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>5th</th>
<th>Average</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.6259</td>
<td>0.7351</td>
<td>0.7823</td>
<td>0.7923</td>
<td>1.00</td>
<td>1.1563</td>
</tr>
</tbody>
</table>

The SHMI figures include patients who were coded as receiving ‘palliative care’ at either diagnosis or specialty level:

<table>
<thead>
<tr>
<th>Patients receiving palliative care</th>
<th>Best</th>
<th>Average</th>
<th>Barts Health</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>44.1%</td>
<td>20.50%</td>
<td>17.6%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Patient Reported Outcome Measures (PROMS)

Definition
The data made available to the National Health Service trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to the trust’s patient reported outcome measures scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.

Data period April 2102- March 2013

<table>
<thead>
<tr>
<th>PROMS i) groin hernia</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>Barts Health</th>
<th>Average</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.157</td>
<td>0.136</td>
<td>0.128</td>
<td>0.087</td>
<td>0.083</td>
<td>0.015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROMS ii) varicose vein surgery</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>Barts Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.175</td>
<td>0.152</td>
<td>0.138</td>
<td>*</td>
</tr>
</tbody>
</table>
**Average** 0.093
**Worst** 0.023  King’s College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>PROMS</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>Average</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii) hip replacement surgery</td>
<td>0.35</td>
<td>0.346</td>
<td>0.343</td>
<td>0.27</td>
<td>0.164</td>
</tr>
<tr>
<td>Barts Health</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROMS</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>Average</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>iv) knee replacement surgery</td>
<td>0.369</td>
<td>0.298</td>
<td>0.294</td>
<td>0.25</td>
<td>0.194</td>
</tr>
<tr>
<td>Barts Health</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Casemix-adjusted figures are not shown for organisations with fewer than 30 modelled records, as the underlying statistical models break down when counts are low and aggregate calculations based on small numbers may return unrepresentative results.

### Readmission to hospital within 28 days of discharge

**Definition**
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged 0 to 14 and 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

**Data period April 2012- March 2013**

**a) Readmissions age 0-14**

<table>
<thead>
<tr>
<th>Readmissions 0-14</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>Average</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>7.62</td>
<td>18.49</td>
</tr>
<tr>
<td>Nottingham University Hospitals NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aintree University Hospital NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**b) Readmissions age 15 and over**

<table>
<thead>
<tr>
<th>Readmissions 15 and over</th>
<th>Best</th>
<th>2nd</th>
<th>3rd</th>
<th>Average</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imperial College Healthcare NHS Trust</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>7.62</td>
<td>18.49</td>
</tr>
<tr>
<td>Nottingham University Hospitals NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barts Health NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Responsiveness to personal needs of patients – patient experience net promoter score

Definition
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust’s responsiveness to the personal needs of its patients during the reporting period.

Data period 2013/14 inpatient survey

<table>
<thead>
<tr>
<th>Net promoter score</th>
<th>Best</th>
<th>84.4</th>
<th>The Clatterbridge Cancer Centre NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2nd</td>
<td>84.2</td>
<td>The Royal Marsden NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>3rd</td>
<td>84.1</td>
<td>Radiological protection centre, St George’s Healthcare NHS Trust</td>
</tr>
<tr>
<td>Barts Health</td>
<td>Average</td>
<td>63.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Worst</td>
<td>68.1</td>
<td>Croydon Healthcare NHS Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>57.4</td>
<td></td>
</tr>
</tbody>
</table>

Venous Thromboembolism (VTE) Risk Assessment

Definition
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Data period Quarter 1 April 2013 to June 2013

<table>
<thead>
<tr>
<th>Percentage of patients admitted to hospital who were risk assessed for VTE</th>
<th>Best</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barts Health</td>
<td>96.33%</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>95.39%</td>
<td></td>
</tr>
<tr>
<td>Worst</td>
<td>78.78%</td>
<td></td>
</tr>
<tr>
<td>Weston Area Health NHS Trust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quarter 2 July 2013 to September 2013

<table>
<thead>
<tr>
<th>Percentage of patients admitted to hospital who were risk assessed for VTE</th>
<th>Best</th>
<th>100%</th>
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<tbody>
<tr>
<td>Barts Health</td>
<td>96.27%</td>
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<tr>
<td>Average</td>
<td>95.69%</td>
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<tr>
<td>Worst</td>
<td>81.7%</td>
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<tr>
<td>Weston Area Health NHS Trust</td>
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</table>
Rates of Clostridium Difficile

Definition
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

Data period April 2012 – March 2013

<table>
<thead>
<tr>
<th>C Diff</th>
<th>Best 0.00</th>
<th>Alder Hey Children’s NHS Foundation Trust</th>
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</thead>
<tbody>
<tr>
<td>2nd</td>
<td>0.00</td>
<td>Birmingham Women’s NHS Foundation Trust</td>
</tr>
<tr>
<td>3rd</td>
<td>0.00</td>
<td>Liverpool Women’s NHS Foundation Trust</td>
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<tr>
<td>Barts Health</td>
<td>13.9</td>
<td>Barts Health NHS Trust</td>
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</tbody>
</table>

Average 16.15
Worst 30.76 North Tees and Hartlepool NHS Foundation Trust

Patient safety incident reporting

Definition
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Data period April 2013 - September 2013 (NRLS)

Rate of patient safety incidents reported in 2012/13 (a higher rate of incident reporting is seen as positive)

<table>
<thead>
<tr>
<th>Rate</th>
<th>Best 12.8</th>
<th>Central Manchester University Hospitals Foundation Trust</th>
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<tbody>
<tr>
<td>Barts Health</td>
<td>7.9</td>
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<tr>
<td>Average</td>
<td>7.79</td>
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<tr>
<td>Worst</td>
<td>4.8</td>
<td>Sheffield Teaching Hospital NHS Foundation</td>
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</table>

Definition
The data made available to the trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Data period April 2013 - September 2013 (NRLS)

Percentage of patient safety incidents which resulted in severe harm or death

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Best 0.0%</th>
<th>Chelsea and Westminster NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Barts Health</td>
<td>0.2%</td>
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<tr>
<td>Average</td>
<td>0.35%</td>
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<tr>
<td>Worst</td>
<td>0.7%</td>
<td>King’s College Hospital NHS Foundation Trust</td>
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</table>
Friends and Family Test

Friends and Family Test - staff

Definition
Friends and Family Test - Question Number 12d – Staff – The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' for each acute and acute specialist trust who took part in the staff survey.

Data period 2013

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<tr>
<th>FFT–staff Question 12</th>
<th>Best</th>
<th>93.92</th>
<th>Papworth Hospital NHS Foundation Trust</th>
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<td>2nd</td>
<td>93.67</td>
<td>Queen Victoria Hospital NHS Foundation Trust</td>
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<td>3rd</td>
<td>93.29</td>
<td>Royal Brompton and Harefield NHS Foundation Trust</td>
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<td>Average</td>
<td>64.58</td>
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<td>Barts Health</td>
<td>53.55</td>
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<td>Worst</td>
<td>38.03</td>
<td>Devon Partnership NHS Trust</td>
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</table>

Friends and Family Test - Patient

Definition
The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)

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<th>FFT patient</th>
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<th>Benenden Hospital</th>
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<tr>
<td></td>
<td>2nd</td>
<td>97</td>
<td>The Clatterbridge Cancer Centre NHS Foundation Trust</td>
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<td>3rd</td>
<td>95</td>
<td>Fairfield Independent Hospital</td>
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<td>Average</td>
<td>68.95</td>
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<td>Barts Health</td>
<td>57</td>
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<td>Worst</td>
<td>10</td>
<td>Medway NHS Foundation Trust</td>
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## Appendix 3 – Action plan in response to the Care Quality Commission inspection in November 2013

### Barts Health CQC Master Action Plan

#### Overall Quality Report: High Level Improvement Actions

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<tr>
<th>Ref No</th>
<th>Key theme or issue</th>
<th>Site(s)</th>
<th>CAG/Service line</th>
<th>Planned action (description)</th>
<th>Measures and monitoring method</th>
<th>Impact for service users (risks until action is completed)</th>
<th>Owner</th>
<th>Executive Lead(s) (designation)</th>
<th>Completion date</th>
<th>Open/Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH01</td>
<td>The Trust must ensure action is taken on identified risks recorded on the risk register</td>
<td>All</td>
<td>All</td>
<td>Risk register to be reviewed at CAG, Corporate and service line performance reviews Approve new risks &gt;12 Approve risk mitigation plans and monitor (evidence on RR) Service Line Managers /equivalents risk workshops to be delivered RMC to review risk ToR to determine how to ensure risk mitigation is on time RMC to escalate poor risk mitigation to TMB</td>
<td>Deep Dive Risk Reports to RMC by each CAG/division CAG/Corporate Risk Metric reports to each RMC Out of review date/mitigation date challenge</td>
<td>Low</td>
<td>Trust Risk Manager</td>
<td>Chief Nurse</td>
<td>Started and on-going</td>
<td>Open</td>
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<td>BH02</td>
<td>The Trust must ensure there is sufficient staff with an appropriate skill mix on all wards to</td>
<td>All</td>
<td>All</td>
<td>Development of monthly reporting of actual staffing levels on a shift by shift basis.</td>
<td>Ward accreditation and KPIs</td>
<td>Medium</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>30.06.14</td>
<td>Open</td>
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<th>Completion date</th>
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<tr>
<td></td>
<td>enable them to deliver care and treatment safely and to an appropriate standard</td>
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<td>Small external review of staffing discussing our approach, evidence base and risk assessments. Peer review of key areas e.g. OPS, Cancer, Caplin. Implementation of Allocate e-rostering system to improve rostering and reduce reliance on bank and agency staff. Allocate includes a process for daily acuity and dependency recording Recruitment programme to fill 95% of establishment to reduce reliance on bank and agency staff underway Roll out Band 7 leadership programme based on Older Peoples Improvement Programme</td>
<td>Safer Staffing Report to April Trust Board Reports from Allocate Steering Board Roll out programme agreed CAG performance reviews</td>
<td>Medium</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>April 2014 &amp; onwards 6 monthly Roll out starts May 2014 for 18 months April 2014 To start February 2014</td>
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| BH03   | The Executive Board must urgently re-engage with staff: they must listen to staff, respond to their concerns and adopt a zero tolerance to bullying | ALL    | ALL             | Conclude the Trust Management Board review of Culture and Leadership and share the recommendations widely in the organisation – early actions being implement include:  
- Programme for embedding First Friday activities for all directors  
- Director-led programme of feedback and action planning on 2013 NHS Staff Survey Findings  
- Introduction of “Speak in Confidence” – with direct, anonymous two-way line to a Director  
- Programme of front line and weekend working for Directors  
- Communications campaign to raise awareness of the Governance of delivery through monthly Performance review with reporting Trust Management Board  
Increase monthly sample size of Pulse Survey to 4,000 (achieved). Publish monthly results as part of Staff Briefing process to supplement current integrated performance reports. Publish staff comments.  
Track impact through monthly Pulse Survey engagement scores and workforce key performance indicators within Integrated Performance Framework | High | Associate Director of Organisational Development | HR Director | March 2014 | Open |
<p>|        |                  |        |                 |                              |                               | High | HR Director | March 2014 | Open |
|        |                  |        |                 |                              |                               | High | HR Director | Started | Open |
|        |                  |        |                 |                              |                               | High | HR Director | Started and on-going | Open |</p>
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<th>Ref No</th>
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<td>Current policy and mechanisms in place to support tackling bullying and harassment</td>
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<td>Commission independent review of high reports of bullying and harassment in 2013 Staff Survey findings</td>
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<td>Develop Staff Partnership Fora in each CAG, in addition to organisation-wide forum</td>
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<td>Add feedback training into Statutory and Mandatory training programme for managers</td>
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<td>Increase the monthly sample size for the Pulse Survey to 4,000 and explore a mechanism for including the option for staff to use this</td>
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<td>route to specifically raise concerns</td>
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<td>Site specific publication of monthly Pulse Survey results, including commentary from staff</td>
<td></td>
<td>Director of HR</td>
<td>March 2014</td>
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<td>BH04</td>
<td>Provision must be made for adolescents to be treated in an appropriate environment and not within the general paediatric wards.</td>
<td>RLH</td>
<td>Childrens Services</td>
<td>Refer to RLH plan item RL01</td>
<td>Refer to RLH plan item RL01</td>
<td>Low</td>
<td>W&amp;C CAG Group Director</td>
<td>Director of Delivery</td>
<td>30.06.14</td>
<td>Open</td>
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<tr>
<td>BH05</td>
<td>Equipment must be readily available when needed.</td>
<td>RLH WX SURG</td>
<td></td>
<td>Greater engagement from CAGs with Medical Devices Group</td>
<td>Governance for Capital investment committee reviewed. Business cases for equipment which are rejected to go to TMB for review.</td>
<td>medium</td>
<td>CSS Group Director</td>
<td>Director of Delivery</td>
<td>30.06.14</td>
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<td>identified as not available refer to site specific action plans</td>
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<td>BH06</td>
<td>Ensure patients receive nutritious food in sufficient quantities to meet their needs</td>
<td>SBH</td>
<td>CVS CANCER</td>
<td>Refer to SBH plan item SB01</td>
<td>Refer to SBH plan item SB01</td>
<td>medium</td>
<td>Director of Estates and facilities</td>
<td>Chief Nurse</td>
<td>30.04.14</td>
<td>Open</td>
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<tr>
<td>BH07</td>
<td>Some parts of the hospital environment do not meet patients' care needs. The hospital environment in the Margaret Centre (at Whipps Cross) and outpatients compromises patients’ privacy and dignity</td>
<td>WX</td>
<td>ECAM OPS</td>
<td>Refer to Whipps Cross plan WX06</td>
<td>Refer to Whipps Cross plan WX06</td>
<td>medium</td>
<td>CSS Group Director Cancer CAG DoN</td>
<td>Director of Delivery</td>
<td>31.05.14</td>
<td>Open</td>
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<tr>
<td>BH08</td>
<td>Patients are not aware of the complaints process and the hospital does not always learn effectively from complaints</td>
<td>WX</td>
<td>ALL</td>
<td>The Chief Nurse will host 2 stakeholder engagement workshops to seek user and community views and consult on the current and future complaints and PALs services.</td>
<td>Stakeholder and user feedback PALs audits monthly NHS inpatient survey indicators</td>
<td>Medium.</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>31/0314</td>
<td>Weekly and on-going</td>
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<td>Continue to audit contacts, response and accessibility of the PALS telephone hub service</td>
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<td>Audit and accessibility results</td>
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<td>To continue with provision of complaint resolution and complaints handling training and its inclusion in staff development and leadership programmes.</td>
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<td>Review BH information leaflet and poster on ‘How To; seek help with a problem, make a comment or complaint across all sites. This following the stakeholder workshop. Relaunch</td>
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<td>All CAG Tier 1’s are accountable for accessible and responsive complaint handling and local resolution in each</td>
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<td>service line. Each CAG to continue monthly thematic learning reviews of complaints by service or subject and report on action each quarter.</td>
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<td>CAG PR and Quarterly complaints reporting at the Quality Assurance Committee</td>
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<td>Started and on-going</td>
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The following are compliance actions for other sites not list as Barts Health “must do”

<p>| NH01   | Trust must ensure medicines and fluids are stored correctly                      | NH      | All              | Refer to Newham plan                                                                                                                                         | Refer to Newham plan                                                                                                                                    | low                                                                                     | Chief Nurse       | April 2014                     | Open     |
|        |                                                                                   |         |                  |                                                                                                                                                               |                                                                                                                                                         |                                                                 |                               |                               |          |
| NH02   | Trust must ensure staff follow national guidance for children undergoing surgery and that they do this sufficiently to maintain their expertise | NH      | W&amp;CH Service     | Refer to Newham plan                                                                                                                                         | Refer to Newham plan                                                                                                                                    | medium                                                                | Medical Director | December 2014                  | Closed   |
|        |                                                                                   |         |                  |                                                                                                                                                               |                                                                                                                                                         |                                                                 |                               |                               |          |
| NH03   | To promote a safety culture, the hospital must improve the visibility of management and embed the CAG structures and processes                        | NH      | All              | Refer to Newham plan                                                                                                                                         | Refer to Newham plan                                                                                                                                    | high                                                                  | Director of Delivery | June 2014                     | Open     |
|        |                                                                                   |         |                  |                                                                                                                                                               |                                                                                                                                                         |                                                                 |                               |                               |          |
| LC01   | Action must be taken to improve                                                   | LC      | ECAM             | Refer to London Chest plan                                                                                                                                   | Refer to London Chest plan                                                                                                                               | medium                                                                | Chief Nurse       | April 2014                     | Open     |
|        |                                                                                   |         |                  |                                                                                                                                                               |                                                                                                                                                         |                                                                 |                               |                               |          |</p>
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<td></td>
<td>staff’s ability to respond in a timely manner to patient's needs at night to ensure their safety and welfare</td>
<td>RL04</td>
<td>Surgery</td>
<td>Refer to Royal London plan</td>
<td>Refer to Royal London plan</td>
<td>medium</td>
<td>Medical Director</td>
<td>April 2014</td>
<td>Open</td>
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<tr>
<td></td>
<td>WX04 - Strengthen governance arrangements. Currently these are not always effective. Staff do not feel empowered to make changes and the governance structures hinder them at times</td>
<td>WX04</td>
<td>All</td>
<td>Refer to Whipps Cross plan</td>
<td>Refer to Whipps Cross plan</td>
<td>high</td>
<td>Director of Delivery</td>
<td>Sept 2014</td>
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<td>WX05 - Address delays to providing care. Patient’s discharge is sometimes delayed. This impacts on other areas of the hospital and its effective functioning</td>
<td>WX05</td>
<td>All</td>
<td>Refer to Whipps Cross plan</td>
<td>Refer to Whipps Cross plan</td>
<td>medium</td>
<td>Director of Delivery</td>
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The following are improvement actions for Barts Health

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<tr>
<td>BH09</td>
<td>Improve the visibility of senior</td>
<td>all</td>
<td>all</td>
<td>Refer to BH03 – engaging with staff</td>
<td>Refer to BH03</td>
<td>low</td>
<td>CAG Group</td>
<td>HR Director</td>
<td>March 2014</td>
<td>Open</td>
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<td>BH10</td>
<td>Address the concerns about implementation of the review of nursing posts and the effects of this on the skill mix of nursing staff</td>
<td>all</td>
<td>all</td>
<td>Refer to BH02 - staffing</td>
<td>Refer to BH02</td>
<td>low</td>
<td>CAG DoNs</td>
<td>Chief Nurse</td>
<td>June 2014</td>
<td>Open</td>
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<tr>
<td>BH11</td>
<td>Improve the dissemination of lessons learned from serious incident investigations across all the CAGs</td>
<td>all</td>
<td>all</td>
<td>Share the learning bulletin from PST to be produced monthly. Communications plan for PST to be developed including use of weekly staff bulletin, monthly staff briefings and bi weekly manager briefing to disseminate key safety/learning messages CAGs to develop own mechanisms to cascade safety and</td>
<td>Staff knowledge during CAG senior staff walkabouts and internal peer reviews</td>
<td>low</td>
<td>Deputy Chief Nurse CAG DoNS</td>
<td>Chief Nurse</td>
<td>30.09.14</td>
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<td>learning messages</td>
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<td>Clinical Standards Committee established – mapping reporting of all groups/committees to give assurance of co-ordinated learning</td>
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<td>BH12</td>
<td>Improve access for all staff to suitable IT to enable them to report incident quickly</td>
<td>all</td>
<td>all</td>
<td>Two reports into network/server performance &amp; design &amp; PC performance have been commissioned and are complete. A number of issues are identified which are at the root of user difficulties outlined in the CQC report. These fall into 3 categories 1 - Network performance 2 - Application performance 3 - PC performance Actions planned 1 Trust Board approved plans to improve network capacity in a number of areas earlier</td>
<td>Network capacity is improved Additional 700 PCs are in use Details of further IT improvement finalised and shared with staff</td>
<td>low</td>
<td>Deputy Director of Informatics</td>
<td>December 2013</td>
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<td>Deputy Director of Informatics</td>
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<td>Director of Informatics</td>
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<td>last year and these changes are now being implemented</td>
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<td>2. The Trust currently utilises 11,100 computers &amp; has 14,000 (approx) staff. A roll out of 700 additional computers has commenced, includes both fixed desktop computers, laptops &amp; workstations on wheels.</td>
<td>Revised training in use at induction</td>
<td>Monitor impact through First Fridays and peer reviews</td>
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<td>31/12/14</td>
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<td>3. Plan in place for intensive piece of work in next few months to further improve performance in IT This project is being built and will be announced in start of financial year</td>
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<td>We plan to enhance the staff induction process to include specific training on how to log an incident using the Trust intranet/Datix web page.</td>
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<td>30/04/14 and on-going</td>
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<td>BH13</td>
<td>Consultant cover on site should be 24 hours a day, seven days a week to provide senior medical care and support for patients and staff</td>
<td>all</td>
<td>all</td>
<td>The Trust has just completed an update audit for its adherence to the London Emergency Care Standards and these have been fed back to CAGs. These are the most stringent standards available nationally and do not mandate the level of cover identified in this improvement action. Professor Sir Bruce Keogh recommends a 3 year journey to meet 7 day working across the English NHS and in this year to identify the cost likely to be associated with that step. The CAGS are currently working through the audit to define the solution for each of the relevant services to meet the London standards. In some cases this will require further changes to policies and working</td>
<td>Continue to review against the London Standards at least annually. A set of Barts Health Standards have also been drawn up and will be used more frequently to ensure regular and senior support.</td>
<td>Low – defined access standards for advice and return to work for scheduled &amp; unscheduled attendance have been defined for high risk areas (e.g. A&amp;E RLH, ICU RLH, trauma RLH, neonatology and obstetrics all sights. The trust is not an outlier for weekend mortality rates – this will continue to be monitored. Mortality rate (SHMI) is continuing to come down.</td>
<td>CAG Group Directors</td>
<td>Medical Director</td>
<td>30/4/2017 for 7 day standards as per BK’s national plan.</td>
<td>Open</td>
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<td>BH14</td>
<td>Provide accessible information for patients who speak English as a second language</td>
<td>all</td>
<td>all</td>
<td>practices and in some cases reconfiguration of services between sites. The outputs will inform job planning changes from April 1st 2014.</td>
<td>low</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>Deputy Chief Nurse</td>
<td>30.6.14</td>
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<td></td>
<td>Develop guidance/policy for staff on how and when to make key patient information available in other languages</td>
<td>Communications to review essential/Trust wide information to ensure it is accessible in other languages where appropriate and in line with guidance/policy</td>
<td>All CAGs to review their service line patient literature/information to make it available in other languages.</td>
<td>CAG DoNs</td>
<td>Chief Nurse</td>
<td>30.09.14</td>
<td>Open</td>
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<td>BH15</td>
<td><strong>There should be pain protocols in place for children and children should be seen by the pain team</strong></td>
<td>all</td>
<td>all</td>
<td>Refer to Women and Childrens’ Health CAG local CQC action plan</td>
<td>Refer to Women and Childrens’ Health CAG local CQC action plan</td>
<td>low</td>
<td>CAG DoN Childrens Services</td>
<td>Chief Nurse</td>
<td>31.03.14</td>
<td>Open</td>
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<tr>
<td>BH16</td>
<td><strong>The reasons for waits and likely length of waits in outpatients should be better communicated to patients</strong></td>
<td>all</td>
<td>all</td>
<td>An audit of 1004 clinics has been undertaken. There is positive evidence of improvement/satisfaction as well as further improvement needed e.g. Findings: No waits – 34% Wait&lt;30min – 50% Wait &gt;30min 16% The Outpatient Transformation team plan to work with teams on service level improvements by end of March 2014. CAG General Managers to develop individual improvement plans by 10 May 2014. Outpatient staff to ensure patients are</td>
<td>Detailed report on the areas with the largest waits shared with CAGs</td>
<td>low</td>
<td>Director of Service Development</td>
<td>Director of Delivery</td>
<td>31.01.14</td>
<td>Closed</td>
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<td>Ref No</td>
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<td>BH17</td>
<td>Where site specific issues have been identified in the CQC reports the Trust will seek assurance that the other sites have maintained an appropriate standards</td>
<td>all</td>
<td>all</td>
<td>informed of waits when they arise</td>
<td>monitor improvement</td>
<td></td>
<td>CSS CAG DoN N&amp;T</td>
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<td>31.03.15</td>
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<td>NH01</td>
<td>Trust must ensure medicines and fluids are stored securely</td>
<td>NUH</td>
<td>All</td>
<td>Re-fresh the trust-wide risk assessment for medicines security and ensure the action plan is updated. Seek resource to install either self-closing brackets on clean utility rooms OR swipe access Raise awareness through the Medicines Safety Team or a trust patient safety notice about the risks associated with poor security of medicines Introduce a zero tolerance approach to the leaving open or wedging open of clean utility rooms. Encourage datix incident reporting of such incidents Develop a medicines management action plan Ward CQC audit programme outcome 9</td>
<td>Low</td>
<td>CSS CAG Director of Therapies and Governance CAG Directors of Nursing Hospital Director</td>
<td>Chief Nurse</td>
<td>30/04/2014</td>
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<td>NH02</td>
<td>The Trust must ensure staff follow national guidance for children undergoing surgery and that they do this sufficiently to maintain their expertise sufficiently</td>
<td>NUH</td>
<td>W&amp;CH/Surgery Children Service</td>
<td>Action has been taken to ensure that children and young people under the care of the orthopaedic teams are reviewed on the ward round by the attending paediatrician. This ensures that treatment is consistent with best practice guidelines. To address the risk of infrequent surgical practice for children under 10 resulting in lack of surgical expertise, new house rules /standards have been implemented for children aged 16 and under admitted to NUH under the surgical teams. (standard rules available on request) The Group Directors of the Surgery and the Women’s and Children’s Health CAG to discuss and report proposals for the future of children’s surgery on</td>
<td>Action plan to be monitored by the Children’s Service Board and W&amp;CH CAG Board Audit compliance with national guidelines</td>
<td>Medium</td>
<td>CAG Group Directors Surgery &amp; W&amp;CH</td>
<td>Medical Director</td>
<td>Completed December 2013</td>
<td>open</td>
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| NH03   | To promote a safety culture, the hospital must improve the visibility of management and embed clinical academic group structures and processes | NUH     | All              | Refer to BH Master Action Plan item staff engagement BH03  
Site based Hospital Director and Hospital Lead Nurse and medical equivalent working in alignment with CAG leads and external stakeholders  
Hospital Management Group – agenda to include Q&S hospital Risk register  
CAG team on site W&C  
Other CAGs to identify senior site leads for each site including Newham  
Re launch First Friday  
Continue with Themed 3rd Friday  
Corporate Nursing team rolling rota of clinical days (proposed) | Refer to BH Master Action Plan item staff engagement BH03 | High | Hospital Director | Director of Delivery | 30.06.14 | Open |

the Newham site.
## Newham Hospital Specific Action Plan

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<td>NH04</td>
<td>Increase the Friends and Family survey response rate</td>
<td>Newham</td>
<td>All</td>
<td>Senior nursing staff provided with the response numbers required per month to achieve the target of 20%  Weekly reporting in place to enable areas which are non-compliant to be supported</td>
<td>FFT response rates</td>
<td>low</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>Year end of each year</td>
<td>Open</td>
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<tr>
<td>NH05</td>
<td>Improve safety for patients by reducing reliance on bank and agency staff and improve critical care consultant cover on evenings and weekends</td>
<td>Newham</td>
<td>All</td>
<td>Bank and Agency use Recruit to 95% campaign started Oct 2013. Consultant cover – refer to BH13</td>
<td>95% achievement in each CAG monitored through performance reviews</td>
<td>low</td>
<td>CAG DoNs</td>
<td>HR Director</td>
<td>31.03.14</td>
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<tr>
<td>NH06</td>
<td>Address the lack on</td>
<td>Newham</td>
<td>Surgery</td>
<td>Service line monitoring. Monitor number of</td>
<td>low</td>
<td>Surgery</td>
<td>Director of</td>
<td>30.04.14</td>
<td>Open</td>
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<td>NH07</td>
<td>high dependency unit facilities and the issue of patients being cared for in the CCU which are potentially compromising patients’ safety</td>
<td>m</td>
<td></td>
<td>Critical care board to be re-established Review HDU provision with cardiovascular CAG and present to PR and TMB.</td>
<td>patients requiring HDU care who are cared for in CCU at Newham</td>
<td></td>
<td>Group Director</td>
<td>Delivery</td>
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<td></td>
<td>To mitigate the risk of potential safeguarding issues, the hospital should consider providing a separate waiting area for children waiting to be seen in the Urgent Care Centre</td>
<td>Newham</td>
<td>ECAM</td>
<td>This will be raised with the 3rd party provider again using the CQC report to support previous conversations.</td>
<td></td>
<td>low</td>
<td>ECAM CAG DoN</td>
<td>Chief Nurse</td>
<td>30.04.14</td>
<td>Open</td>
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<tr>
<td>NH08</td>
<td>Formal review of the guidelines currently in use at Barking Birth Centre</td>
<td>Barking Birth Centre</td>
<td>Womens and Childrens CAG</td>
<td>The guidelines are the same across all sites - lead midwife to archive the out of date guidelines and ensure all staff aware of how to access the updated guidelines that are pertinent to practice at the Birth Centre.</td>
<td>Monitor through leadership visits and Clinical Fridays</td>
<td></td>
<td>DoM W&amp;C CAG</td>
<td>Chief Nurse</td>
<td>30.04.14</td>
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| RL01   | Ensure that adolescents are treated appropriately and not within general paediatric wards | RLH     | RLH              | Scoping exercise to be undertaken for care of young people across the Trust and develop business case  
Adolescent working group to be established  
Ward Managers all making one key change for adolescents in January  
Children's Patient Panel member to review our wards and departments  
Ward managers ensuring choice is offered on admission and documented | Business case complete and presented to TB  
Actions from AWG  
Audit of choice offered to adolescents | Low | CAG Group  
Director | Director of Delivery | 30.06.14 | Open |
| RL02   | Ensure that equipment is readily available when requested                           | RLH     | Surgery          | Theatre department did not have paediatric bronchoscopy equipment – issue is recorded in risk register- Four in use. One away for repair | Equipment back in use  
Datix IR form to be | No impact on service  
Low risk | Director of Nursing & Governance Surgery | Director of Delivery | 20/02/14 | Closed |
## Royal London Hospital Specific Action Plan

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<tr>
<td>RL03</td>
<td>Ensure there are sufficient staff with an appropriate skill mix on all wards to enable them to deliver care and treatment safely and to an appropriate</td>
<td>RLH All</td>
<td>RLH All</td>
<td>Refer to Barts Health Master Action Plan item on staffing BH02 Refer to Barts Health Master Action Plan item on staffing BH02</td>
<td>completed when trays not available, or problems with equipment in the trays. To be reviewed monthly at the Anaesthetics Governance, operational and PRs.</td>
<td>Medium</td>
<td>CAG DoNs Chief Nurse</td>
<td>30.6.14</td>
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<td>RL04</td>
<td>Ensure there are sufficient medical staff available</td>
<td>RLH</td>
<td>Surgery</td>
<td>The medical rotas are all WTD compliant and this has resulted in the use of B&amp;A to fill the gaps to achieve this. There is an active drive for recruitment to remove locum posts and fill substantively. Rota of concern is for general surgery at nights and weekends at RLH which relies on the same numbers of juniors as at WX and NUH and yet with a significantly heavier on call. There is an additional consultant for vascular/trauma but not extra juniors. This is reflected in the colorectal strategy to reduce on call services from 3 to 2 sites. There have not been any safety events directly</td>
<td>Datix completed when shifts not filled. Escalated to senior team. Monitored through service line PRs and CAG PRs.</td>
<td>Medium</td>
<td>Group Director Surgery</td>
<td>Medical Director</td>
<td>01/04/14</td>
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<td>Outcome 13</td>
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<td><strong>RL05</strong> Ensure that action is taken on identified risks recorded on the risk register</td>
<td>RLH</td>
<td>All</td>
<td>Refer to Barts Health Master Action Plan Item on Risk Register BH01</td>
<td>Refer to Barts Health Master Action Plan Item on Risk Register BH01</td>
<td>low</td>
<td>Trust Risk Manager</td>
<td>Chief Nurse</td>
<td>30.06.14</td>
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<td><strong>RL06</strong> Actively listen to staff and respond to their concerns</td>
<td>RLH</td>
<td>All</td>
<td>Refer to Barts Health Master Action Plan Item on Staff Engagement BH03</td>
<td>Refer to Barts Health Master Action Plan Item on Staff Engagement BH03</td>
<td>high</td>
<td>Associate Director of OD</td>
<td>HR Director</td>
<td>30.04.14</td>
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<td>RL07</td>
<td>Outcome 21 Records</td>
<td>RLH</td>
<td>All</td>
<td>We will seek further guidance from the CQC regarding compliance notice for RLH Outcome 21</td>
<td>Review of records to be part of internal peer review process.</td>
<td>Action plan in place and monitored at CAG DoNs Forum</td>
<td>Deputy Chief Nurse</td>
<td>CAG DoNS</td>
<td>March 2014</td>
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<td>Internal peer review audit tool updated for use on 27.02.14</td>
<td>Results of on-going ward CQC audits for outcome 21</td>
<td>Chief Nurse</td>
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<td>February 2014</td>
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<td>DoNs to review peer review results and develop action plans to address the findings of the internal peer review and on-going CQC ward audit outcome 21 findings</td>
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<td>April 2014</td>
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<td>Action plan in place and monitored at CAG DoNs Forum</td>
<td></td>
<td>March 2014</td>
<td>Sep 2014</td>
<td>Open</td>
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</table>

**Key theme or issue:** There is “no must do” related to records in the RLH CQC site report

- Incomplete care records
- No nursing care plan,
- Fluid and food intake charts incomplete.
- Weight not completed.
- SSKIN bundle no training/unsure what to document.
- WHO checklist not always completed.
- Incomplete or unreadable observations charts for neonates.
- End of Life - resuscitation decisions not always appropriately.
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<th>Ref No</th>
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<tr>
<td>SB01</td>
<td>The Trust must ensure patients receive nutritious food in sufficient quantities to meet their needs</td>
<td>SBH</td>
<td>Cancer/CVS</td>
<td>New ordering system was being piloted. Ward staff unclear on how best to manage the new system. Meeting with Carillion, catering and Trust Nutrition team instruction given was to ensure that all meal orders equate to ward bed count. Further training for Carillion housekeeping staff who provide &amp; serve meals to ensure that portion sizes are adhered. Ward staff encouraged to raise issues. The Trust with CHL and Carillion continue to monitor. Further feedback from patients in January to assess changes Trust Nutritional team to review the nutrition value of food provided</td>
<td>Patient feedback Friends and Family Test results Staff feedback <a href="#">CQC ward audit programme outcome 5 on-going results</a> Internal Peer review</td>
<td>Medium</td>
<td>Director of Estates and Facilities CAG DON Head of</td>
<td>31.03.14</td>
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<td>Ref No</td>
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<tr>
<td>SB02</td>
<td>Ensure there are sufficient staff with an appropriate skill mix on all wards to enable them to deliver care and treatment safely in a timely manner</td>
<td>SBH</td>
<td>Cancer/CVS</td>
<td>Refer to Barts Health Master Action Plan item on staffing BH02 and further review undertaken following CQC visit. Paper submitted to Cancer CAG board in December 13. Discussion and review with Chief Nurse/Medical director and CAG director.</td>
<td>Workforce KPIs: Vacancy rates Ward 5A and 5B to be on risk register and closely monitored re nurse KPIs over the next 3-6 months following completion of recruitment to establishment.</td>
<td>medium</td>
<td>Cancer/CVS CAG DoN</td>
<td>Chief Nurse</td>
<td>30/06/14</td>
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<tbody>
<tr>
<td>WX 01</td>
<td>Ensure staffing levels meet people’s needs on all medical and surgical wards.</td>
<td>WX</td>
<td>ALL</td>
<td>Refer to Barts Health Master Action Plan item on staffing BH02</td>
<td>Refer to Barts Health Master Action Plan item on staffing BH02</td>
<td>medium</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>30.6.2014</td>
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<td>WX 02</td>
<td>Ensure that the hospital's risk register is managed more effectively</td>
<td>WX</td>
<td>All</td>
<td>Refer to Barts Health Master Action Plan item on Risk Register BH01</td>
<td>Refer to Barts Health Master Action Plan item on Risk Register BH01</td>
<td>low</td>
<td>Trust Risk Manager</td>
<td>Chief Nurse</td>
<td>30.06.14</td>
<td>Open</td>
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<td>WX 03</td>
<td>Improve staff morale is low across all grades</td>
<td>WX</td>
<td>All</td>
<td>Refer to Barts Health Master Action Plan item on staff engagement BH03</td>
<td>Refer to Barts Health Master Action Plan item on staff engagement BH03</td>
<td>High</td>
<td>Hospital Director/ CAG Group Directors</td>
<td>Director of Delivery</td>
<td>30.4.2014</td>
<td>Open</td>
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<td>Ref No</td>
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<tr>
<td></td>
<td>issues without fear.</td>
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<td></td>
<td></td>
<td>high</td>
<td>Hospital Director/ CAG Group Directors</td>
<td></td>
<td>Director of Delivery</td>
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<tr>
<td>WX 04</td>
<td>Strengthen governance arrangements. Currently these are not always effective. Staff do not feel empowered to make changes and the governance structures hinder them at times</td>
<td>WX ALL</td>
<td></td>
<td>Refer to Barts Health Master Action Plan item on staff engagement BH03 Site based Hospital Director and Hospital Lead Nurse and medical equivalent working in alignment with CAG leads and external stakeholders Hospital Management Group – agenda to include Q&amp;S hospital Risk register CAG team on site ECAM Other CAGs to identify senior site leads for each site including Whipps Cross Re launch First Friday. Continue with themed</td>
<td>Refer to Barts Health Master Action Plan item on staff engagement BH03 Improved Staff engagement score for Whipps Cross site Improved results of Pulse survey for Whipps Cross Site</td>
<td>high</td>
<td>Hospital Director</td>
<td>Director of Delivery</td>
<td>30.09.14</td>
<td>Open</td>
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<td>WX 05</td>
<td><strong>Address delays to providing care. Patient’s discharge is sometimes delayed. This impacts on other areas of the hospital and its effective functioning</strong></td>
<td>WX</td>
<td>ALL</td>
<td>External engagement of commissioners and Multi-disciplinary team in developing new patient pathways Winter planning and Barts Health way implementation including:- Maintaining patient flow through ED, with support from Admission Avoidance Teams and all CAGs to maintain performance. Length of stay; We will ensure requests for</td>
<td>Setting up of fully functional ambulatory care and hot clinics in collaboration with GP partners. Measured by numbers of patients referred and treated. Refining processes for non-elective admissions. Measured by performance against 4 hour standard in ED. 24 hour standard</td>
<td>Medium</td>
<td>ECAM Group Director</td>
<td>Director of Delivery</td>
<td>31.10.14</td>
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<td>WX 06</td>
<td>Make changes to the hospital environment. Some parts of the hospital</td>
<td>WX Cancer OPs</td>
<td>Outpatients: Environment review to be carried out by CSS team.</td>
<td>Risk assessment complete</td>
<td>Medium</td>
<td>CSS Group Director and CAG DoN T&amp;G</td>
<td>Director of Delivery</td>
<td>31.03.14</td>
<td>Open</td>
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Diagnostic tests are made as soon as possible.

Seven day working: no delay for care in theatre, diagnostics or patient assessment.

Continuing to work closely with community colleagues to provide Care Outside Hospital and alternatives to hospital.

Discharging patients as swiftly and safely as possible by fully utilising the discharge lounge to free up beds earlier in the day.

Improving discharges over the weekend, supported by additional services available on site.

For turnaround of standard diagnostic tests. Measured by audit.

Working with clinical teams on 7 day models for non-elective patients. Measured by audit of delays in care. Integrated care work, and admission avoidance.

Integrated care work, and admission avoidance.
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<td></td>
<td>do not meet patients' care needs. The hospital environment in the Margaret Centre and outpatient's compromises patients' privacy, dignity and safety</td>
<td>Premises</td>
<td></td>
<td>Risk assessment to be completed. Business case for required changes to the OP environment to be developed and presented at CAG PR and TMB</td>
<td>Business case completed and presented to TB</td>
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<td>Cancer CAG DoN</td>
<td>30.05.14</td>
<td>Open</td>
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<td>Margaret Centre</td>
<td>Plan to refurbish Margaret Centre in February. This will provide additional disabled bathroom and improve floors and walls. Further options appraisal led by medical director to review possibility of a charity managing the hospice on behalf of Barts Health.</td>
<td>Refurbishment completed on time</td>
<td></td>
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<td>Directors hard and soft FM</td>
<td>31.03.14</td>
<td>Open</td>
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<td></td>
<td>Medical Wards</td>
<td>Refurbishment programme in progress</td>
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<td>Director of Estates &amp; Facilities</td>
<td>31.07.14</td>
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<td>CAG</td>
<td>Nursing practice in medical wards</td>
<td>Observations of care First Friday Peer review</td>
<td>ECAM CAG DoN</td>
<td>Chief Nurse</td>
<td>31.03.14</td>
<td>Open</td>
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<td>WX 07</td>
<td>Ensure that equipment on the medical and surgical wards and in ICU is always available, appropriately maintained and checked in accordance with the Trust's policies and guidelines</td>
<td>WX</td>
<td>ECAM/ SURG</td>
<td>Refer to Barts Health Master Action Plan item on equipment BH05</td>
<td>Inventory check of bladder scanners</td>
<td>Business case is developed for new stock, additional 2 at WX 1 at MEH, 1 and NUH and 1 at RLH. This equates to circa £43,000. Whilst procurement process is happening undertake train the trainer and request loan equipment. Mattresses - Contract allows for adhoc hire in addition to a float number of mattress on site. Review and check the current float number of mattresses on site</td>
<td>medium</td>
<td>CAG DoNs</td>
<td>Director of Delivery</td>
<td>30.04.14</td>
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<td>Ref No</td>
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<td>and ensure sufficient for everyday working.</td>
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<td>Ensure wards are provided with local information/procedure for ordering and who to escalate delays to.</td>
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<td></td>
<td>Surgery</td>
<td>Surgery</td>
<td>Only one ventilator trolley (WX ICU). This refers to transport ventilators</td>
<td>New ventilator trolley in use</td>
<td>medium</td>
<td>Surgery CAG DoN</td>
<td>Director of Delivery</td>
<td>14.03.14</td>
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<td>Funding Approved from CIC November 2013. With procurement, order being place 16.1.14</td>
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<td>Oxygen and suction equipment on surgical wards</td>
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<td>All beds within Surgery at WXH have wall points for oxygen and suction at the bedside</td>
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<td>WX 08</td>
<td>Ensure that patients know how to make a complaint. Changes are needed to ensure the hospital</td>
<td>WX</td>
<td>All</td>
<td>Refer to Barts Health Master Action Plan item on complaints BH08</td>
<td>Refer to Barts Health Master Action Plan item on equipment BH05</td>
<td>medium</td>
<td>Deputy Chief Nurse</td>
<td>Chief Nurse</td>
<td>30.09.14</td>
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<td>effectively learns from complaints. Outcome 17 Complaints</td>
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| LC01   | Action must be taken to improve staff’s ability to respond in a timely manner to patient’s needs at night to ensure their safety and welfare | LCH     | ECAM             | Refer to Barts Health Master Action Plan item on staffing BH02  
Night shift staffing is ratio 1:7 with higher skill mix band 6 on the wards.  
We will review vacancy rates and highlight Caplin as an area for the external staffing/peer review to re-assess as part of that work plan  
Implement Allocate e-rostering with Acuity and Dependency tool | Patient survey/comment cards  
Friends and Family Test results  
Vacancy rates to no greater than 5%  
Fill rates for Bank and Agency staff  
Observation of care  
Safer Staffing reports to Trust Board | Medium | ECAM CAG Director of Nursing | Chief Nurse | 30.06.14 | Open |

Outcome 4  
Care and welfare of patients
Appendix 4 – Statements from our stakeholders and our auditor’s opinion

Commissioners Statement for 2013/14 Quality Account

NHS Tower Hamlets Clinical Commissioning Group (CCG), NHS Newham CCG, NHS Waltham Forest CCG, NHS Redbridge CCG and colleagues from NHS North and East London Commissioning Support Unit welcome the opportunity to review the Barts Health NHS Trust Quality Account and to provide this statement.

We confirm that we have reviewed the information contained within this Quality Account and compared the data provided against available sources. We are pleased to note that this year’s Quality Account provides a greater level of information than for the previous year.

We agree with the six priorities for 2014/15 identified for Barts Health NHS within the Quality Account, these are:

1. Reducing avoidable harm
2. Improving mortality rates
3. Sharing the learning
4. Ensuring the right patient is treated in the right place at the right time
5. Improving standards of care, listening and feeding back to staff
6. Compassionate care

In line with the Francis Report recommendations we will continue to actively monitor and hold Barts Health Trust to account for the quality improvements required for the population we serve.

In 2013/14 we worked in partnership with Barts Health to support quality improvements, examples being: engagement with quality assurance visits and support in the management of Serious Incidents, holding a joint forum to improve management processes and learning.

To build upon previous years supportive interventions we plan to host a Quality Summit in 2014 with the aim of identifying innovative and outcome focused support to help the Trust deliver the required improvements in quality. We will continue to incentivise quality innovation projects through the national and local CQUIN schemes; and for 2014/15 we have developed additional Key Performance Indicators to ensure quality improvements are made and sustained.
From this review and comparing the content against the prescribed information, form and content as set out by the Department of Health it is noted that in the main this account reflects that guidance. There are some areas where we believe further or more detailed information is required to meet the guidance and the priorities of the CCGs. These areas are:

- Service line information including information specific to community health services’ and performance of Clinical Academic Groups, specialities and consultanteams
- Increased use of patient stories (including where relevant the experience of carers) across the Trust to demonstrate learning from patients
- Data to be presented in tabular form for ease of review, with more benchmarked data provided
- Plans for the implementation of the recommendations of the Francis enquiry and government response ‘Hard Truths’
  - Staffing skill mix review with a process for monitoring outcomes
  - Continued emphasis on improving communication with General Practice
- Provide more information and detail on patient survey results and site specific findings
- Provide information on and plans for monitoring what percentage of elderly patients have been assessed for dementia
  - Better signposting for patients, their carer’s and the public to provide feedback on the Quality Account
- Clear evidence of the intention to improve accessibility of the Quality Account e.g. translation into other languages

We are committed to working with Barts Health NHS Trust and take our responsibility to improve the quality of services provided to patients seriously.

Jane Milligan, Chief Officer Tower
Hamlets CCG

Sam Everington,
Chai Tower Hamlets CCG

On behalf of the collaborative commissioning arrangements for Barts Health NHS Trust
Response from the Inner North East London Joint Health Overview and Scrutiny Committee

Cllr Winston Vaughan
Chair, INEL JHOSC
c/o Luke Byron-Davies
London Borough of Newham
Newham Dockside
London
E16 2QU

21 May 2014

Mr Peter Morris
Chief Executive
Barts Health NHS Trust
Aneurin Bevan House
81 Commercial Road
London E1 1RD

Dear Mr Morris

Barts Health NHS Trust: Quality Account 2013-14

Thank you for sending your Quality Account for 2013/14 to members of the Inner North East London Joint Health Overview and Scrutiny Committee, which comprises of Newham, Tower Hamlets and City & Hackney.

As you will be aware, this Committee has spent a considerable amount of time over the period that this Account covers by scrutinising the quality of your Trust. We have done this along with a range of partners that have included the Care Quality Commission and local HealthWatch.

During our discussions the following key points were noted:

a) The Financial “Turnaround”
   Although the Account is rightly focused on quality, we are conscious that there is still concern from many quarters that the Trust will be able to continue to maintain high quality services with a patient centred approach, while also remaining on track to make challenging financial savings. We heard evidence from yourself and your senior leadership team earlier in 2013 that care will not be compromised and while this went some way to reassuring members, this will remain as a key focus for the Committee. We are though in part reassured by some of the high level data in the Account that indicates that areas such as expected mortality levels are better than would be expected.

b) The Care Quality Commission’s Reports
   A major part of the Committee’s role has been to work with the Care Quality Commission in regards to the in-depth inspections and this has both as individual boroughs and collectively as INEL. While we are pleased to see that improvements have been made in many areas, we do note that the findings indicated that there are areas of improvement. We were able to comment on the action plan and we will be keen to continue to monitor the progress of it.
c) **Underperformance in general**

The Quality Account highlights a number of underperforming areas and one particular worrying area is in regards to “Never Events”. The Committee notes that there has been a reduction, but is concerned that ten such events took place. We also note that there is site specific variation in the achievement of a range of performance indicators, which we would expect to be reduced over the coming year to make sure that there is a more consistent standard across Barts.

d) **IT integration issues**

In the Committee’s response to the 2012/13 Account, the issue of IT integration was focused upon. While the 2013/14 Account does indicate that some progress has been made, the Committee is still aware that the IT system resulting from the merger is still causing distress to patients, employees of the Trust and other non-Trust clinicians such as GPs. We ask that going forward that is a priority that is addressed.

e) **Staffing**

A year ago, we highlighted the issue of ‘bank’ and agency clinicians and we support your efforts to reduce this. Although, we note that there have been recruitment drives over the last few months, we are expecting to see continued and sustained improvement in this area.

Over the course of the last twelve months we have also heard a range of evidence that morale amongst staff was poor and that staff did not have confidence in their management structures. As such the Committee agrees with the Account’s finding that there is much more that can be done in this area. However, we acknowledge that you are beginning to address this issue.

Although there is still much work to be done, we acknowledge and commend the Trust on many successes such as the encouraging mortality data and the improvement and development of many clinical pathways. We look forward to continuing to work with you during 2014/15.

Yours sincerely

[Signature]

Cllr Winston Vaughan
Chair, Inner North East London Joint Health Overview and Scrutiny Committee
Healthwatch statement from Tower Hamlets, Newham, Waltham Forest and City of London

The Quality Account was considered by members of Healthwatch Tower Hamlets, Newham, Waltham Forest and the City of London who welcome the Trust's commitment to putting patients first and improving their care, experience and outcomes.

This is a much clearer, comprehensive and honest document which indicates where performance has not been up to standard and provides an outline of actions being taken. Mandated Care Indicators such as Standardised Hospital Mortality Indicators (SHMI) and Patient Reported Outcome measures (PROMS) in appendix 2, clearly show what Barts Health is doing well and where it needs to improve.

The action plan in response to the CQC inspection in November 2013 and issues highlighted by Francis Inquiry is comprehensive and clearly achievable provided that the senior management team is successful in sustaining a culture which is fair, open, supportive and learning.

Involvement of patients across the clinical academic groups is a welcome move and patient stories at Trust Board meetings provide Non–executive Board members an opportunity to champion the cause of patients.

Our members would like to congratulate the Trust for successfully participating in over three dozen National Clinical Audit Projects which clearly encourage transparency, improve the quality of care and provide learning opportunities to better patients’ outcomes.

Our engagement with the community and our efforts to capture patients experience over the year indicate that:

- The complaint handling procedures need to be streamlined; the response has to be open and not simply legalistic and defensive.
- Staff attitude particularly those working in wards during the night and agency staff requires improvement and nursing staff are sometimes too busy to make patients comfortable.
- There are still problems accessing out-patient appointments in certain specialities and there appears to be problems with staff attitudes and communication with patients particularly in the ENT outpatients. There are ongoing issues with phone and text message services not working effectively and as a result patients are being taken off waiting lists and being
returned to their GP for a new referral. This does have implications for a NHS moving to a
digital system of appointments and bookings.

- We were very grateful to the Trust for sharing PALS, complaints and friends and family test
results with us on a regular basis. However it can be difficult for small Healthwatch teams to
analyse this data alongside of the multitude of other patient experience data, surveys and
tests. It would help if the Trust could provide a summary of patient experience data that
could be tracked over time. This might also include actions taken as a result of Board patient
stories.

- We have been concerned about the slow progress in developing the Barts Health Patient
Forum and the hospital panels, perhaps due to a constantly changing and an unclear patient
experience and engagement team structure.

- We strongly support the steps to improve staff morale as the wellbeing of staff is directly
linked to the wellbeing of patients. We are concerned that staff are not necessarily engaged
in the ongoing changes being implemented across Barts and these are largely still driven
from the top down on a target by target basis. It is important that staff hear the positive
individual stories not just the targets and clinical outcomes.

- There must be a clear way to share best practice between sites such as the volunteer
service function supporting discharge at Whipps Cross.

A survey of Barts Trust in November 2013 by Healthwatch City of London identified that:

- The Royal London hospital had less patients feeling that they had been treated with dignity
and care than St Bartholomew’s and Whipps Cross. This mirrors the comments made from
plastic surgery outpatients at the Royal London on page 10 of the quality account. The
comments on the maternity ward at Whipps Cross in the quality account describe the
’swiftness in decision making and expertise shown by the team’ which is line with the
comments we received in the survey on Barts Trust.

- An area of concern across Barts Trust that was raised in the survey was that 61.9% of
respondents indicated that they were unaware as to which hospital staff they could speak to
if they had concerns or fears. It is good to see that there is a section in the quality account
on listening to patients although the figures on page 90 on whether patients found someone
on the hospital staff to talk to about their worries and fears indicate that the numbers of
patients unable to find somebody is rising. It is good to see that the proportion of patients
that found somebody to talk to is high in the survey run by Barts, ranging from 62% to 66%
over a five month period.

As the independent consumer champion Healthwatch is in a unique position to support the Trust
to hear from its patients and undertake targeted work to drill down into some of the problem
areas around patient experience, performance breaches and quality of service, such as those
identified in this quality account. We would urge the Trust to work more proactively with
Healthwatch to identity and support the undertaking of joint initiatives to involve patients in
analysing issues and helping to drive forward service improvements.

We congratulate the Trust for producing this comprehensive Quality account. It is however
difficult for patients to negotiate. We would, therefore, recommend adding a “bite-size” summary
in plain English highlighting what you have improved this year and what you intend to do next
year. This would certainly go a long way in creating trust.
INDEPENDENT AUDITORS’ LIMITED ASSURANCE REPORT TO THE
DIRECTORS OF BARTS HEALTH NHS TRUST ON THE ANNUAL QUALITY
ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance
engagement in respect of Barts Health NHS Trust’s Quality Account for the year ended 31
March 2014 (“the Quality Account”) and certain performance indicators contained therein as
part of our work under section 5(1)(c) of the Audit Commission Act 1998 (“the Act”). NHS
trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must
include prescribed information set out in The National Health Service (Quality Account)
Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011
and the National Health Service (Quality Account) Amendment Regulations 2012 (“the
Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the
following indicators:

- The percentage of patient safety incidents resulting in severe harm or death
- The percentage of patients who were admitted to hospital and who were risk assessed for
  venous thromboembolism (VTE)

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of Directors and auditors

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 annual
Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the
Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves
that:

- the Quality Account presents a balanced picture of the Trust’s performance over the period
covered;
- 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 that they are working effectively in practice;
- the data underpinning the measures 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 are required to confirm compliance with these requirements in a statement of
directors’ responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in
  the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the
  NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17
  February 2014 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited
  assurance in the Quality Account are not reasonably stated in all material respects in
  accordance with the Regulations and the six dimensions of data quality set out in the
  Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the
Regulations and to consider the implications for our report if we become aware of any material
omissions.
We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 23/05/2014;
- feedback from Local Healthwatch dated 30/05/2014
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated April 2014;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated February 2014;
- the latest national staff survey dated December 2013;
- the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 25/05/2014;
- the annual governance statement dated 04/06/2014; and

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.

This report, including the conclusion, is made solely to the Board of Directors of Barts Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Barts Health NHS Trust for its work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; 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 which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandatory indicators which have been determined locally by Barts Health NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

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30 June 2014
Further information

For further information about our Quality Account and our commitment to quality improvements, contact us using any of the details below:

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