Quality Accounts 2016

Hospital of St John & St Elizabeth
160 years of compassion and excellence supporting St John's Hospice

St John's Hospice
THE HOSPICE OF THE CHARITABLE HOSPITAL OF ST JOHN & ST ELIZABETH

CONTENTS

WELCOME FROM THE CHAIRMAN

On behalf of the Board of Trustees and the Hospital Management Board, it gives me great pleasure to present the 2016 Quality Accounts for the Hospital of St John & St Elizabeth.

The Trustees are required under the Health Act 2009 to prepare a Quality Account for each financial year as St John's Hospice is part funded by the NHS.

In preparing the account, the Trustees are required to take steps to satisfy themselves that the Quality Accounts presents a balance percentage of the Hospital's performance over the period covered. The data underpinning the measures of performance reported in the quality accounts is robust and reliable, conforms to specified data quality standards and is subject to appropriate scrutiny and review.

The Trustees confirm to the best of our knowledge and belief they have complied with the above requirements in preparing the Quality Accounts.

The Hospital of St John & St Elizabeth is committed to enhancing our organisational culture that puts the patient at the centre of everything we do.

Our aim is to continue developing our initiatives around quality and safety to ensure we are able to bring further benefits to our patients and the care they receive.

Together with the Board of Trustees our thanks must go to not only our staff and volunteers who work tirelessly to provide high quality services but also to our faithful and committed supporters who enable us to raise the necessary funds to provide our services free of charge to our Hospice patient's and their families.

Field Marshal The Lord Guthrie of Craigiebank GCB LVO OBE DL
CHAIRMAN

FROM THE MEDICAL DIRECTOR

We continue to encourage all staff to absorb our core values which are; compassion, excellence, charity, responsibility and innovation. A new programme for all staff is underway to replace the old Excellence programme. Our mission for providing patient centred compassionate care with our charitable Hospice at the centre continues.

We were inspected by the Care Quality Commission (CQC) in October 2016 and much work and effort was devoted to, as far as possible, insuring that we were found to be in good order throughout. I am very pleased to report that we were found to be 'Good' within all of the CQC domains which are safety, caring, well-led, effective and responsive.

We have a new Director of Governance, Alison Newman who has started her new role and will bring many innovations and improvements to us as she brings a wealth of governance experience with her from her previous post. Already plans are afoot to restructure our reporting and committee framework so that we have good coverage of all clinical aspects to enhance as far as possible our performance in patient centred care.

Dr David Mitchell
MEDICAL DIRECTOR

The Urgent Care Centre gets increasingly busy and the new ten-bedded medical ward which was opened in the summer, providing state of the art high quality accomodation for patients and has increased our capacity to admit more patients needing our care.

The new medical ward has set the standard for a ward refurbishment programme which will be part of the new Hospital Development Scheme, plans for which are now well advanced for a new three storey building incorporating new operating theatres, a day care unit and new urgent care centre.

We are a Designated Body for GMC medical revalidation for doctors and I am the GMC Responsible Officer for Revalidation. We currently have 26 doctors who are attached to our hospital. We are responsible for ensuring that they have regular appraisals and can be recommended for revalidation to the GMC when required. We have an online appraisal and revalidation system for this.

To the best of my knowledge, the information in these Quality Accounts is correct.

The CQC inspected us in October 2016 and the report showed we achieved 'Good' in all domains.


Emmy Gates
Registered Nurse
Nina Groeteke
Registered Nurse
CATERING 4297

ABOUT US

The Hospital of St John & St Elizabeth is an independent Charitable Hospital, able to treat almost any illness whilst providing the highest standards of care.

Patients enjoy luxurious surroundings, state of the art technology and the reassurance of being treated by world class Consultants and nurses with a reputation for excellence. This is why Bupa patients rate us as the highest quality private provider in the UK.

Facilities include 72 rooms all with ensuite bathrooms, 5 theatres and state-of-the-art imaging and diagnostic facilities. Our Hospital has a zero hospital acquired infection rate and has not reported an MRSA or MSSA imfection for 8 years.

Based in St John's Wood, minutes from Central London, our services include Casualty First, our walk in urgent care centre, which is able to treat children from the age of one year and adults with no appointment.

Uniquely, profits support our onsite Hospice, St John's, which provides care to 3,000 terminally ill patients and their families each year free of charge.

QUALITY AND SAFETY ASSURANCE

The quality and safety assurance framework at the Hospital of St John & St Elizabeth is made up of both internal and external audit. Internal audit of the services provided within the Hospital gives us the opportunity to identify and manage specific risks and a system of robust reporting and feedback mechanisms throughout the organisation to ensure lessons are learned and processes are strengthened as part of our continual quality improvement programme.

The Quality and Risk Safety Assurance Committee (QRAC) is the overarching quality and safety committee that provides Board oversight for the services we provide to our staff, patients and their family and friends.

QUALITY AND SAFETY ASSURANCE: INTERNAL AND EXTERNAL AUDIT

The QRAC seeks assurance from all of the other Hospital Quality Committees that all processes and systems within the hospital are robust, 'fit for purpose' and embedded. This ensures priority is given at the appropriate level to identify and mitigate risks to quality and safety. The QRAC provides the scrutiny to ensure that the accountable directors are

SETTING STANDARDS

MEASURING ACHIEVEMENT

RECOMMENDING AND TAKING ACTIONS

DRIVING QUALITY

BENCHMARKING

MANAGING RISKS

MOST RECENT CQC RESULTS

The Care Quality Commission (CQC) carries out regulatory monitoring and inspection of our Hospital and the services we are registered to provide. We were inspected by the CQC in October 2016 under their new inspection regime which was rigorous in its approach. The Hospital achieved an overall rating of 'Good' and 'Good' for all domains - Safe, Effective, Caring, Responsive and Well Led.

'Staff were kind, caring and compassionate in all areas of our observation.'
– CQC Inspector

'Staff were involved and keen to improve systems and processes to ensure patients received the best care.'
– CQC Inspector

CEO Caroline Fox said, 'We are delighted with the result from the CQC; this result is testament to the way in which our staff put the patients at the heart of everything they do.'

The Hospital maintains a number of certifications for quality standards that have been awarded by external bodies:

Hotel and Catering Environmental Health Audit awarded 5 stars

Diagnostic Services All IRMER regulations met

Laser inspection excellent inspection report received for 2016

Electro-biomedical Engineering (EBME) underwent ISO 14001 and ISO 9001 inspections and continued to meet all standards.

We achieved the highest scores as 'best provider of patient care' by BUPA insured patients during 2016 and we will strive to build upon these scores during 2017.

PROTECTING PATIENTS FROM AVOIDABLE HARM AND ABUSE

During the most recent CQC inspection (October 2016) the inspection team rated the 'safe' domain as overall 'Good'.

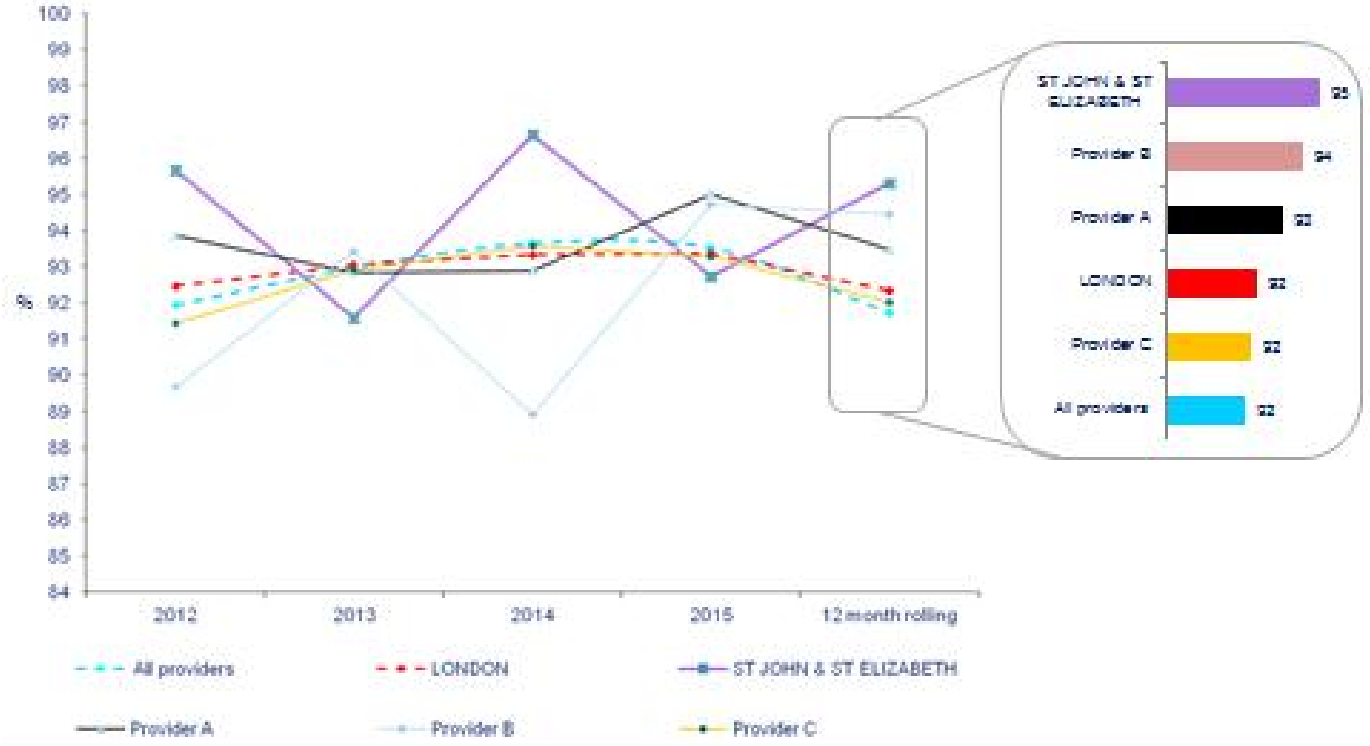
Ensuring our Hospital is safe for our patients, relatives and staff remains our highest priority. Our overarching aim is protecting patients from avoidable harm and abuse.

In order to achieve this we strive wherever possible to ensure the facilities are developed and maintained to keep people safe; equipment used within the Hospital is maintained in line with manufacturers guidance and used safely and effectively; staff receive mandatory training and other training to ensure they maintain the correct levels of competence. Risk assessments are undertaken within all departments and reviewed on a quarterly basis. Risk registers are reviewed within the appropriate quality assurance committees and any actions escalated as required. We continue to report safety events both internally and externally as required. If things do go wrong we are open and transparent in our approach and we apologise to those affected. Investigations are carried out to ensure the 'root cause' is identified and lessons learned are shared across the Hospital.

We were proud to achieve the highest scores as 'best provider of patient care' by BUPA insured patients during 2016 and we will strive to strengthen and build upon these scores during 2017.

Overall hospital assessment

KPI: Overall rating of patient care received - Trend Graph – LONDON PROVIDERS



Q2) Overall, how would you rate the care you received?

Results represent 'Excellent' & 'Very good' responses combined. '12 month rolling' includes Q3 2015, Q2 2015, Q1 2015 & Q4 2014

AVOIDABLE INFECTIONS

Our Infection Prevention and Control processes and standards are subject to internal and external audit and review. They formed part of the inspection undertaken by the Care Quality Commission during the inspection of the Hospital in October 2016.

INFECTION PREVENTION AND CONTROL

Our well established Infection Prevention and Control Committee continues to work closely with all Hospital departments to embed good practice and safe hygiene processes including monitoring of compliance with the Department of Health (DH) initiative 'Bare below the elbow' and 'handwashing audits' for all staff working in clinical areas.

The requirement for clinical staff to be 'bare below the elbow' is discussed during induction and at all infection prevention and control training sessions. Staff are encouraged to actively challenge any observed non compliance and to escalate to their Head of Department for further action if required.

SURVEILLANCE AND EXTERNAL REPORTING

The Hospital has an excellent record regarding the management of avoidable infections and we continue to participate in the appropriate Public Health England (PHE) National Mandatory Surveillance and reporting of Healthcare Associated Infections (HCAI's). Over the past 8 years we have had no Methicillin resistant Staphylococcus aureus bacteraemia(MRSA) or Methicillin sensitive Staphylococcus aureus bacteraemia(MSSA).

During 2016 there have been no cases of Hospital acquired E Coli bacteraemia – one patient was admitted positive for the bacteraemia. There was one case of Clostridium Difficle reported – although this did meet the criteria for surveillance, the patient had undergone surgery at another hospital prior to their admission and was found to have been positive for Clostridium Difficle immediately post surgery.

No cases of MRSA or MSSA reported in over 8 years

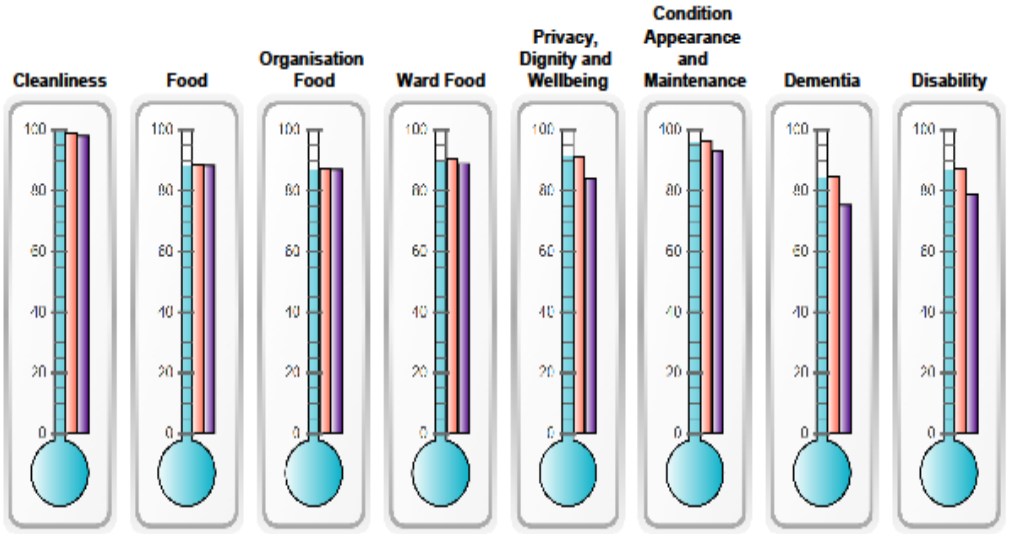
Where an avoidable infection is detected a comprehensive root cause analysis (RCA) investigation is undertaken with appropriate action plans for learning and training being shared throughout the Hospital.

PATIENT-LED ASSESSMENTS OF THE CARE ENVIRONMENT (PLACE)

Every patient should be cared for with compassion and dignity in a clean, safe environment. PLACE is the system for assessing the quality of the patient environment and the assessment provides motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The assessment applies to hospitals, hospices and day treatment centres providing care.

The assessment team consisted of four volunteer members from the local health watch dog along with the Hospital's Deputy Matron, Infection Prevention and Control Nurse and the Estates and Facilities Manager. Below are the results of our annual unannounced assessment which was undertaken on the 24th April 2016 which shows we were above the national average in all areas.

HOSPITAL OF ST JOHN & ST ELIZABETH- Collection: 2016



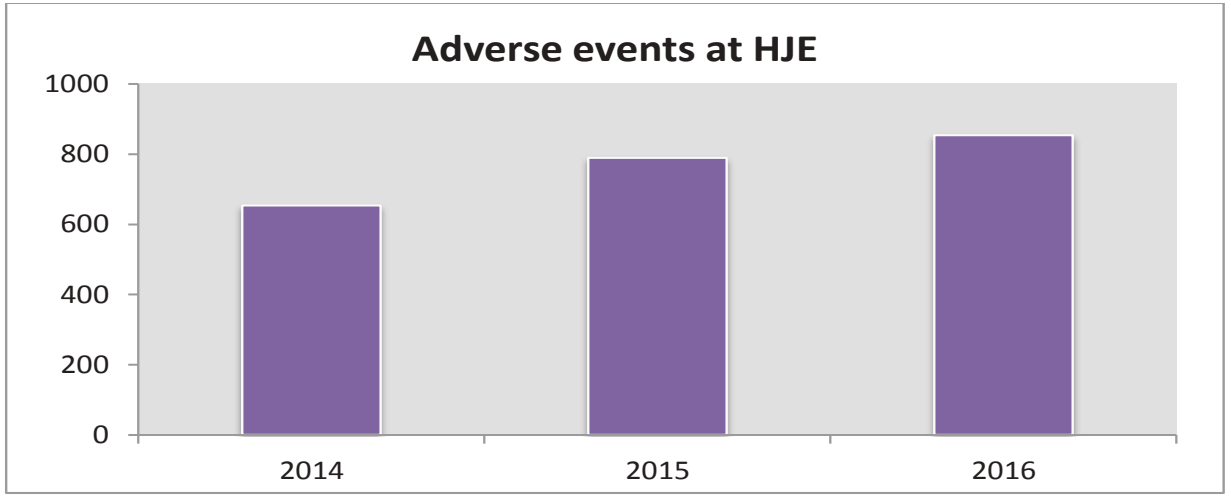
	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1738.0000	163.8191	99.7477	64.0714	188.0000	922.0000	327.0756	230.3193
Available Score (Actual)	1752.0000	185.4956	114.5880	70.9076	206.0000	958.0000	386.8571	264.3697
Site Score	99.20%	88.31%	87.05%	90.36%	91.26%	96.24%	84.55%	87.12%
Organisation Average	99.20%	88.31%	87.05%	90.36%	91.26%	96.24%	84.55%	87.12%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

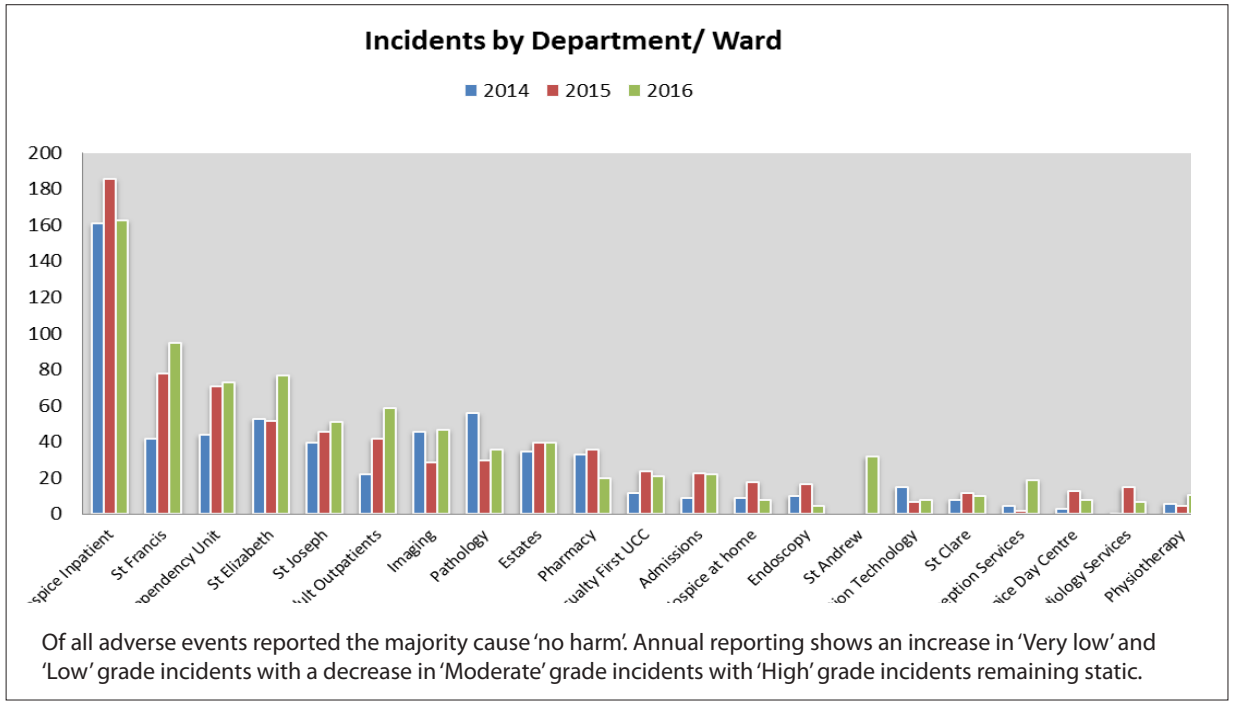
ADVERSE EVENTS OVERVIEW

Adverse events are captured on the Hospital DATIX risk management system and are investigated by the department where the incident occurred, and is discussed at the weekly Incident Review Group.

Any lessons learned or identified training is communicated to the relevant quality and safety committee for appropriate action, monitoring and review.

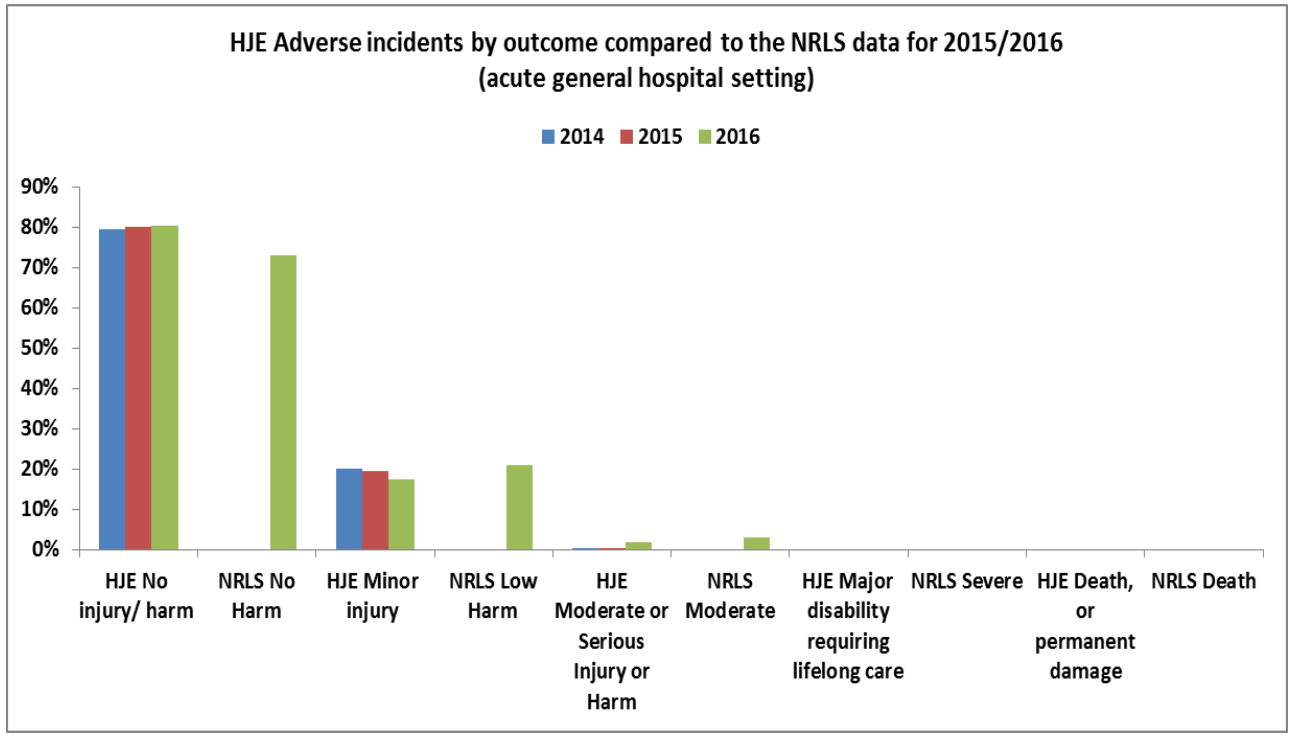
There has been a steady increase in incident reporting since 2014. In 2015, we saw a 21% increase in incident reporting, with a further 8% increase in 2016.





Of all adverse events reported the majority cause 'no harm'. Annual reporting shows an increase in 'Very low' and 'Low' grade incidents with a decrease in 'Moderate' grade incidents with 'High' grade incidents remaining static.

We compare favourably to the incidents reported in the National Reporting and Learning System (NRLS) for 2016 data as the table below demonstrates:



However we are fully aware that incident reporting is only a part of the overall picture.

During 2016 we continued our monthly breakfast meetings with staff and our 'board to floor walk-arounds'. These walk-arounds consist of unannounced visits to Hospital departments where we encourage discussion with staff regarding any areas of concern or good practice they may wish to raise. This enables the management team to have a deeper understanding of the Hospital's risks and to share learning from incidents which benefits all staff. These 'walk-arounds' will continue during 2017.

SAFETY NEVER EVENTS

Never Events are serious incidents affecting patients that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Never Events include incidents such as: wrong site surgery.

No reported 'Never Events' in over 3+years

SAFETY- VENOUS THROMBOEMBOLISM

Venous thromboembolism (VTE) is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. It is a significant patient safety issue in hospital and proactive action to prevent occurrence is essential. The aim is to ensure 100% of eligible patients will be risk assessed to reduce the occurance of a VTE.

In 2016 100% of patients admitted to the Hospital were risk assessed for VTE on admission. This compares very well with NHS England data which shows 98% NHS patients were assessed on admission.

In the rare situation where a VTE is diagnosed, a Root Cause Analysis is undertaken by a member of the pharmacy team in line with NICE guidance and if there are any lessons to be learned these are communicated to the appropriate quality working group. To date no trends have been identified and our incidence of VTE remains very low at less than 0.1% of admitted patients.

EFFECTIVENESS

Our services are developed and reviewed against the relevant and most up-to-date evidence based guidance and standards including those issued by the Royal Colleges, the National Institute for Health and Care Excellence and other appropriate professional bodies. The CQC reported that overall our hospital effectiveness rating was 'Good'.

LOCAL AUDIT PROGRAMME

The Hospital Clinical Audit Group continued to grow throughout 2016. The group identifies key areas for audits, with a view to agreeing an annual planned programme for the coming year. The audit programme continues to develop and evolve through the year to meet the changing needs of the Hospital and national requirements.

THE FOLLOWING KEY INTERNAL CLINICAL AUDITS TOOK PLACE IN THE HOSPITAL IN 2016:

- **Infection Prevention & Control** – A comprehensive audit programme has taken place throughout the year. This includes monthly Hand Hygiene and Bare below the Elbow Audit, quarterly Sharps Audit and an annual Environmental Audit; Patient Led Assessment of the Care Environment (PLACE).

- **Pharmacy Audits** – Key audits included Safe and Secure Handling of Medicines, Medicines Reconciliation, Pharmacy Interventions, Missed Doses and Allergy Status, Controlled Drug Audit and an IV Antibiotic Prescribing Audit. All audits provided action plans for the continued improvement of clinical practice in the Hospital.

- **Falls Audit** – A Falls Audit was conducted in September 2015, to review inpatient slips, trips and falls. In 2016, a 'task and finish' group was introduced to develop the revised risk assessment, individualised care plan, falls leaflets, training plan and change in handover sheet.
The Hospital Falls Policy was updated in October 2016 and training was rolled out simultaneously to the policy; this was implemented as part of the mandatory clinical manual handling training that all staff must attend.
New equipment purchased specifically to address patient falls included Eazy Raiser Chairs, Hover Jack and Elk which help with patients' post-fall and to reduce / prevent further injury.

- **Pressure Ulcer Audit** – In early 2016 an audit of all pressure relieving devices was undertaken to ensure the Hospital had appropriate equipment. Trends show that during 2016 the majority of pressure ulcers were imported - that is patients were admitted with an established pressure ulcer while patients acquiring ulcers after admission to the Hospital, show a downward trend.

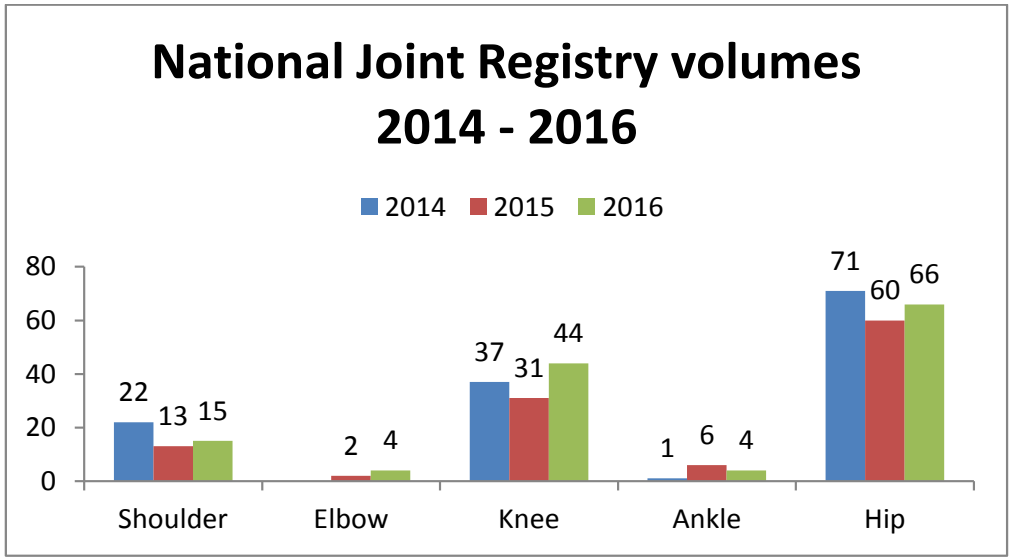
- **Inpatient Clinical Records Audit** – The Clinical Records Policy was implemented in February 2015, this policy incorporated the Royal College of Physicians (RCP) Generic Medical Record Keeping Standards. Ongoing monthly audits take place with twice yearly reporting.

- **Consent audit** – This was conducted in Q2 2016, results were disseminated through the clinical Audit group and the surgical governance committee with the policy circulated to all consultants via email.

- **Urgent Care Centre** – During the course of the year the urgent care centre has initiated environmental audits, a waiting times audit and antibiotic prescribing for suspected UTI audit.

NCEPOD UPDATE / STUDIES PUBLISHED IN 2016

The Hospital aims to take part in all relevant audits conducted by NCEPOD. However the Hospital did not meet the requirements of any of the studies undertaken during 2016.

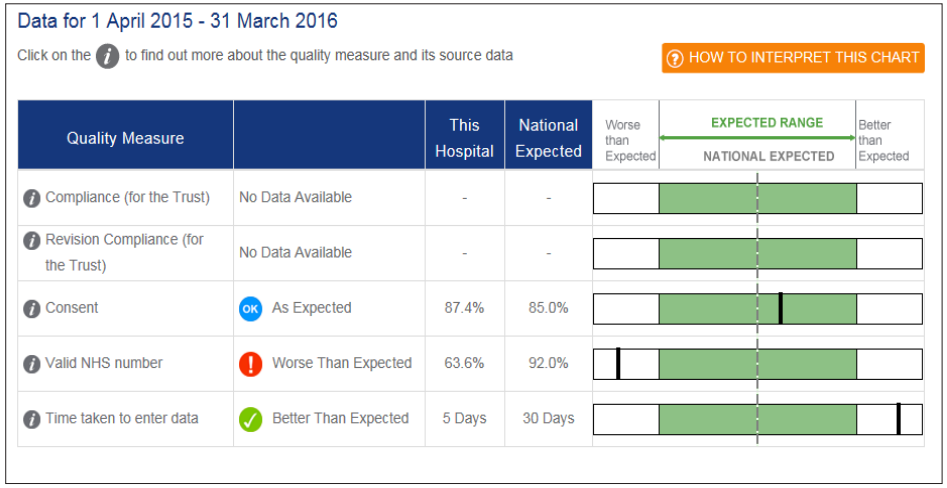


Hospital compliance (number of cases submitted to the NJR)

The chart below was taken from the NJR annual report and shows that the Hospital is 'as expected' in obtaining the patients consent and 'better than expected' in the time taken to enter our data.

NATIONAL JOINT REGISTRY (NJR)

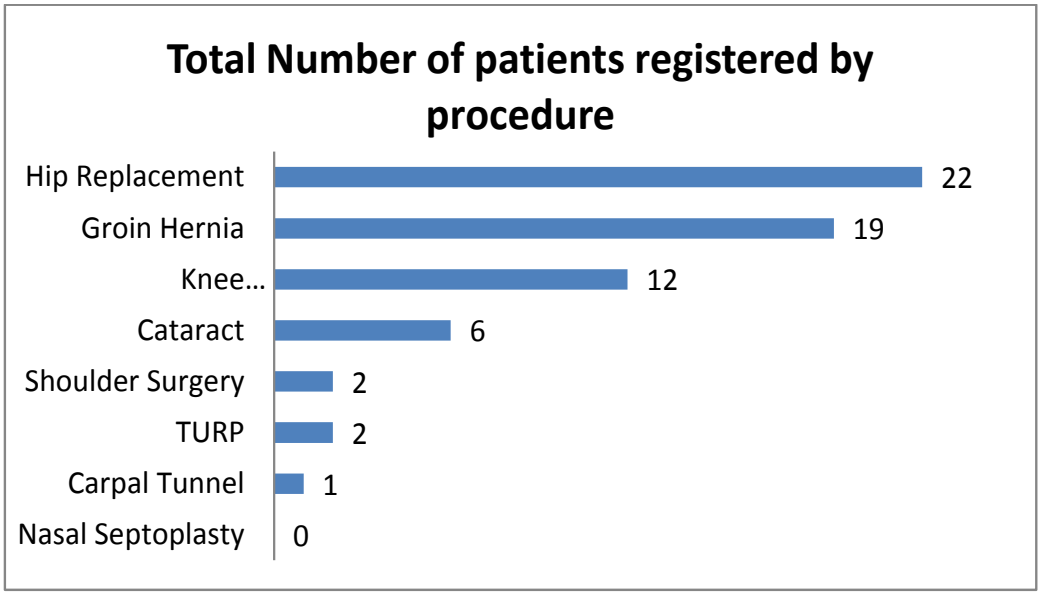
The Hospital continues to export data to the National Joint Registry (NJR) The NJR was set up by the Department of Health to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. Patients are required to consent to share their data with the registry.



Providing the NHS Number to the registry has been difficult for all private providers and we will continue to work towards obtaining the NHS numbers of all patients treated at the Hospital during 2017.

PATIENT REPORTED OUTCOME MEASURES (PROMS)

The Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to patients from the patient perspective. Currently covering eight clinical procedures, PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. The Hospital contracted with 'My Clinical Outcomes' during April 2016 to electronically collect data on the eight procedures detailed below.



We will continue to work with our Consultant users and patients to increase the capture of this data in 2017

EFFECTIVE

During the most recent CQC inspection (October 2016) the inspection team rated the 'effective' domain as overall 'Good'.

Key Performance Indicators

As part of the CQC's move to risk-based assessment, they collect data from independent acute services on their performance against a range of indicators, which are submitted by the Hospital on a quarterly basis. The performance indicators are:

0%
SURGICAL SITE INFECTION FOR KNEE REPLACEMENT

0.6%
NATIONAL AVERAGE

0%
SURGICAL SITE INFECTION FOR HIP REPLACEMENT

0.7%
NATIONAL AVERAGE

18 / 0.21%
UNPLANNED RETURN TO THEATRE WHICH IS 0.21% OF ALL THEATRE CASES

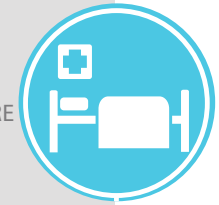
Surgical Site Infections (SSI)
Surgical site infection is a healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure.
A review of all patients who had a knee or hip replacement at the Hospital over a 12 month period has shown that the rates of infection following surgery are below the national average.

Every NHS Trust and private provider undertaking orthopaedic surgery is required to carry out an annual review of surgical site infections by the Public Health England Surgical Site Infection Surveillance Service.
The analysis of infections that occur after surgery in the part of the body where the surgery took place show that between January 2016 and December 2016, no patient having a knee replacement suffered from a surgical site infection, compared to a national average of 0.6%. Again no patient having a hip replacement suffered from a surgical site infection against a national average of 0.7%.

Unplanned Return to Theatre (RTT)
Every surgical intervention carries a risk of complication, and therefore incidence of returns to theatre is normal. This measurement is to ascertain any trends for surgical teams or for specific operations. During the year we had **18** cases return to theatre. The rate remains very low at 0.21% of all theatre cases and slightly lower than the previous two years.

Mortality Rate (Inpatient deaths, excluding our palliative care deaths in the Hospice)
It is important to collect the rates of death in acute hospitals and to review all cases to ensure all care had been provided in a timely and effective way. All deaths are audited in line with the Care Quality Commission (CQC) requirements and are discussed at the Hospital Medical Advisory Committee and both the Surgical and Medical Governance Committees. There have been no trends identified to date - 10 deaths occurred during 2016 and all of these patients were under the care of general physicians and were expected deaths of elderly inpatients with an average age of 91yea

10
DEATHS OCCURRED DURING 2016 AND ALL OF THESE PATIENTS WERE UNDER GENERAL PHYSICIANS AND WERE EXPECTED DEATHS OF ELDERLY INPATIENTS WITH AN AVERAGE AGE OF 91YEARS.

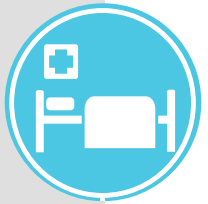


PERI-OPERATIVE DEATHS

2014
0
2015
0
2016
0

61
UNPLANNED TRANSFERS TO HDU

50%
WERE MEDICAL PATIENTS



Unplanned Admissions to HDU
The condition of inpatients can deteriorate and they may need a more intense level of care unexpectedly. Prompt identification of these patients is vital and we use a national early warning system (NEWS) to escalate care to our Critical Care Outreach team who treat the patient and then transfer them to HDU, if appropriate.
61 patients were unplanned transfers to HDU and of these just over 50% were medical patients.

71
UNPLANNED READMISSIONS DURING THE YEAR

0.78%
OF ALL DISCHARGED PATIENTS

Unplanned Readmission Within 29 Days
This is defined as "an inpatient readmission for the same or related condition that was not scheduled at the time of the previous discharge". There were 71 unplanned readmissions during the year. The unplanned readmission rate remains low when measured as a percentage of all discharged patients (0.78%) showing a slight increase from 0.74% in 2015.

18
(0.2%)
UNPLANNED TRANSFERS TO OTHER HOSPITALS

(0.2%)
OF ALL DISCHARGED PATIENTS

Unplanned Transfers Out To Other Hospitals
The majority of the patients who are unplanned transfers out require services that we do not provide such as ongoing adult level three critical care, dialysis or invasive cardiology.

There were **18** (0.2%) patients who were unplanned transfers out to other hospitals and these were predominantly medical cases (72%). Half of the patients were transferred for specialist treatment/care not provided at our Hospital.

We have the expertise of a resident Critical Care Fellow (Doctor) on site at all times who supports our level 2 High Dependency Unit and provides emergency cover for the Hospital alongside the admitting Consultant and Registered Medical Officer.

40 to 45
PRE-ASSESSMENT CASES SEEN PER MONTH

Pre-assessment Clinics
Pre-operative assessment helps to establish that the patient is fully informed and wishes to undergo the procedure. It ensures the patient is as fit as possible for the surgery and the anaesthetic, minimising the risk of late cancellations as it ensures all essential resources and discharge requirements are identified and coordinated. The pre-assessment clinic was relaunched to consultants in May 2016 and this resulted in an increase in numbers of patients being seen in pre-assessment from August onwards with an average of 40 to 45 patients being seen per month.

EIDO Healthcare
During 2016 we contracted with EIDO Healthcare to help us achieve excellence in the vital areas of informed consent and clinical governance.

INFOrm4U is a library of over 360 treatment-specific informed consent patient information leaflets. Each leaflet bears a Plain English Campaign Crystal Mark. This helped to strengthen our already extensive library of patient information leaflets to ensure all patients have enough information prior to their procedure to give informed consent.

CARING

Our aim, mission and values are enduring and include our aim to achieve the best outcomes for our patients and carers, supported by compassionate and caring staff in a safe environment. By caring we mean that employees involve and treat people with compassion, kindness, dignity and respect.

During the most recent CQC inspection (October 2016) the inspection team rated the 'caring ' domain as overall 'Good'. In their report CQC noted that all the patients and carers they spoke to were very happy with the services they had received or were receiving.

Hospital staff interviewed by the inspection team also spoke of how satisfied they were with the care they were able to deliver during their working day.

We see our role as being a privileged partner with our patients on their individual health journey. We proactively involve them in the planning and decisions about their care and goals. All relevant staff were compliant with the mental capacity, deprivation of liberty and safeguarding training.

In 2016 we commissioned a review of our services from the Alzheimer Society and introduced Dementia training. We continue to work with the society to ensure we build upon our provision of care for people who are living with dementia, ensuring we meet all of the objectives identified within the report.

Outcome	2012 = 97	2013 = 70	2014 = 60	2015 = 98	2016 = 119
Upheld	(37) 38%	(26) 37%	(30) 50%	(45) 47%	44 (37%)
Partially upheld	(17) 17.5%	(20) 29%	(9) 15%	(13) 13%	29 (24%)
Not upheld	(39) 41%	(24) 34%	(21) 35%	(39) 40%	46 (39%)

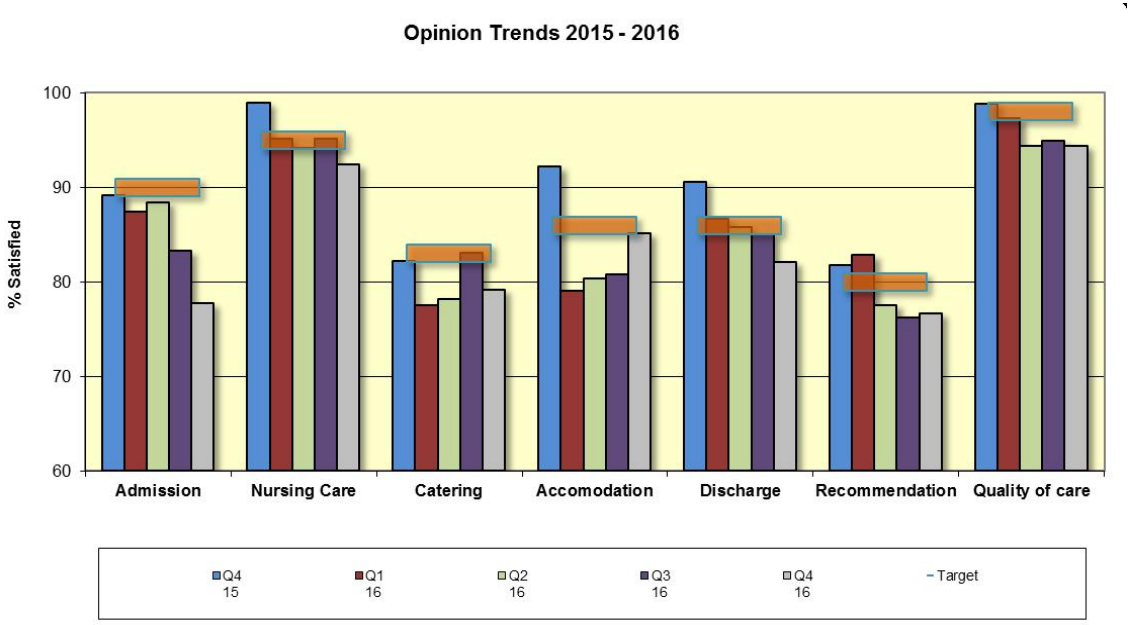
COMPLAINTS

During 2016 no complaints escalated to stage 2 or 3 and all were investigated and replied to within the correct timeframe. The majority of complaints were regarding financial issues and we have been working across all departments to ensure sufficient financial information is provided to the patient throughout their healthcare journey including a review of our self pay package pricing.

PATIENT SATISFACTION

The Hospital has a contract with two external companies for the capturing and analysis of patient satisfaction. HWA provide in-patient questionnaires and CRA capture our outpatient satisfaction and comments.

During 2016 satisfaction with nursing care remains high and we are continuing to move forward with our planned refurbishment programme of the inpatient accommodation and outpatient department areas throughout 2017/2018. We are also reviewing how we collect patient feedback and are working to strengthen the patient representation in our quality groups and committees.



RESPONSIVE

During the most recent CQC inspection (October 2016) the inspection team rated the 'responsive ' domain as overall 'Good'

In the last quarter of 2016 we launched our patient call centre to improve the service provided to general practitioners and the public who may be seeking consultant information or a medical review. We have continued to roll out this service across a large number of our specialties and will continue to do so during 2017.

We have expanded the variety of outpatient diagnostic tests we can offer including musculoskeletal, dermatology and cardiology and have invested in state of the art equipment including a new CT scanner and upgrading of our RIS PACF imaging modality.

We continue to look at other areas where we can adopt services or processes to allow us to be more responsive to the patient population we serve.

WELL-LED SERVICES

During the most recent CQC inspection (October 2016) the inspection team rated the 'well-led ' domain as overall 'Good'

LEADERSHIP

The Hospital's leadership programme is now well established with a number of modules delivered during 2016. This included appraisal, plus a specific module focussing on leadership and personal impact which over 70% of managers attended.

RECRUITMENT & RETENTION

The Hospital approved a new Recruitment and Retention Strategy in Spring 2016. Recruitment was therefore a significant focus for the Hospital in 2016 and we successfully reduced vacancies month on month from 11.8% in April 2016 to 4.8% in December 2016.

Average monthly staff turnover for 2016 was 1.4% which was below the target of 5% and remained consistently lower than the levels seen in 2015. Annually this translated to a total staff turnover rate of 18% in 2016 which compared favourably to a much higher rate of 22% seen in 2015.

STAFF SICKNESS

For 2016 the average monthly sickness absence was 1.6% against a target of 2.8% and compared favourably against 2015 when the rate for the year was 2.38%.

There was a very slight increase from previous months in November and December 2016 which can be attributed to usual seasonal variations. However, even these months remained below the annual target.
Managers continue to manage individual cases and provide support to staff via the Occupational Health Department and the Staff Healthcare Scheme.

MAGIC MOMENTS

The Magic Moments scheme which recognises excellence from individual staff as well as departments within the Hospital continued in 2016 and took place on a quarterly basis. Nominations are received from patients, staff and other stakeholders.

STAFF APPRAISALS

The Hospital has an established appraisal system operating for employees and this is well embedded within the organisation. Annual appraisals for most staff are undertaken between December and March each year and the coverage for the last period was reported at 99%.

Local induction arrangements are now fully embedded into the probationary period which all new employees complete.

STAFF QUESTIONNAIRE

The Hospital undertook a staff survey during Summer 2016. This was independently administered by Imperial College on behalf of the Hospital and focussed on organisational health. The response rate was very positive with 46% of staff taking time to complete and return the survey, which was the highest update they have recorded.

The Hospital scored favourably on all questions when compared to averages from other healthcare providers in 2013 when the survey was last undertaken (both private and NHS).
A sample of results across the key themes are illustrated in the table:

Theme	HJE 2016	Average 2013
Overall	5,03	4.32
Resilience	4.63	4.01
Leadership and management	5.24	4.12
Staff wellbeing	5.07	4.32
Finance and Investment	4.59	3.30
Patient Safety	5.16	4.19
Efficiency	4.88	3.62
Communications	5.10	4.09
Strategy	5.38	4.32

A sample of results across the key themes

QUALITY IMPROVEMENTS FOR 2017

SAFETY

In 2017 we will continue to improve safety and protect people from abuse and avoidable harm.

We will do this by:

- Learning lessons and implementing corrective actions where things are found to need improvement from analysis of adverse events, claims or complaints. During 2017 the quality improvement groups will set measureable objectives to demonstrate improvements – this will form the Hospital safety dashboard which will be discussed at all Hospital Management Board meetings and will include all reportable KPIs.

CARING

In 2017 we will continue to improve upon the way we involve people and treat them with compassion and respect.

We will do this by:

- Listening to our patients and staff to further understand their needs and the feedback they provide to us

- Continue with our weekly 'board to floor' walkabouts which allows us to listen to our staff and patients and provide immediate feedback on any issues they may raise with us Maintain our (100%) standard regarding responding to and closing complaints within the nationally defined timescales

- Involve people who use our services in the planning of our refurbishments, new extension works and invite them to sit on our quality working groups

- Undertake a review of our existing patient satisfaction provision to ensure it is accessible to all who wish to use it, hold a user focus group meeting and review more innovative ways to support grieving families and loved ones

- Develop our established staff appraisal system as a means of enhancing succession planning and talent management

- Review and build upon our existing annual staff satisfaction survey

RESPONSIVENESS

In 2017 we will continue to improve the access to our services to meet the needs of the community we serve.

We will do this by:

- The Hospital - investing in more equipment, screening and diagnostics, with more efficient bed management, increased number of patients using the Patient Support Centre and increasing the number of patients receiving diagnostic services within the Hospital

- The Hospice - investing in growth and in capability to support a diverse range of end-of-life conditions and wider variety of methods of support including increasing the 'outreach' and 'hospice@home' services

- Centralise the booking process for inpatient care, including provision on self pay pricing

- Increase opportunities to promote our services and consultants – review and expand website, GP liaison and media coverage

WELL-LED

In 2017 we will continue to improve the quality of care we deliver, support our staff learning and promote innovation in an open and fair culture.

We will do this by:

- Continuing to comply with our CQC statutory requirements

- Undertaking an external accreditation programme to ensure we are continually evaluating and improving our services

- Maintaining compliance with the Information Governance toolkit

- Continuing to comply with the Competition Marketing Authority remedies – working in partnership with the Private Health Information Network (PHIN)

- Maintaining an active membership with AIHO and ISCAS

- Continuing to invest in our staff – introduction of a new 5 day corporate induction programme, review of our existing mandatory 'core' training, leadership programme and introduce a new customer care programme

St John's Hospice

THE HOSPICE OF THE CHARITABLE HOSPITAL
OF ST JOHN & ST ELIZABETH

PATIENT SATISFACTION

A revised inpatient survey was implemented in November 2015, following feedback from the Hospice's User Involvement Forum.

The questions with the highest positive response included: satisfaction with cleanliness (98%), being treated with dignity and respect (96%), satisfaction with symptom relief (96%), and satisfaction with communication (93%), satisfaction with welcome (92%) and being provided with timely responses to care needs (91%).

The least positive answers related to being given information on how to raise concerns (70%), satisfaction with written information (79%), support for religious and spiritual needs (82%) and choice of food (83%).
94% of people answered that there were either extremely likely or likely to recommend the Hospice to a friend or family member who required similar care.

INCIDENT REPORTING

The total number of incidents reported decreased to 184 for 2016 (2015: 225), with a sustained decrease in incidents reported quarter on quarter.

Incidents are analysed and graded with a residual risk rating. For 2016, there was a considerable reduction in incidents graded as moderate, with 11 in year compared to 42 for 2015.

Of these 184 incidents, 130 were reported as near miss incidents in which no harm was sustained, but where it was identified that there was a problem with the delivery of care which if unaddressed had the potential to cause harm in the future.

The main areas in which incidents were found remain in medicines management, pressure area care and patient falls. St John's is working with other hospices to develop practice in these areas through the Executive Clinical Leads in Hospice and Palliative Care (ECLiHP) forum, facilitated by Hospice UK. All three areas are subject to regular planned audit.

MEDICINES MANAGEMENT

Medication errors are any incident where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. In 2016, the Hospice provided over 5,000 nights of care on the inpatient unit and most patients receive complex medication regimes, which are regularly adjusted throughout their time on the unit.

In this context, 60 incidents were recorded in relation to medicines management in 2016, down from 70 in 2015. Of these 60 incidents, patient harm was identified in 5 cases, these included one late administration, one wrong low dose, and two issues in which communication with primary care resulted in medication issues in the community.

In addition, one medication error was reported as a Serious Incident to the Care Quality Commission. This involved a wrong high dose being administered. A full Root Cause Analysis was carried out and a major remodelling of the Hospice Treatment Room and an enhanced programme of Observed Structured Clinical Examinations (OSCEs) for qualified nurses was put in place following this incident.

PRESSURE AREA CARE

The management of skin breakdown associated with pressure area care is complicated in patients receiving palliative care because of multiple risk factors and comorbid conditions.

In 2016, 31 incidents of pressure damage were identified, of which 19 related to imported pressure ulcers. This compares to 25 recorded incidents in 2015, of which 16 were imported.

Of the remaining 12 in 2016, 3 involved grade 1 wounds that were present on admission deteriorating during the provision of terminal care.

The Hospice has used the SSKIN Bundle as a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers, and recruited a nurse with extensive Tissue Viability experience to help support the Inpatient Team.

PATIENT FALLS

Incidents related to slips, trips, falls and collisions reduced significantly compared to 2015, with 23 reported incidents compared to 40 in the previous year. One fall resulted in a fracture, this occurred for a patient who was offsite at an NHS trust for treatment as an outpatient.

Grade	2016	2015
High	0	1
Moderate	11	42
Low	129	140
Very low	44	42
Total	**184**	**225**

SAFETY THERMOMETER

The NHS Safety Thermometer is a point of care survey that is carried out on 100% of patients on one day each month completed for the Hospice Inpatient Unit. The survey measures the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (inpatients with a catheter) and venous thromboembolism.

For 2016, Hospice inpatients were assessed as harm free in 81.6% of cases, all bar of the measures of harm were related to pressure ulcers that were present on admission to the Hospice, and when these are excluded, the measure rise to 99.3% harm free care.

STAFFING

Over the course of 2016, 74% of all regular inpatient shifts were covered by permanent Hospice staff, with a further 12% covered by regular Hospice bank staff. Agency staff were used to cover 14% of shifts.

Staff turnover was lower than in previous years with twelve leavers, of whom one has subsequently rejoined the Hospice and three have signed up to work bank shifts.

Suzy Croft, our Senior Social Worker, retired in March 2016, and was subsequently recognised with a Lifetime Achievement Award at the Social Worker of the Year Awards.

COMPLIMENTS

The Hospice received much positive feedback from patients and family members in 2016, and the comments below are a representative sample of the feedback received.

"Every time we visited there was such an incredible sense of calming care and we got to know so many of the nurses so well. My sister always felt at ease and able to rest as much as possible and I know you all did everything to help make her life as pain free as possible".

"You do an incredible job and we really are truly grateful for all of your constant hard work and dedication. It never went un-noticed"

"My father was very happy here and he felt at home. This is the most wonderful place. All the doctors, nurses and the staff are the very best"

"You have been the most amazing group of people, from the nursing staff to the volunteers, the wonderful front of house team, the Healthcare Assistants with their kind caring attitude, the cleaning staff, the catering team who produced so many amazing dishes, the physios, occupational therapists. I hope I have not forgotten anyone."

"I really think all hospital nurses should have to work in a hospice for 6 months before being let loose on the public, as I'm sure your staff could really give them a lesson in treating patients like real people."

COMPLAINTS

Two complaints relating to Hospice Clinical Services were received in 2016, of which both were upheld, this compares to three in 2015. Both complaints related to poor communication, one involved transfer from the hospice to an acute hospital, and one related to the process for reviewing patients in day services.

In response to the learning from these complaints, we changed our policy regarding transfer to an acute hospital to ensure that all patients are assessed by a doctor on the day of transfer before leaving the hospice, and introduced new processes for communicating the nature of day service patient reviews.

AUDIT

A comprehensive audit programme was completed in 2016, with audits being completed exploring the areas of:

- Care of Deceased Patients (Medication)
- Controlled Drugs
- Lone Worker
- Venous Thromboembolism
- Clinical Record Keeping
- Day Services (Hospice UK Audit)
- Nursing Assessment and Care Plans
- DNA-CPR
- Patient Falls
- Nutrition and Hydration
- Pressure ulcers

Each audit has lead to the development of a tailored action plan for the area in question and progress against these has been monitored through monthly audit meetings. Where appropriate, Hospice UK audit tools have been used which have been developed by Members of the Hospice UK National Quality Advisory Group.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