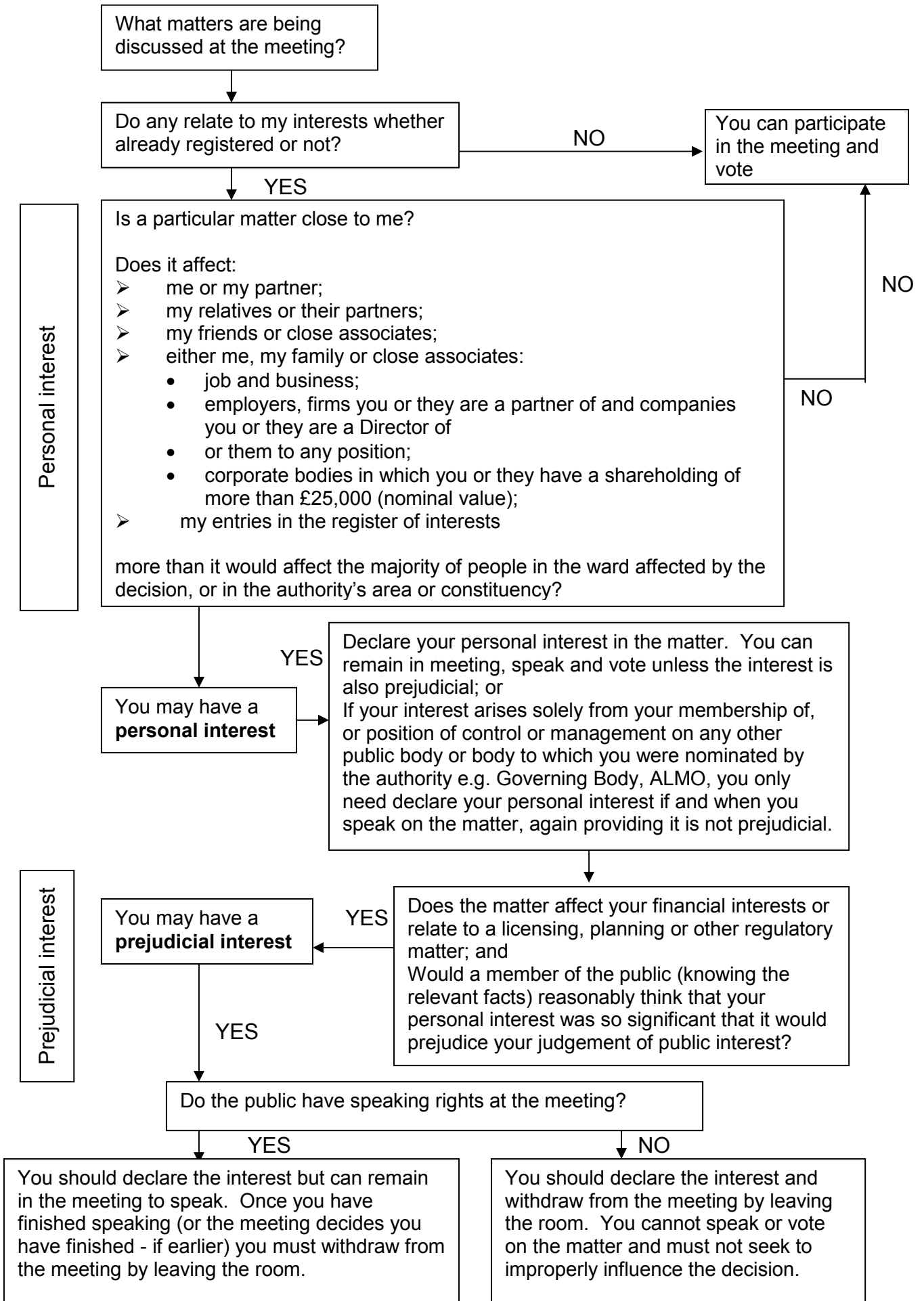


## DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF



**Note:** If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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## **NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 25 March 2011 at Hendon Town Hall, The Burroughs, Hendon, NW4 4BG.

**Present Councillors:** Alison Cornelius and Graham Old (Barnet), Peter Brayshaw and John Bryant (Camden), Gideon Bull and Dave Winskill (Haringey), Kate Groucutt and Martin Klute (Islington)

**Officers:** Andrew Charlwood, Paul Frost and John Murphy (Barnet), Katie McDonald (Camden), Pete Moore (Islington) and Rob Mack (Haringey),

### **1. WELCOME AND APOLOGIES FOR ABSENCE**

Cllr Gideon Bull (Chair) welcomed everyone to the meeting. Cllr Alison Cornelius gave apologies for absence in respect of Cllr Maureen Braun and introduced Cllr Graham Old as substitute for Barnet.

### **2. URGENT BUSINESS**

None.

### **3. DECLARATION OF INTEREST**

The following declarations were made:

Councillor Bull – Employee at Moorfields Eye Hospital

Councillor Cornelius – Chaplaincy at Barnet Hospital

Councillor Groucutt – Governor at University College London Hospital (ULCH)

### **4. MINUTES**

#### **RESOLVED:**

That the minutes of the meeting held on 21 January 2011 be approved.

### **5. NHS NORTH LONDON – TRANSITION AND GOVERNANCE**

Martin Machray, Associate Director, Communications and Engagement NHS Islington, presented a report on the NHS North Central London Transition and Governance Arrangements. The report described the North Central London (NCL) governance arrangements which will operate with a single Management Team and Cluster Board effective from 1 April 2011, in accordance with Department of Health (DH) guidance.

The logistical and personnel arrangements arising from the creation of the new NHS NCL Cluster Board were discussed. In response to questions from the Committee, it was stated that candidates for the positions of Non-

Executive Directors would be appointed over the course of April 2011 and that appointees would serve a term of three years. In response to suggestions that the large size of the Cluster Board, which will number 48 including all parties, would be difficult to manage, it was acknowledged that goodwill on the part of all parties will be required through the transitional period.

The Committee suggested that consideration should be given to specialised services that were provided locally, such as Islington's Prison Health Services.

**RESOLVED:**

1. That the report and appendices be noted.

**6. VASCULAR SURGERY**

Nick Losseff, Consultant Neurologist and Clinical Director NHS North Central London (NCL), was joined by Mr Darryl Baker and Ms Meryl Davis, consultant vascular surgeons from the Royal Free Hampstead NHS Trust, who answered questions relating to the criteria being used by NHS NCL to ensure vascular services are configured according to best clinical practice. Activity data was also presented for different areas of vascular surgery including Aortic Aneurysms, Lower Limb Revascularisation and Carotid Endarterectomy.

The Committee was advised that vascular surgeons supported the centralisation of services as high volume provides the best clinical results. This was detailed in national guidance that found patients receive the best clinical outcomes when cared for by an appropriately staffed and equipped specialist vascular service. Central to establishing and maintaining this service is the concept of focusing around a single "hub" hospital supported by day case and out-patient care in appropriate locations closer to patient's homes.

The Committee was advised that a minimum population of 800,000 is considered necessary for a vascular service. This figure was derived from the population required for an aortic aneurysm screening service; the number of patients needed to maintain competence among vascular specialists and nursing staff; and the most efficient use of specialist equipment, staff and facilities.

The Committee noted that if a mapping process considered Barnet and the areas north of the borough together, the required minimum population size would be achieved. Furthermore, as long as any party could provide a case outlining how they meet the required clinical standards, they could be considered for fulfilling the hub hospital role. It was envisaged that the decision regarding the choice of hub hospital would be achieved through agreement by providers; if not, a bidding process would be necessary.

In response to the Committee's concern over the Royal Free Hospital and UCLH receiving the bulk of resources and the issue of achieving critical mass,

the Committee were advised that 90 per cent of patients did not need major surgery and could continue to be treated in their local hospital. Further to this the hub hospital will not handle preparatory checks for patient's suitability to undergo surgery.

In response to queries relating to involvement in the consultation process and the negative response from the Barnet and Chase Farm NHS Trust which had expressed concern over the proposed model, particularly with regard to patient access, the Committee were advised that the Trust were fully involved in the current process.

**RESOLVED:**

1. That the report and appendices be noted.
2. That representatives from Barnet and Chase Farm NHS Trust be invited to the next meeting of the JHOSC to address their concerns relating to the proposed service model.

**7. NCL COMMISSIONING STRATEGY AND QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN**

Anna Bokobza, Assistant Director – Strategic Programmes NHS NCL, presented to Members a report and overview presentation of the key components of NHS NCL QIPP Plan for 2011/12-2014/15.

The report detailed the explanation of why the NCL requires a QIPP Plan, outlining the financial and policy context of the case for change. The report identified five challenges underpinning the development of the QIPP Plan:

- Population needs;
- Sustainable providers;
- Delivering uniformed quality;
- Financial challenge; and
- Workforce sustainability.

The Committee was informed that three priority work streams had been identified:

- Clinical areas;
- QIPP areas; and
- Enablers.

The immediate priority for developing the QIPP Plan was identified as closing the £25 million budget gap for 2011/12. The longer term priority was the placement of greater emphasis on referral management within Primary Care and Pathway redesign.

In response to the Committee's questions relating to the £25 million overspend for the current year, it was stated that the NCL was aiming to negotiate with providers or get more out of work streams to achieve savings to balance the budget.

It was noted that patients typically received 7 – 14 days of medication on discharge from hospital. No charge could be made for this. It was likely that there was some scope to make savings in this area particularly in view of the fact that the medication was often not all used.

The Committee commented that not all GPs were currently fulfilling the full range of their responsibilities. It was noted that, with the advent of GP consortia, GPs would now have to take greater responsibility for performance levels as well as budgetary issues.

It was noted that there were changes within the QIPP plan that might require formal consultation, such as the reconfiguration of mental health services in Camden and Islington.

### **RESOLVED:**

1. That the report and appendices be noted.
2. That future meetings of the JHOSC be updated on proposals to address the £25 million overspend.

### **8. FINANCE**

Richard Quinton, Interim Director of Finance, NHS Islington presented an overview of the financial position of PCTs within the sector for 2010/11 and 2011/12. The presentation outlined the historical context of budget deficits for 2010/11 and the implications of these deficits for the 2011/12 budget. Members were informed that the 2011/12 budget was based upon sound assumptions that:

- Acute growth based on historical trends;
- QIPP programmes rigorous and well developed;
- Contracts linked to performance requirements and
- Detailed informatics database.

It was noted that the budget position required £16 million support to break even. Finally, the presentation identified the risks going forward as:

- The time required for new structure to bed in;
- Loss of historical knowledge;
- Contracts negotiations with acute providers to be complete; and
- QIPP Plan is demanding.

Each PCT would be required to balance its books and any transfers of funding to make good deficits would need to be repaid.

**RESOLVED:**

1. That the report and appendices be noted.

**9. BARNET, ENFIELD, AND HARINGEY CLINICAL STRATEGY**

The Committee received a verbal update on the latest position in respect of Barnet, Enfield and Haringey (BEH) Clinical Strategy. The Committee was advised that on 10 March 2011 the Secretary of State for Health, Andrew Lansley, said that there was scope for alternative options to be considered for the future of Enfield's hospitals. A deadline of 7 April 2011 had been set for views and suggestions from local residents and General Practitioners. Further to this a public meeting was arranged by London Borough of Enfield for the 28 March 2011 which would report back for the April deadline.

**RESOLVED:**

1. That the Committee consider further how non-BEH members can best contribute on this matter.
2. That support officers be requested to investigate the legal standing of the JHOSC in respect of this matter.
3. That the MP for Enfield North be invited to the next meeting of the JHOSC to discuss the issue.

**10. JHOSC NCL – SUPPORT AND ADMINISTRATIVE ISSUES**

Issues were discussed relating to the support and administration arrangements for JHOSC.

**RESOLVED:**

1. That support and administrative arrangements including costings to be shared between member authorities.
2. That a forward plan for the JHOSC be developed based around workstreams within the QIPP.
3. That agendas to be cleared 10 days before meeting with any subsequent questions relating to specific issues emailed to officers in advance to allow for considered responses.

**11. DATE AND VENUE OF NEXT MEETING**

Agreed as follows:

27 May – Camden

15 July – Islington

## **12. NEW ITEMS OF URGENT BUSINESS**

### Camidoc

The Committee noted that a report had been commissioned by Camden PCT on the circumstances surrounding leading to the demise of Camidoc. Access to this had been requested by Members of the Committee in order that lessons could be learnt. However, the authors of the report would only allow this if a non disclosure agreement was signed. The Committee was of the view that this was a matter of public concern and that, as representatives of the community, they should be granted unconditional access to it.

### **RESOLVED:**

That a letter be sent on behalf of the Committee to NHS NCL formally requesting access to the report.

GIDEON BULL  
Chair



<b>NHS NORTH CENTRAL LONDON</b>	<b>BOROUGHES:</b> BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON <b>WARDS:</b> ALL
<b>REPORT TITLE:</b> NHS North Central London Quality Innovative Productivity and Prevention (QIPP) Plan Medicines Management – An Overview	
<b>REPORT OF:</b> Liz Wise, QIPP Director, NHS North Central London	
<b>FOR SUBMISSION TO:</b> North Central London Joint Health Overview & Scrutiny Committee	<b>DATE:</b> 27 May 2011
<p><b>SUMMARY OF REPORT:</b></p> <p>Around 10% of the total NHS spend is spent on medicines. Since their inception, Primary Care Trusts have employed Medicines Management teams to support the appropriate use of drugs locally, the management of the introduction of new medicines, ensuring compliance with NICE recommendations and to manage all other local medicines related issues.</p> <p>The creation of the NHS North Central London cluster has allowed us to review relative performance against prescribing practice across Barnet, Camden, Enfield, Haringey, and Islington. The vehicle for review is the Quality Innovation Productivity and Prevention (QIPP) Plan.</p> <p>The QIPP programme in Medicines Management (MM) is split into workstreams focused on GP prescribing and hospital prescribing.</p> <p>Liz Wise, QIPP Director, NHS North Central London will present this paper and respond to any questions the Committee might have.</p> <p><b>CONTACT OFFICER:</b> Stephen Deitch Senior Responsible Officer, QIPP – Medicines Management NHS North Central London Stephen.Deitch@haringey.nhs.uk</p>	
<b>RECOMMENDATIONS:</b> The Committee is asked to note the comments of the report.	
<p>Liz Wise QIPP Director, NHS North Central London</p> <p><b>DATE:</b> 19 May 2011</p>	

## **NHS North Central London Quality Innovative Productivity and Prevention (QIPP) Plan Medicines Management – An Overview**

### **Introduction**

All PCTs have a responsibility for managing their resources appropriately. Around 10% of the total NHS spend is spent on medicines, and since their inception, PCTs have always employed Medicines Management teams to support the appropriate use of drugs locally, the management of the introduction of new medicines, ensuring compliance with NICE recommendations and to manage all other local medicines related issues.

### **Background**

The QIPP programme in Medicines Management (MM) is split into workstreams focused on GP prescribing and hospital prescribing.

**GP Prescribing** - NHS North Central London (NCL) is made up of the five Boroughs, Camden, Islington, Barnet, Enfield and Haringey. Having managed medicines at borough level since 2001, the creation of a cluster has allowed us to review relative performance against prescribing practice. This review, unsurprisingly, shows large degrees of variation in prescribing practice that cannot be explained wholly by demography, levels of diversity or need. Each Borough has tackled issues of effectiveness, cost-effectiveness and prescribing performance in different ways and with different levels of resource. Now that individual PCTs are part of the same 'cluster', there is an unprecedented opportunity to optimise prescribing performance by working with clinicians from across North Central London, making best use of the workforce to support individual practitioners and practices, and reducing unexplained variations where they exist.

**Hospital Prescribing** - NHS NCL commissions services from eight acute Trusts. Drug costs make up a significant part of these contract values, and currently represent a rate of growth that far outstrips the growth allocations the Trusts receive. There is also variation in how the drugs are charged to the commissioning organisation, such that the same drug in the same quantity could be costing up to 71% more, depending on the Trust. It is important to agree a consistent and fair approach for reimbursement of these drugs and to be clearer about which drugs are prescribable in which circumstances.

### **QIPP Initiatives**

#### **1) GP Prescribing**

Each PCT area has a local Medicines Management Committee that is usually chaired by a local GP and includes membership from medical, pharmaceutical, public health and other professions. Its main purpose is to review current evidence in prescribing and recommend a range of initiatives to promote the highest quality and most cost-effective prescribing amongst local GPs.

There are over 30 initiatives in total and individual practices are likely to "sign up" to five to ten of these depending on how they vary from locally agreed standards. Below are three examples of individual initiatives that give some idea of the range of areas that are being tackled.

**Prescribing of Lipid Lowering Drugs** – NICE guidance produced in January 2006, made it clear in whom statins were most effective and that despite the range of statins available "When the decision has been made to prescribe a statin, it is recommended that therapy should usually be initiated with a drug with a low acquisition cost."

MM teams from PCTs supported this national guidance to ensure that the right people were being prescribed a statin and that the right one was used. In 2011, there is still variation in practice. For example Haringey GP's prescribe the most cost effective statins 81% of the time, while Barnet GPs prescribe them only 68.3% of the time. Because there is at least a five-fold difference in cost of these equally effective medicines, Barnet could save £3/4m by moving to the London average, at no clinical detriment to their patients.

**Prescribing of Glucosamine** – This health supplement has been prescribed for a number of years to alleviate the pain of osteo- and rheumatoid arthritis. Recent reviews of evidence have been unequivocal in their findings regarding its ineffectiveness in these conditions. Yet while Enfield and Barnet GPs have responded by reducing their prescribing to £2000 per month, Camden GPs are still prescribing over £21,000 every month. In total over £0.5m is prescribed annually with no significant clinical benefit.

**Prescribing of Specials** – Not all drugs are available in a proprietary formulation suitable for every patient. For instance not all tablets are manufactured in liquid form, and not all adult medicines are available in suitable paediatric doses. There are a number of “specials manufacturers” who supply these vital medicines, but there is no regulation on the charges they make to the NHS. It has recently become possible to analyse individual charges, and there are surprising variations in both absolute and relative costs. Tablets that cost £2 per month are costing the NHS up to £200 per month when supplied in liquid form. Two manufacturers of the same ointment charge the NHS £15 and £300. At its height in July 2010, these medicines were costing almost £600k per month. NHS NCL MM teams have been working with local prescribers to rationalise this area and have already reduced the monthly bill to £475k, but will be continuing to work further so that everyone will continue to get the medicines they need at the most appropriate cost to the local NHS.

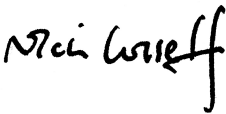
## 2) Hospital Prescribing

As stated earlier in this paper, the initiatives in hospital prescribing are mostly to bring in line drug costs with other parts of London and the country. Currently routine profit margins and handling charges are being charged by some Trusts and not by others. We want to reimburse hospitals for their acquisition costs of their drugs in line with common practice, and only pay additional charges exceptionally where unavoidable costs have been incurred by the Trust. NHS NCL are London outliers on costs of erythropoietin, an important drug to support patients having renal dialysis. Unlike other parts of London who have negotiated an agreed Tariff, NHS NCL is paying very different amounts. Bringing in line with other areas of London could save £2.5m. Finally, we would like to work with Trusts on a small number of expensive “high-tech” drugs. These drugs are now available as “biosimilars” – versions with the same effect and safety profile but very much cheaper. Where we can get clinical agreement to use these preferentially in the right patients, we could save NHS NCL up to £1.6m per year.

## Conclusion

NHS NCL spends £162m (actual cost) on GP prescribing and up to £80m (estimate) on hospital prescribing. Initiatives designed with full clinical engagement in both primary and secondary care have been created to save a total of £9.3m (3.9%) by reducing clinical variation, prescribing in line with best practice, and reducing the prescribing of ineffective drugs.

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<b>NHS NORTH CENTRAL LONDON</b>	<b>BOROUGHS:</b> BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON <b>WARDS:</b> ALL
<b>REPORT TITLE:</b> North Central London Arterial Vascular Service Commissioning Intentions	
<b>REPORT OF:</b>  Nick Losseff Medical Director – Secondary Care, NHS North Central London Associate Clinical Director – UCLH Comprehensive Stroke Service	
<b>FOR SUBMISSION TO:</b> North Central London Joint Health Overview & Scrutiny Committee (JHOSC)	<b>DATE:</b> 25 March 2011
<b>SUMMARY:</b>  Following presentations at the previous JHOSC meetings (21 January 2011 and 25 March 2011), Members requested further information about the criteria being used by NHS North Central London (NCL) to ensure vascular services are configured according to best clinical practice. Members also requested representation from Barnet and Chase Farm NHS Trust.  Attached in Appendix 1 are the North Central London Arterial Vascular Services Commissioning Intentions – May 2011. Dr Nick Losseff will discuss this document.  Nick Losseff will be joined by Mr Nicholas Law, Consultant Vascular Surgeon from Barnet and Chase Farm NHS Trust. Together, they will respond to any questions the Committee may have.  <b>CONTACT:</b> Dr Nick Losseff Medical Director, Secondary Care, NHS North Central London PA: Sarah Ditty email temp.executive@nclondon.nhs.uk or telephone 020 7685 6167	
<b>RECOMMENDATIONS:</b>  The Committee is asked to note the content of the Appendix 1.	
<b>SIGNED:</b>    Dr Nick Losseff Clinical Director, NHS North Central London DATE: 19 May 2011	

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## North Central London Arterial Vascular Services Commissioning Intentions – May 2011

### EXECUTIVE SUMMARY

Cardiovascular disease has a huge impact on the UK and the NHS London. It is therefore incumbent upon all stakeholders to ensure that services are equitably and efficiently provided and of high quality. This document provides guidance on future commissioning arrangements for a new networked arterial vascular service in North Central London (NCL) migrating to a single hub and supported by spoke services. It summarises:

- the case for change,
- model of care and
- the framework developed to encourage the correct system behaviours in order to achieve the intended benefits.

The enclosed analysis indicates that consolidating some existing services onto one site within the NCL area proposes a more clinically effective route for the provision of these services. Public responses to the *Case for Change* Cardiovascular project engagement consultation indicates broadly based public support for such an initiative. The measurable improvements achieved by the proposed reorganisation are summarised as follows:

- All emergency and elective vascular surgery will be undertaken by a consultant vascular specialist or by staff under their supervision. All vascular surgeons will undertake sufficient operations per annum to maintain competence.
- A vascular specialist and support staff with competences in interventional radiology will be available for all elective and emergency vascular radiology procedures.
- There will be a reduced aortic aneurysm repair length of stay, due to increased uptake of endovascular aneurysm repairs.
- There will be a reduced mortality rates for Vascular Surgery
- There will be an increased commitment to research
- There will be an improved patient experience

The NCL Vascular Working Group proposes that in NCL, non-emergency lower limb surgery should continue to be performed at the spoke organisations. The rationale for continuing lower limb bypasses surgery at the Spoke Organisations being:

- the *Case for Change* clinical reasoning behind the movement of the service to a centralised “hub”, in terms of altering morbidity/mortality rates, was not as strong for this avenue of surgery,
- The group believe that, in order for the NCL Vascular Service to offer the whole sector a gold standard service, it would be beneficial for the spoke organisations to remain viable and quality feeder organisations. The treatment of elective lower limb bypass work at the spokes would not only ensure the continuation of a viable vascular service, but would also maintain a high skill base, which in itself will maintain quality outcomes.
- The dissemination of lower limb work to the spokes will prevent a “flooding” of work to the hub
- The model proposed would alleviate the need for patients to travel further distances for day surgery procedures
- The proposed joint MDT meetings would also ensure the maintenance of a high quality elective lower limb service at the spokes, reducing the need for

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## 1. Introduction

### 1.1. Rationale for developing a new strategic approach to vascular health

Cardiovascular disease has a huge impact on the UK, with more than four million patients affected, costing the country around £30 billion annually.<sup>1</sup> The premature death rate may be falling, but cardiac and vascular conditions remain the leading cause of death in the UK. Heart disease, stroke, kidney disease and diabetes currently affect the lives of over four million people in England, cause 170,000 deaths a year, and are responsible for one fifth of all hospital admissions.<sup>2</sup> In 2007, over 65,000 people in the UK had surgery for a problem relating to vascular disease. The prevalence of cardiac and vascular disease will increase as the population ages, as risk factors increase, and as more people survive premature cardiac and vascular events. The major risk factors for cardiac and vascular diseases, such as smoking, abnormal blood lipid values and hypertension, are increasingly better prevented or treated but there is room for improvement. Some risk factors, particularly obesity and lack of physical activity, are increasing.<sup>3</sup>

The document *Cardiovascular Project: The case for change; an analysis of London's provision of Cardiac Surgery, NSTEMIs and Vascular services*, was published in August 2010<sup>4</sup> based on the London review. This detailed the conclusions arrived at by a working party led by Prof Matt Thompson, Vascular Surgeon at St Georges Healthcare Trust. According to the working party, UK patients have significantly worse mortality outcomes after an abdominal aortic aneurysm repair compared with other European countries, are less likely to be treated using new technologies and have among the longest lengths of stay in hospital in western Europe. In London, the standard of care for patients with acute cardiovascular disease varies across the capital. Some patients are being treated in hospitals that do not regularly perform complex surgical procedures, despite clinical evidence showing this does not give the best outcomes. Both The Vascular Society<sup>5</sup> and NCEPOD<sup>6</sup> had also recently published recommendations around emergency vascular provision. The Vascular Society stated that the best outcomes are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, seven days a week. The documents also emphasised that it is in the best interests of patients that hospitals should come together to provide high volume units and that the NHS in London needs to guarantee patients equal access to the treatment in order that they get the highest possible standard of care for their condition.

Consequently, North Central London has been tasked to improve treatment, care and outcomes for the local population who suffer cardiovascular disease. According to data collected by NCL in 2010, (see Appendix 3) the sector is

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<sup>1</sup> <http://www.londonhp.nhs.uk/publications/cardiovascular/>

<sup>2</sup> Ibid

<sup>3</sup> Lyratzopoulos, 2006

<sup>4</sup> <http://www.londonhp.nhs.uk/publications/cardiovascular/>

<sup>5</sup> <http://www.library.nhs.uk/Vascular/ViewResource.aspx?resID=304457>

<sup>6</sup> <http://www.ncepod.org.uk/2005report2/Downloads/AAAorgdata.pdf>

already achieving good standards of care e.g. Crude in-hospital mortality rate of 2.7% (Target = 4%). However, in order to further improve all measures, a strategic approach is needed to further prioritise and implement measures to continue to improve the service.

## **1.2. Types of vascular surgery under discussion**

The type of vascular surgery a patient receives depends on the individual needs of the patient. Surgery is available to treat varicose veins, transluminally re-open or surgically bypass regions of blocked or diseased blood vessels, repair aneurysms and remove built-up fatty deposits. (See Appendix 4) Vascular surgery is a specialty in which close co-operation and teamwork between surgeon, radiologist, anaesthetist and multidisciplinary teams, is essential, to ensure optimal management and patient outcome.<sup>7</sup>

## **2. Vascular project governance**

The cardiovascular project for London was supported by Caroline Taylor, Chief Executive, NHS Croydon (now CEO of NCL Cluster), as the Senior Responsible Officer. It was then divided into three clinical areas and had a clinical lead nominated to develop that area of work. The Vascular Surgery work stream was led by Prof Nick Cheshire, Vascular Surgeon at Imperial College, London. Following the publication of the *Case for Change* document, NHS London nominated the sectors (now clusters - in this case NHS NC London) to implement the changes recommended therein, For the purposes of this Project, therefore, the NCL Vascular Working Group reports to the NCL Board. The CEO and medical director of NCL wrote to providers in NCL last September asking them to find a co-operative solution to the London-wide proposals and 3 early meetings were held with providers, NCL chaired by Professor David Fish, MD of UCLP.

Consequently, the commissioning intentions for NCL were developed from discussions with the NCL Vascular Group (see 2.1). The project is clinically- led and has a nominated clinical lead, Dr. Nick Losseff, NCL Medical Director for Secondary Care and SRO for Vascular in NCL. Furthermore, the Project has been supported by UCLP<sup>8</sup> and North Central London Cardiac & Stroke Network, and it is proposed that they will continue to support implementation. Figure 1 documents the NCL Vascular Project reporting structure. (see over)

### **2.1. Project strategy adopted by the NCL Vascular Group**

This document has been prepared by the NCL Vascular Group. In order to facilitate the delivery of this document, early communication channels were set up with Clinicians, Managers and patient groups. Any challenges could therefore be identified early in the process, which should ensure the implementation process will run more smoothly. To this effect, four groups have been set up:

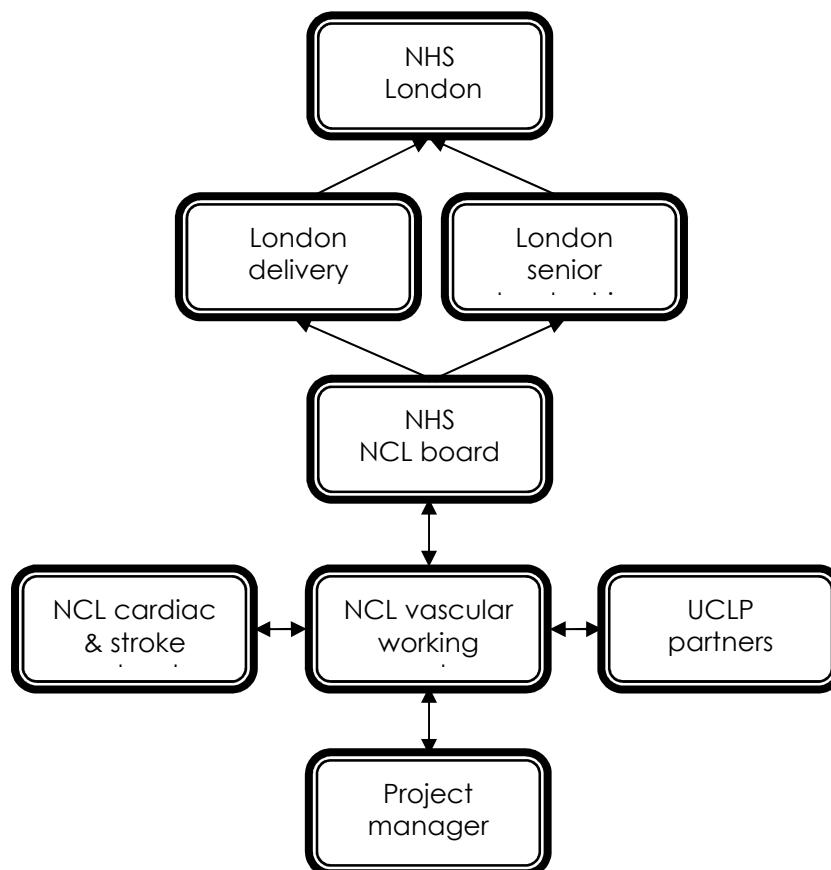
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<sup>7</sup> The Vascular Society of Great Britain & Ireland. (2007). ([http://www.bsir.org/files/File/C\\_Provision\\_of\\_Emergency\\_Vascular\\_Services\\_Final\\_Doc.pdf](http://www.bsir.org/files/File/C_Provision_of_Emergency_Vascular_Services_Final_Doc.pdf))

<sup>8</sup> <http://www.uclpartners.com/>

1. A Vascular Working Party, consisting of two Surgical representatives and one Radiological representative from each site, together with the Project Manager, met weekly;
2. A wider NCL Vascular Group, consisting of senior and regular clinicians, radiologists, NHS Provider Managers and UCLP met monthly, to discuss and ratify decisions from the working party;
3. A Data Group, made up of one representative from each site (nominated by the wider group), met to ensure data collection standards were robust and timely;
4. Initially, patient representatives were consulted via the NCL Cardiac & Stroke Network Cardiovascular patient Advisory Panel, which meets every 6 weeks. (Currently, no Vascular Panel exists.) A representative was then invited to the initial meeting with Commissioners, GPs etc and henceforth will attend the Vascular working party meetings.

**Figure 1: Governance Structure NCL Vascular Project**



### **3. The Case for Change**

According to *Case for Change*, in 2010, over 4,000 people in London underwent an abdominal aortic aneurysm repair, carotid endarterectomy, lower extremity

arterial bypass or limb angioplasty procedure. In North Central London, in 2010, 99 carotid endarterectomy procedures were carried out (82 symptomatic), 222 abdominal aortic aneurysm repairs (184 Elective and 38 Emergency), 523 limb angioplasties and 137 lower extremity arterial bypasses. (See Appendix 3) These figures have been increasing, due largely to changes in population demographics and is set to grow more rapidly following the recommendation of the NHS National Screening Committee that all men aged 65 should be screened for abdominal aneurysms.

Around 6,000 deaths are caused by a ruptured abdominal aortic aneurysm each year in England and Wales, accounting for two per cent of deaths in males over 65.<sup>9</sup> Currently, UK patients have significantly worse mortality outcomes after an abdominal aortic aneurysm repair compared with other European countries, are less likely to be treated using new technologies and have among the longest lengths of stay in hospital in Europe.<sup>10</sup> Consequently, *Case for change* identified several issues that need to be addressed in order to improve outcomes for patients undergoing vascular surgery, including inappropriate distribution of surgery, poor uptake of endovascular repair and wasted hospital resources. The NCL Vascular Group aims to address these issues and deliver recommendations, developed by consensual agreement, by March 2012.

### 3.1. Public Response to questions on the vascular surgery project

In *Cardiovascular project engagement*, the pan-London consultation on the proposed framework, respondents were asked three questions in relation to vascular surgery. 89% of respondents agreed with the first question “are you in favour of creating specialist vascular units?” Specific responses are displayed in Figure 2 below.

Secondly, respondents were asked about the number of arterial vascular sites that there should be across London. 81% agreed that arterial vascular surgery should be centralised onto five sites across London. All responses are displayed in Figure 3 below.

Finally, respondents were given a free text box to write about which services should be provided locally. The vast majority of these responses mimicked what was proposed in the model of care.

It is anticipated that at the next stage of the project, when individual bidding Trusts prepare their business cases to become a “hub” organisation, patient’s feedback contained in the document *Cardiovascular Services: The Patient Perspective*<sup>11</sup> will incorporate recommendations contained therein as appropriate.

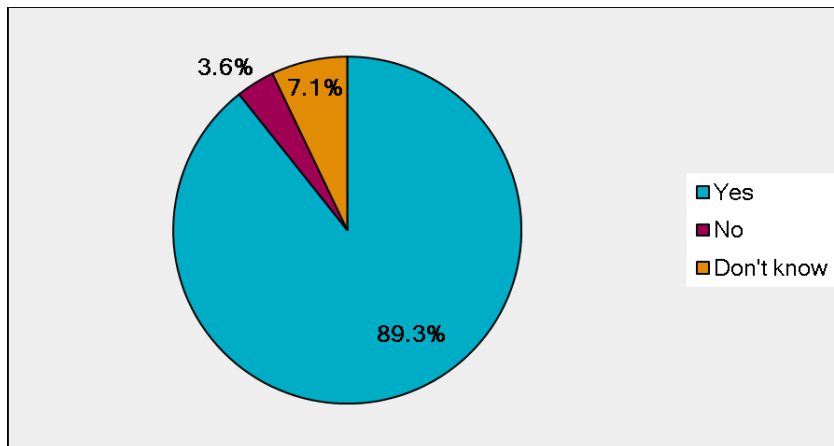
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<sup>9</sup> Holt, P. J. E., Poloniecki, J. D., Michaels, J. & Thompson, M. (2007). *An epidemiological study of the relationship between annual surgical volumes and outcomes from abdominal aortic aneurysm surgery in the UK from 2000 to 2005*. *British Journal of Surgery*, 94: 411-418)

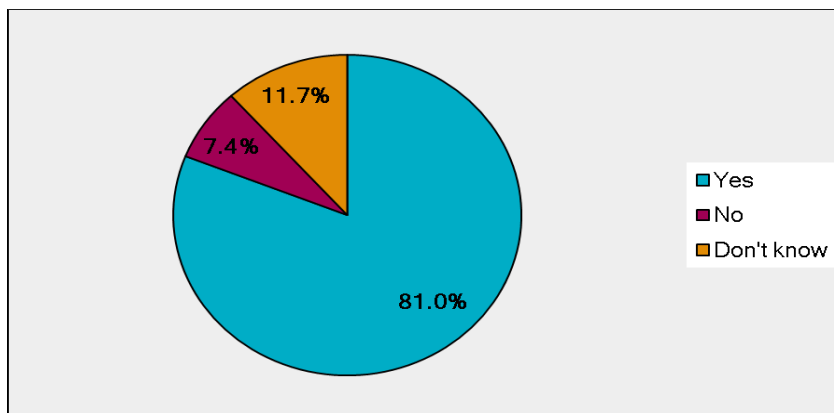
<sup>10</sup> <http://www.ncepod.org.uk/2005report2/Downloads/AAAorgdata.pdf>

<sup>11</sup> <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cardiovascular-services-the-patient-perspective.pdf>

**Figure 2: Do you agree that the clinical evidence provides a compelling case for change for vascular surgery?**



**Figure 3. Do you agree that arterial vascular surgery should be centralised onto five sites across London?**



#### **4. Model of Care and Service Standards**

##### **4.1. Overall Aims of re-organised Vascular Service**

At the heart of the cardiovascular project is a desire to improve the quality of London's vascular service to patients. The project aims to achieve better outcomes for patients by making vascular surgery in the capital the best in the world. As well as improving outcomes, quality also means making the best possible use of the resources available to the NHS. Time spent in hospital following surgery should be as short as is clinically appropriate, allowing patients to return home sooner. NCL providers and commissioners considered the best

way forward for ensuring a quality service for the local population and consequently agreed the following aims and objectives:

- As the best outcomes are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, seven days a week, it is therefore in the best interests of patients that hospitals should come together to provide high volume units. Currently in London, three-quarters of abdominal aortic aneurysm work is performed in six hospitals and the rest is spread across 13 hospitals. A “hub” and “spoke” model is proposed for NCL, with complex and difficult procedures being carried out at a central unit. Service specifications should be developed to ensure a gold-standard service at both hub and spoke organisations.
- In addition, the Vascular Service in NC London should ensure that it uses modern technology more frequently and use resources more effectively by working in multidisciplinary teams, including interventional radiology. Evidence suggests that the uptake of new technologies can be enhanced, clinical outcomes improved, quality developed and efficiency optimised, if arterial services in London are undertaken in considerably fewer high volume units and venous services continue locally.<sup>12</sup> NB: There is evidence that patients with a ruptured aortic aneurysm can be transferred safely for journeys of more than an hour by road or over 25 miles.<sup>13</sup>
- Vascular surgery should not be considered or take place unless all essential elements of perioperative care are available.
- There should be better integration of the patient pathway across health and social care.
- The need for service change should be accompanied by the opportunity for developing a patient centred approach. People with vascular disease, together with their carers and family, should be centrally involved and empowered. It is also an opportunity to redefine local services and ensure that a high quality, effective service is attained at all vascular sites.
- Alongside clinical care, the Vascular Service in NCL should show commitment to research to improve the management of patients with vascular conditions and work towards the prevention and cure of vascular diseases. Both the centralised and local vascular units should contribute to high quality translational research and patients at all units must have access to clinical trials.
- There should be an enhancement of the patient experience, based on the recommendations outlined in *The Patient Perspective* – a paper written by the cardiovascular patient panel in March 2010.<sup>14</sup>

## 4.2 Project Objectives

<sup>12</sup> <http://www.ncepod.org.uk/2005report2/Downloads/AAAorgdata.pdf>

<sup>13</sup> Ibid.

<sup>14</sup> <http://www.londonhp.nhs.uk/publications/cardiovascular/>

NCL providers and commissioners agreed the following objectives should be delivered by the reorganised service:

- All service providers in North Central London should meet the commissioning requirements as outlined by NHS London. The current commissioning standards are for units to complete:
  - 50 or more abdominal aortic aneurysms (AAAs)
  - 30 or more carotid endarterectomies
  - 50 or more percutaneous angioplasties
  - 50 or more open revascularisation surgeries (with an aim for greater proportion of angioplasty to bypass)
- All emergency and elective vascular surgery should be undertaken by a consultant vascular specialist or by staff under their supervision. All vascular surgeons should undertake sufficient operations per annum to maintain competence.
- A vascular specialist and support staff with competences in interventional radiology should be available for all elective and emergency vascular radiology procedures.
- A reduced aortic aneurysm repair length of stay due to increased uptake of endovascular aneurysm repairs
- Reduced mortality rates for Vascular Surgery
- An increased commitment to research
- An improved patient experience as evidenced by regular patient surveys and feedback
- The development of a Vascular Patient panel
- The aim of the NCL Vascular Project working party is to start to implement changes determined by March 2012, in a way that is essentially cost neutral.

#### **4.3. Proposed Model for a Centralised Arterial Vascular Surgery Hub**

A service model has been developed in consultation with the NCL Vascular Group:

##### **4.3.1. Procedures**

A centralised arterial vascular surgical hub unit should be commissioned to exclusively undertake the following procedures on both an emergency and elective basis:

- Aortic surgery (both open and endovascular surgery should be commissioned)
- Carotid endarterectomy surgery and stenting
- Thoracic outlet surgery

- Complex visceral & renal Interventions
- Vascular malformations should be discussed centrally and treated locally or centrally as appropriate
- Emergency Lower Limb Surgery/Angioplasty
- Lymphatic Surgery

#### 4.3.2. **Contracts**

All vascular surgeons will have access and formal contracted sessions at the hub and spokes as appropriate to their job plan. The hub hospital should provide appropriate clinical, managerial and administrative support to all surgeons to assist them in treating their patients and fulfilling their contractual obligations.

#### 4.3.3. **Emergency service**

The hub unit should offer an emergency arterial vascular service on a seven day a week, 24 hour basis. Patients that present at a local unit who require emergency, arterial surgery should be transferred to the centralised hub unit. Local protocols will need to be put in place between each local vascular unit and the London Ambulance service to ensure the safe and timely transfer of patients.

#### 4.3.4. **Role in the network**

Hub units would have overall responsibility for coordinating all arterial surgery to take place at the unit, including referrals and transfers from local units. This would also involve coordinating surgeon rotas across the network so they can attend the unit for elective and emergency surgical lists.

It would be the responsibility of the hub unit to monitor standards of all vascular services and units across the network. These standards would include:

- Audit data collections and analysis.
- Standardisation of administrative and clinical practices across the network (for example, discharge protocols and intervention strategies).

Results, analysis and submission of correctly coded data for the entire network to the Department of Health, NHS London (London's Strategic Health Authority) and National Vascular Database. (See Appendix 1 for further details)

#### 4.4. **Proposed Model for Local Arterial Vascular Surgery Spoke Units**

A service model has been developed in consultation with the NCL Vascular Group:

##### 4.4.1. **Procedures**

NCL Vascular Working Group proposes that in NCL, non-emergency lower limb surgery should continue to be performed at the spoke organisations. The rationale for continuing lower limb bypasses surgery at the Spoke Organisations being:

- 1) The *Case for Change* clinical reasoning behind the movement of the service to a centralised "hub", in terms of altering morbidity/mortality rates, was not as



strong for this avenue of surgery as for e.g. carotid or aortic procedures. The same went for Vascular Society recommendations.

- 2) The group believe that, in order for the NCL Vascular Service to offer the whole sector a gold standard service, it would be beneficial for the spoke organisations to remain viable and quality feeder organisations. The treatment of elective lower limb bypass work at the spokes would not only ensure the continuation of a viable vascular service, but would also maintain a high skill base, which in itself will maintain quality outcomes.
- 3) The dissemination of lower limb work to the spokes will prevent a “flooding” of work to the hub
- 4) The model proposed would alleviate the need for patients to travel further distances for day surgery procedures
- 5) The proposed joint MDT meetings would also ensure the maintenance of a high quality elective lower limb service at the spokes, reducing the need for centralisation.

This arrangement will be under constant review, with a full benefit analysis one year post hub/spoke arrangement being put in place.

Consequently, the spoke units should provide the following services:

- Varicose vein surgery
- Any other day-case venous vascular surgery
- Lower Limb revascularisation and bypass surgery
- Lower Limb angioplasty and stenting
- Amputation
- Vascular malformations should be discussed centrally and treated centrally or locally as appropriate

In addition, spoke units should continue to deliver a full range of vascular diagnostics and outpatient services. Vascular surgeons based at the local units should continue to provide an outpatient service and the full range of vascular diagnostics. They should have their own regular operating list at the central unit, onto which they can carry out the surgery for patients from the local unit. For the majority of patients this means that any surgical work-up will be undertaken locally and they will travel to the central unit for their complex surgery.

GPs should continue to refer their patients to the hospital of choice in the usual way. Once referred, patients would be seen on an outpatient basis in the usual way for any venous surgery. Local units would be responsible for triaging and transferring elective arterial patients to a central unit, where appropriate.

#### 4.3.2. **Emergency services**

In conjunction with the hub unit and London ambulance service, spoke units should develop protocols so that any patients presenting who require emergency arterial surgery can be safely transferred to the hub.

#### 4.4 **Quality service Standards**

In order to define a gold – standard vascular service, Quality Standards have been developed in consultation with the Vascular Working group (See Appendix 1) and are based on the Vascular Society’s guidance ‘The Provision of Services

for Patients with Vascular Disease 2009' and other relevant national guidance. Input has also been received from patient groups, via the NCL Cardiac & Stroke Network Patient Cardiac Advisory Panel. The next stage of the process will include the development of full service specifications.

The quality standards have been developed in such a way that they will be suitable for use in service specifications and in quality reviews. The Quality Standards aim to follow the patients' pathway and to ensure that the highest possible quality of care is available at each stage of the patients' journey and help to answer the question "If I walk into a vascular service today, how I will know that best-practice guidance has been implemented?" For ease of measurement, the Standards have been colour coded to reflect those that apply to both Hub and Spoke organisations and those that refer specifically to the Hub.

It would be the responsibility of the hub unit to monitor standards of all vascular services and units across the network and report regularly to commissioners. This would provide assurance that the standards and improvements are being delivered.

#### 4.5 Co-dependencies for the Vascular Service in NCL

The Vascular Society's 2009 report *The Provision of Services for Patients with Vascular Disease*<sup>15</sup> outlined the essential components of a vascular service and supports the view that additional specialty services improve the quality of emergency and elective vascular services for patients. Other studies have also suggested that collocating support services contributes to improved patient outcomes at high volume hospitals.<sup>16</sup> However, at present, according to *Case for Change*, although vascular surgery has demonstrable dependencies on other services, these services are not always located in the same hospital or, in some cases, in the same trust.

The London cardiovascular project states that the absolute co-dependencies (same site) for arterial vascular surgery are cardiology (inc PCI), general intensive care, specialist anaesthesia, interventional radiology, filtration and diabetes services. Same trust co-dependencies include cardiac surgery, plastics, neurology or neurosurgery and general surgery. Absolute co-dependencies for allied specialities (on vascular surgery) are all types of cardiac surgery including TAVI. No one site in NCL fulfils these requirements and there is also the local issue of relationship of the HASU to a vascular service.

Due to the current state of flux in the NHS and taking into account possible changes in service location recommended by other work streams in the Cardiovascular Project, the NCL Vascular group suggest that the co-dependencies required ultimately by the service should be determined locally and at the next stage of the process, where the site proposing to host a vascular hub develops clinically acceptable and assured procedures for addressing the co-dependent issues. An analysis will need to be made, regarding not only

<sup>15</sup> [The Provision of Services for Patients with Vascular Disease 2009, The Vascular Society](#)

<sup>16</sup> (1) [Association of Surgeons of Great Britain and Ireland. \*Emergency General Surgery: the Future. A consensus statement.\* London 2007.](#) ; (2) [Association of Surgeons of Great Britain and Ireland. \*The impact of the European Working Time Directive on Delivery of Surgical Services: a consensus statement.\* London 2008.](#); (3) [National Aortic Aneurysm Screening Programme: \*Standard Operating Procedure 2008\*](#)

which services individual units believe they will require access to (and how closely), but which services have a dependency upon the Vascular service itself. Individual business cases will have to identify what is currently available in their Trust and state what their local trust strategic plans are to develop those that are not currently available and within what timescales.

In essence, according to the Vascular Society Report (2009)<sup>17</sup>, the location and dependency of services to be considered for a vascular hub should be: Interventional radiology; Cardiology; Cardiac Surgery; Diabetic services; Dermatology, Clinical Laboratory Services; Neurology; Renal Services and Plastic Surgery.

## 5. **Financial Implications**

The *Cardiovascular project: Financial analysis*, published in August 2010<sup>18</sup> details a summary of the direct costs to commissioners and providers of implementing the recommendations in the model of care. The financial modelling was based on relocating arterial surgery to the current highest volume unit in each of the five sectors. Based on the modelling, there would be an overall projected cost to commissioners, due to changes in market force factors of the providers. (In most cases high volume units occupy central London locations, which incur a higher market force factor cost relative to those units in outer London). The *Cardiovascular project: Financial analysis* calculated whether there would be a cost saving or cost incurred for the proposed relocation of services to one central hub. The calculations were based on 2007/8 HES data and showed that there would be a £10k cost incurred for the relocation for NC London, for example, if arterial surgery were relocated to the highest volume unit in the sector.

No specific modelling has yet been carried out for the proposed NCL changes, especially considering it is proposed that the Lower Limb Surgery should continue to be provided at the Spoke Units. This will be initiated at the next stage of the process.

There are also likely to be financial implications resulting from the differences in prices for critical care, which do not form part of the national tariff but are negotiated locally. Whilst market force factors only impact on national tariff prices, there can be a similar theme in pricing for non-tariff activity. There is insufficient robust data available for critical care to inform this paper and this will be considered at a local level at the next stage of the process. Although some providers will lose some income as a result of activity being relocated, there will be a reduced bed requirement and therefore an opportunity for provider savings on workforce and equipment costs.

### 5.1 **Increase uptake of endovascular aneurysm repair**

The model predicts an increased uptake of endovascular aneurysm repair procedures rather than open repair techniques for abdominal aortic aneurysm surgery, as a result of centralisation of arterial services. In essence, Endovascular

<sup>17</sup> [The Provision of Services for Patients with Vascular Disease 2009, The Vascular Society](#)

<sup>18</sup> <http://www.csl.nhs.uk/Publications/Documents/Cardiovascular%20Finance%20Paper.pdf>

aneurysm repair requires less critical care compared with open surgery, but incurs costs for non-tariff devices (stents). For the next stage of the modelling, the 2010 NCL data should be used to determine true cost implications.

### **5.2 Reduced aortic aneurysm repair length of stay due to increased uptake of endovascular aneurysm repairs**

Endovascular aneurysm repair is associated with a lower length of stay compared with open repair techniques. Patients receiving abdominal aortic aneurysm repair surgery using endovascular surgery have a lower length of stay compared to those receiving open surgery. Increasing usage of endovascular aneurysm repair will give providers a saving in bed days and costs related to those bed days. Additionally, there will be a reduced usage of costly intensive treatment unit beds as a result of increased uptake of endovascular aneurysm repair.

### **5.3 Assessment of beds and theatres required for the NCL Vascular Service and Imaging Access**

An assessment of bed and theatre needs for NCL is required for the next stage of the process, as is an evaluation of the required imaging access. Consequently, the group will be tasked to obtain relevant information, in order that a cogent analysis can be made.

## **6. Next Steps and Conclusion**

Cardiovascular disease has a huge and multifaceted impact on the UK and by extension the demands placed on the NHS in London. It is therefore incumbent upon the all stakeholders to ensure that services are equitably and efficiently provided.

The Vascular Working Party, backed up by the wider NCL Vascular Group, intend to capture the impetus gained so far on the Project and continue to meet. These meetings will facilitate the development of cross sector documentation e.g. clinical algorithms, patient pathways, clinical guidelines etc. The Vascular Group has also set up quarterly Audit meetings where data is already presented on current performance.

The preceding analysis indicates that consolidating existing services onto one site within the NCL area proves a more effective route to the provision of these services. Furthermore, public responses to CSL's Cardiovascular project engagement consultation indicates broadly based public support for such an initiative.

**NICK THIS SPACE IS TO PUT THE CONTENTS OF YOUR LETTER TO CHIEF EXECs.....**

The Vascular  
Project Working Party,  
March, 2011.



## Appendix 1: VASCULAR QUALITY STANDARDS

### 1. Organisation of Vascular Services

National guidance on the organisation of vascular services identifies that clinical outcomes will be improved if patients are cared for by an appropriately staffed and equipped specialist vascular service. This service should comprise a single hospital with in-patient facilities supported by day case and out-patient care in appropriate locations closer to patients' homes. For some patients, especially those needing care in an emergency, this will involve transfer to a hospital with appropriate facilities. There are, however, significant benefits of maintaining local out-patient and day case vascular services and supporting links with local acute and rehabilitation services. These benefits extend to vascular bypass surgery and limb angioplasty. A minimum population of 800,000 is considered necessary for a vascular service. This is based on the population required for an aortic aneurysm screening service, the number of patients needed to maintain competence among vascular specialists and nursing staff and the most efficient use of specialist equipment, staff and facilities. The population of NCL is 1.2 million.

The expected improvements to the quality of vascular services following implementation of the Quality Standards can be summarised as:

Access	Access to out-patient, day case and rehabilitation services will be unchanged (and quality improved).
Patient experience	<ul style="list-style-type: none"> <li>• Reduced length of hospital stay for vascular surgery patients</li> <li>• AAA repair is carried out by a specialist vascular team</li> <li>• NCL will offer patients a high quality, gold-standard Vascular Service.</li> </ul>
<b>Clinical outcomes</b>	<ul style="list-style-type: none"> <li>• Reduction in mortality rates for Aortic Aneurysm (AAA) repair</li> <li>• Vascular surgery is carried out by a "high volume" team at a "high volume" centralised hospital in a hybrid theatre</li> <li>• The vascular surgeon is supported by a vascular specialist team including radiologists</li> </ul>

	<ul style="list-style-type: none"> <li>• Specialist radiologists are available 24 hours per day for AAA repair</li> <li>• Increased endovascular aneurysm repair rate</li> </ul>
<p><b>Service Outcomes</b></p>	<ul style="list-style-type: none"> <li>• Vascular Surgery patients should be treated in a centre with appropriate (close relationships with) co-dependencies. For example <ul style="list-style-type: none"> <li>- (1) interventional radiology,</li> <li>- (2) specialist anaesthetists,</li> <li>- (3) dedicated vascular specialist nursing care,</li> <li>- (4) dedicated vascular specialist PAM staff e.g. Physiotherapists, Occupational therapists and Social Workers</li> <li>- (5) specialist neurology staff and facilities</li> <li>- (6) interventional cardiology,</li> <li>- (7) specialist intensive care unit, / HDU</li> <li>- (8) diabetic specialists,</li> <li>- (9) cardiac surgery</li> <li>- (10) step down intensive care facility,</li> <li>- (11) renal support services</li> <li>- (12) plastic surgery *</li> <li>- (13) ECT specialist imaging (what is this?)</li> <li>- (14) paediatrics *</li> </ul> </li> </ul> <p>* desirable to have good access to these but not essential for co location</p>

## 2. Introduction to Quality Standards

These Quality Standards are based on the Vascular Society's guidance '*The Provision of Services for Patients with Vascular Disease 2009*' and other relevant national guidance. The Quality Standards reflect the guidance in a form that is suitable for use in service specifications and in quality reviews. The Quality Standards aim to follow the patients' pathway and to ensure that the highest possible

quality of care is available at each stage of the patients' journey. The Quality Standards help to answer the question "If I walk into a vascular service today, how I will know that best-practice guidance has been implemented?" They should be achievable by all services in two to five years. They concentrate on the structure and process aspects of quality and should be seen alongside indicators of outcomes. For ease of measurement, the Standards have been colour coded to reflect:

**HS** : those that apply to both Hub and Spoke organisations and **H** those that refer specifically to the Hub.

### 3. Definitions and Abbreviations

**Vascular service:** A vascular service provides specialist care for people with vascular disease. Services for patients will be provided in several different locations by staff with specialist expertise in the care of patients with vascular disease who work together and link closely with support staff and other local services. The service may work across more than one Trust, although one Trust should host the service and take overall responsibility for its governance.

**Vascular specialist:** A consultant vascular specialist is a consultant vascular surgeon or a consultant vascular interventional radiologist. A consultant vascular interventional radiologist is a consultant who has been formally trained to provide expertise in both diagnostic imaging and image guided minimally invasive vascular procedures.

#### Policies, Protocols, Guidelines and Procedures

The Quality Standards use the words policy, protocol, guideline and procedure based on the following definitions:

**Policy:** A course or general plan adopted by a Trust, which sets out the overall aims and objectives in a particular area.

**Protocol:** A document laying down in precise detail the tests/steps that must be performed.

**Guidelines:** Principles which are set down to help determine a course of action. They assist the practitioner to decide on a course of action but do not need to be automatically applied. Clinical guidelines do not replace professional judgement and discretion. For simplicity, some standards use the term 'guidelines and protocols' which should be taken as referring to policies, protocols, guidelines and procedures. All clinical guidelines should be based on national guidance, including NICE guidance where available. Local



guidelines and protocols should specify the way in which national guidance will be implemented locally and should show consideration of local circumstances.

**Abbreviations:**

AAA Abdominal Aortic Aneurysm

CT Computer Tomography

HES Hospital Episode Statistics

MDT Multi-Disciplinary Team

NSF National Service Framework

PCT Primary Care Trust

TIA Transient Ischaemic Attack

HASU Hyper Acute Stroke Unit PAP Patient Advisory Panel

<b>Hospital Name:</b>	<b>Date action plan last amended:</b>
Lead Surgeon accountable for delivery of service standards:	
Lead Nurse accountable for delivery of service standards:	
Lead Manager accountable for delivery of service standards:	

Quality Standard	Demonstration of Compliance	Base RAG	Action Plan	Date Completion
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**1. SERVICE CONFIGURATION**

1 <i>HS</i>	<p>All service providers in North Central London should meet the commissioning requirements as outlined by NHS London. The current commissioning standards are for units to complete</p> <ul style="list-style-type: none"> <li>• 50 or more abdominal aortic aneurysms (AAAs)</li> <li>• 30 or more carotid endarterectomies</li> <li>• 50 or more percutaneous angioplasties</li> <li>• 50 or more open revascularisation surgeries (should be aiming for greater proportion of angioplasty to bypass)</li> </ul>	<p>Catchment area for the service agreed by the Acute Commissioning Unit.</p> <p>Activity Data</p>		
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2 <i>HS</i>	<p>The service should have defined the locations on which in-patient, day case and outpatient vascular services are provided and the locations for the treatment of varicose veins. Each vascular service should normally have one main in-patient service. Outpatient vascular services should take place on, at least, all hospital sites accepting general medical and surgical emergency admissions. In NCL, aortic and carotid interventions and all emergency vascular surgery will be centred at the hub. Limb open and endovascular interventions (angioplasty, stenting, bypass surgery, amputations), veins and common OPD DSU services and interventions will continue at all sites i.e. hub and spoke hospitals.</p>	<p>Locations of services agreed by Acute Commissioning Unit.</p>			

**2. SUPPORT FOR PATIENTS AND CARERS**

	Quality Standard	Demonstration of Compliance	Base RAG	Action Plan	Date Completion
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3 H	<p>A member of the vascular team will act as an advocate for the patient and their family/ representative. This role should involve:</p> <ul style="list-style-type: none"> <li>• ensuring continuity of care</li> <li>• identifying and resolving patient areas of concern</li> <li>• ensuring patients and their representatives are aware of days/times for ward rounds</li> <li>• ensuring that information is given in an understandable manner</li> <li>• encouraging “buddy” system with other patients as appropriate</li> </ul>	<p>List of nominated advocates Job description Patient Feedback results</p>			
4 HS	<p>Information should be offered to all patients and appropriate others (e.g. carers) covering at least:</p> <ul style="list-style-type: none"> <li>• Vascular disease, including its causation and physical impact,</li> <li>• Treatment options available</li> <li>• Promoting good health, including smoking cessation.</li> <li>• Symptoms and action to take if become unwell and who to contact with queries or for advice.</li> <li>• Where to go for further information, including useful websites.</li> <li>• Support groups available; named Vascular</li> </ul>	<p>Examples of information available</p> <p><i>Note: Information should be available in formats and languages appropriate to the needs of the patients. This may include large print and or CD / DVD information.</i></p>		<p>1. Enlist patient Advisory Panel representative to ensure appropriate communication link with service users</p>	

	advocate (see standard 3) • Vascular service staff and facilities available, including facilities for relatives				
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**3. STAFFING AND SUPPORT SERVICES at SPECIALIST SITE**

5 <del>5</del>	All vascular surgeons will have access and formal contracted sessions at the hub and spokes as appropriate to their job plan. Vascular interventional radiologists based at the spokes may also have sessions at the hub as appropriate to their job plan. The service should have a nominated lead consultant vascular specialist to support audit and governance. The service should also have a nominated lead with responsibility for ensuring implementation of the Quality and governance Standards.	Name of lead consultant and lead nurse. <i>Note: The lead consultant and nurse may be supported by senior clinicians who take a lead role on particular aspects of the service, for example, screening or training.</i>			
6 <del>6</del>	A vascular specialist and support staff with competences in interventional radiology should be available for all elective and emergency vascular radiology procedures.	List of competencies – standards defined by RCR; BSIR and the Vascular Society			

7 H	All emergency and elective vascular surgery should be undertaken by a consultant vascular specialist or by staff under their supervision. All vascular surgeons should undertake sufficient operations per annum to maintain competence.	<p>Details of staffing available. Including consultant job plans junior Drs job plans and on call rotas. Evidence of registration with GMC.</p> <p>Audit results.</p> <p>Details of up to date MDT training and education programmes  <i>Note: For the purpose of considering operations to maintain competence, activity undertaken in hospitals outside the vascular service under review may be included as part of surgeons' activity.</i></p>			
8 H	Endovascular aneurysm repair and carotid stenting should be undertaken only by vascular specialists with competences in these procedures.	Audit results.			
9 H	A consultant vascular surgeon should be available at all times.	Staffing details. A consultant vascular specialist is defined as a consultant vascular surgeon who has undertaken a minimum of two years final stage training in a recognised vascular unit or who			

		<p>has equivalent experience and who regularly manages patients with aortic aneurysm disease and its associated conditions.</p> <p><i>Note: A minimum of a 1:5 on call rota is required to achieve QS.</i></p>			
10 <del>11</del>	A Vascular interventional radiology consultant should be available at all times.	Staffing List. (A consultant interventional radiologist is a consultant who has been formally trained to provide expertise in both diagnostic imaging and image guided minimally invasive vascular procedures.)			
11 <del>12</del>	24/7 cover should be available from dedicated middle grade vascular trainees	Deanery competencies			
12 <del>13</del>	A consultant anaesthetist with up to date vascular experience in dealing with major complex surgical cases such as acute trauma vascular and other emergencies should be available at all times.	Detail of services available including rotas and job plans			

<p>13 <i>HS</i></p>	<p>PAMs with specialist expertise in the following areas should be available on all sites that provide a vascular service:</p> <ul style="list-style-type: none"> <li>• Wound and diabetic foot management.</li> <li>• Explanation and lifestyle advice</li> <li>• Amputation and liaison with rehabilitation</li> <li>• Podiatry</li> </ul> <p>These teams should have responsibility for leadership and service development for their area of specialist expertise and be accountable to the Vascular team. There should be arrangements for cover during absences.</p>	<p>Staffing details, including cover arrangements</p> <p><i>1 Specialist expertise should be available to all patients across the network. The roles may, however, be undertaken by different people in different localities.</i></p> <p><i>2 A system should be in place to support and train new members of staff working on the unit.</i></p>			
<p>14 <i>HS</i></p>	<p>Sufficient, designated, administrative and clerical support should be available at hub and spokes for patient administration, staff coordination, data collection and coding, timely discharge summaries and follow-up arrangements.</p>	<p>Discussion with staff Staff Job descriptions Rotas etc</p> <p><i>Note: 'Sufficient' is not strictly defined. Clinical staff should not be spending unreasonable amounts of time on administrative duties, including data collection, which detracts from their ability to provide patient care.</i></p>			



<p>15 H</p>	<p>A member of staff with competences in vascular ultrasound should be available during normal working hours. At weekends there should be a system for identifying patients needing vascular ultrasound and providing scanning, if required, on a daily basis.</p>	<p>Staffing details including 7/7 working schedules</p>			
<p>16 H</p>	<p>Physiotherapy services should be available with time allocated for their work with in-patients with vascular disease 7/7</p>	<p>Details of services available</p>			
<p>17 HS</p>	<p>In hospitals providing in-patient vascular services, the following facilities and services should be available:</p> <ul style="list-style-type: none"> <li>• Dedicated vascular specialist PAM staff e.g.</li> <li>• Vascular Physiotherapists,</li> <li>• Occupational therapists and</li> <li>• Social Workers</li> <li>• Specialist Neurology staff and facilities</li> <li>• Podiatrists</li> <li>• Ulcer nurses</li> <li>• Specialist Amputee services</li> </ul>	<p>Details of facilities and staffing available</p>			

#### 4. GUIDELINES AND PROTOCOLS

18 <i>HS</i>	Clinical guidelines should be agreed with LAS covering the clinical indications for triaging and transferring patients from Accident and Emergency Departments of spoke hospitals to the hub hospital and standards of time for transfer	Written guidelines agreed with the ambulance service. Evidence of standards of time for transfer			
19 <i>HS</i>	Protocols and Guidelines should be developed for inter- site transfer of patients, ensuring expeditious travel times and efficiency. A bed must always available at the hub for immediate transfer of vascular patients	Written protocols			
20 <i>HS</i>	Clinical guidelines covering referral to the vascular service should be in use in all Emergency Departments and General Surgery services. These guidelines should cover: <ul style="list-style-type: none"> <li>• Investigation and management of emergency vascular patients</li> <li>• Management of haemodynamically unstable vascular patients</li> <li>• Indications for seeking advice from the vascular service</li> <li>• Indications and arrangements for</li> </ul>	Written guidelines <i>Notes:</i> <i>The network will provide a structure and process to support clinical engagement.</i>  <i>1 This QS applies to all Emergency Departments and general surgery services within the catchment area of the vascular service.</i>			

	<p>emergency transfer</p> <ul style="list-style-type: none"> <li>• Indications and arrangements for non-urgent referral.</li> </ul>	<p>2 Guidelines should be explicit about the arrangements for transfer of cross-matched blood.</p>			
21 <i>HS</i>	<p>A surveillance protocol should be in place for patients with vascular disease including small aneurysms, post aneurysm repair and post lower limb arterial revascularisation.</p>	<p>Written protocol  <i>Note: The protocol may be that no surveillance is undertaken unless further evidence of effectiveness becomes available.</i></p>			
22 <i>HS</i>	<p>Guidelines should exist for efficient and effective patient preoperative planning and should take place as close to home as possible</p>	<p>Written guidelines</p>			
23 <i>HS</i>	<p>Discharge planning guidelines should be in use covering, at least:</p> <ul style="list-style-type: none"> <li>• Discharge to rehabilitation facilities</li> <li>• Discharge home with support from local rehabilitation facilities</li> <li>• Referral to limb-fitting service</li> <li>• Communication with the patient's General Practitioner.</li> <li>• Primary care nurses for the support of long term conditions</li> </ul>	<p>Written guidelines</p> <p>Will include clear referral process and protocols for transferring care back to local units and clinicians</p> <p>Local steering groups will be in place as part of A2 standards to monitor and manage the referral process and identify risks</p>			

24 <i>HS</i>	The vascular service should be aware of local guidelines for end of life care.	Availability of guidelines relating to end of life care that are used by specialist palliative care services in the local area.			
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**5. SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES**

25 <i>HS</i>	<p>A multi-disciplinary team meeting to review the care of patients with vascular disease should be held as appropriate, involving at least:</p> <ul style="list-style-type: none"> <li>• Vascular specialists</li> <li>• Radiologists regularly involved with the care of patients with vascular disease</li> </ul> <p>An MDT coordinator should be in place to ensure smooth running and organisation of meetings.</p>	<p>Notes of meetings held. <i>Notes:</i> <i>Meetings will have records of attendance.</i> <i>Recommendation/plan will be formally recorded in the medical notes</i> <i>10 notes to be audited for quality assurance</i></p> <p><i>1 All interventional radiologists and surgeons providing vascular services should attend the MDT meeting regularly.</i> <i>2 Other staff, for example, ward manager, may also attend the MDT meetings.</i></p>			
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26 H	The vascular service hub should have close liaison with local TIA services.	A representative from the service should have representation on the local HASU group			
27 HS	The Vascular Service should have access to and accountability for: <ul style="list-style-type: none"> <li>• Claudication classes</li> <li>• Diabetic Management Classes</li> <li>• Best medical therapy/cardiovascular risk management clinics</li> </ul>				

## 6. GOVERNANCE

	Quality Standard	Demonstration of Compliance	Base RAG	Action Plan	Date Completion
28 H	A ward-based multi-disciplinary team meeting to discuss the care of patients with complex rehabilitation and discharge needs should be held at least weekly involving at least: <ul style="list-style-type: none"> <li>• Ward manager</li> <li>• Nurse with specialist expertise in care</li> </ul>	Notes of meetings held <i>Note: This QS applies only to hospitals with in-patient vascular services.</i>			

	<p>of patients with amputations (QS7)</p> <ul style="list-style-type: none"> <li>• Physiotherapy (QS34)</li> <li>• Occupational therapy (QS35)</li> <li>• Social work (QS35)</li> </ul>				
29 <i>HS</i>	<p>The service should be collecting and submitting data on all index procedures to the National Vascular Database, as well as local Trust data.</p>	<p>National Vascular Database reports showing risk-adjusted comparative outcomes for the service. <i>Note: Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient services.</i></p>			
30 <i>HS</i>	<p>The service should have a quarterly programme of audits covering at least:</p> <ul style="list-style-type: none"> <li>• Number of vascular operations undertaken by surgeon across the service's catchment area.</li> </ul>	<p>Details of audit programme. <i>Note: Audits should cover all parts of the vascular service including activity in spoke hospitals and should include comparison of HES data and National Vascular Database numbers. Audits of operations by surgeon should include all vascular operations.</i></p>			
31 <i>HS</i>	<p>All policies, procedures and guidelines should comply with Trust document control procedures.</p>	<p>Policies, procedures and guidelines meeting reasonable document control quality requirements of monitoring, review and version control.</p>			

32 <i>HS</i>	Contingency Planning: The in patient service must have detailed business continuity plan to ensure that in the event of technical break down, theatre unavailability or other emergency situation, a formal protocol and back up service arrangements are available for the management of emergency and urgent patients. This may include formal transfer protocols within or outside NC London Vascular service	Business continuity plans for Imaging Theatre Services Emergency Transfers, with clear links to LAS Others			
<b>7. TRUST AND COMMUNITY STAFFING AND SUPPORT SERVICES</b>					
33 <i>HS</i>	In-patient and community-based rehabilitation services with expertise in the care of patients with vascular disease, including amputees, should be available, including at least: <ul style="list-style-type: none"> <li>• Physiotherapy</li> <li>• Occupational therapy</li> <li>• Social Work</li> <li>• Podiatry</li> <li>• Leg Ulcer Nursing</li> <li>• Tissue Viability Nursing</li> </ul>	Description of services available and the local arrangements for patients being discharged back to a referring hospital without a complex vascular service. <i>Notes: These services should be available for the whole of the vascular service's usual catchment population but may be organised in different ways in different locations.</i>			

<b>8. SUPPORT FOR PATIENTS AND CARERS</b>					
	<b>Quality Standard</b>	<b>Demonstration of Compliance</b>	<b>Base RAG</b>	<b>Action Plan</b>	<b>Date Completion</b>
34 <i>HS</i>	The following support services should be available: <ul style="list-style-type: none"> <li>• Interfaith and spiritual support</li> <li>• Interpreters</li> <li>• Bereavement support</li> <li>• Information about these services should also be available.</li> </ul>	Support services and relevant information available.  <i>Note: 'Availability' of support services is not defined but should be appropriate to the case mix and needs of the patients.</i>			
35 <i>H</i>	The vascular service should have a Vascular Patient Focus Group, which should have an input in developing feedback forms and monitoring performance of the service	Description of current arrangements. Examples of changes made as a result of feedback from patients and carers.			
36 <i>HS</i>	Guidelines on lifestyle advice for all patients should be in use covering, at least: <ul style="list-style-type: none"> <li>• Support for smoking cessation</li> <li>• Dietary advice</li> </ul> Programmes of physical activity and weight management	Written guidelines  Evidence of secondary health promotion protocols for patients; follow up advice including contact details of key worker.  Audit of numbers of patients referred to primary care smoking cessation teams			



		Review 10 sets of notes.			
37 HS	When leaving hospital, the patient advocate should ensure that patients are encouraged to keep a “patient passport” or similar wallet with them at all times, containing up-to-date medical information including discharge letters, latest medication, details of GP and consultants, test results, appointments, and any other papers the patient would like to be readily available in an emergency. (It would be the responsibility of the individual patient to keep the document updated)	Annual Patient Satisfaction survey			

**9. FACILITIES: HOSPITAL SITES ACCEPTING VASCULAR ADMISSIONS**

38 H	A dedicated Vascular in-patient ward should be available, staffed by nurses and HCAs with appropriate competences in care of patients with	Staffing details, competence framework showing expected competences and summary of competence assessments.			
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	<p>vascular disease. The competence framework should cover at least:</p> <ul style="list-style-type: none"> <li>• Acute Life-threatening Events Recognition and Treatment (ALERT) or equivalent</li> <li>• Tissue viability and wound care</li> <li>• Pain management</li> <li>• Care of patients with diabetes</li> <li>• High Dependency Care</li> <li>• Podiatry</li> </ul>				
39 H	<p>All vascular surgery should take place in a theatre with:</p> <ul style="list-style-type: none"> <li>• Theatre staff trained in vascular instruments, prosthetics and techniques, in the use of cell salvage devices for blood conservation and endovascular skills</li> <li>• Stocks of grafts, instruments and sutures required for patients with vascular disease</li> <li>• Hand-held Doppler ultrasound machine and portable duplex devices</li> <li>• Access to blood and blood products</li> </ul>	<p>Viewing facilities</p> <p><i>Note: QS applies to all vascular surgery, including day case surgery on hospital sites other than that where in-patient vascular services are based.</i></p>			

40 <i>HS</i>	In hospitals providing in-patient vascular services, magnetic resonance angiography should be available during normal working hours and CT at all times.	Viewing facilities  <i>Note: This QS is applicable only to hospitals with in-patient vascular services.</i>			
41 <i>H</i>	<p>The Vascular Outpatient Service should have access to</p> <ul style="list-style-type: none"> <li>• Vascular ultrasound during normal working hours</li> <li>• Facilities to perform ankle brachial pressure tests</li> <li>• Portable duplex scanner</li> <li>• Access to electronic transfer of imaging across all sites</li> </ul> <p>All staff will be expected to evidence a competence framework for assessing, scanning and reporting carotid duplexes.</p>	<p>Observation of facilities and equipment</p> <p>Staffing details</p> <p>Summary of competence assessments.</p> <p><i>Note:</i> <i>1 The service may be available within the outpatient clinic or imaging department. The service may be provided by a vascular technologist, radiographer, nurse or radiologist.</i></p>			
42 <i>H</i>	<p>Access to co-dependencies (as detailed in the hub) should be available at all times e.g.:</p> <ul style="list-style-type: none"> <li>• Emergency theatre</li> <li>• Vascular angiography suite</li> </ul>	Details of facilities and staffing available			

	<ul style="list-style-type: none"> <li>• Critical care (at least level 3)</li> <li>• Haematology (for urgent cross-match and blood products)</li> <li>• Facilities for electronic transfer of imaging from, or ability remotely to view imaging at, other acute hospitals within the Network.</li> <li>• Renal support that includes dialysis facilities</li> <li>• Cardiac surgery</li> </ul>				
43 <i>HS</i>	<p>In-patient vascular wards at hub and spokes should have:</p> <ul style="list-style-type: none"> <li>• Hand-held Doppler ultrasound machine</li> <li>• Portable ultrasound Scanners</li> </ul>	Viewing facilities			
44 <i>HS</i>	Spoke Hospitals providing Vascular Services should provide vascular ultrasound 5 days a week, during working hours	Staff rotas			
<b>10. GUIDELINES AND PROTOCOLS</b>					
45 <i>HS</i>	Clinical guidelines should be in use covering indications for involvement of cardiology services in the care of	Written guidelines agreed with cardiology service and pre-assessment.			

	patients with vascular disease.				
46 <i>HS</i>	Clinical guidelines should be in use covering indications and arrangements for referral for psychological support.	Written guidelines			
47 <i>H</i>	A meeting with local rehabilitation services (QS13) should be held at least annually to review the links with the vascular service and address any problems identified.	Notes of meetings held.			

## 11. GOVERNANCE

48 <i>HS</i>	The service should produce an annual report summarising activity, compliance with quality standards and clinical outcomes. The report should also contain the results from a patient satisfaction survey. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report and should be circulated to all relevant trust	Annual report/s. <i>Note: The National Vascular Database reports will provide much of the data for the annual report.</i>			
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## 6. Outcome Indicators

	No.	Standard description	TARGET		
			Elective	Emergency	Comments Unplanned removed
Pre-operative	1	Proportion of patients who are operated on who came in from screening and surveillance programme?	Target: Monitor	n/a	
	2	Proportion of patients with a known un-ruptured AAA of at least 5.5cms that are declined surgery / 5cms for Women	Monitor	Monitor	Request field added to NVD
	3	Pre-operative length of stay for elective patients to be kept below 1 day average.	Target: 1 day	n/a	NVD
	4	On the day cancellation rate for elective AAA procedures	Target: Monitor	n/a	Not on NVD Trust data
	5	Number of patients who suffer a ruptured AAA whilst on the elective AAA waiting list	Target: Monitor	n/a	Not on NVD Local data collection
Operative & in-hospital	6	Proportion of AAA procedures performed using EVAR	Target: 60%	Monitor	NVD
	7	30 day in-hospital mortality rate following elective open AAA repair	Target: 4%	Target: 40%	NVD
	8	EVAR – 30 day Mortality Rate	Target: <3%		NVD Need to clarify from date of admission or date of op?
Post-operative					

	9	Proportion of patients discharged to level 3 critical care/ITU bed immediately following surgery	Monitor	Monitor	Clarify individual units practice eg PACU at UCLH =ITU
	10	30 day re-admission rate for patients who have undergone AAA surgery	Monitor	Monitor	Readmission rate for ANY cause –local data
	11	Total length of hospital stay	Monitor	Monitor	NVD

#### Carotid endarterectomy quality markers

Area	No.	Standard description	Target		Comments
			Symptomatic	Asymptomatic	
Pre-operative	1	Proportion of clinically appropriate patients treated within two weeks of referral	Target: 100%	Monitor	Need to clarify – from symptoms to surgery
	2	Pre-operative length of stay to be kept below 1 day for elective patients	Target: 100%	Target: 100%	NVD
Operative & in-hospital	3	Stroke Rate (self reported, 30 day) Disabling Non Disabling	Target: 2%	Target 2%	NVD
	4	30 day in-hospital mortality rate Carotid Endarterectomy	Target: 3%	Target: 1%	NVD
	5	Proportion of procedures undertaken using a carotid artery stent	Monitor	Monitor	NVD
o p e r	6	30 day re-admission rate for patients who have	Target: 5%	Target: 5%	NVD

		undergone CEA surgery			
	7	30 day persistent evidence of cranial nerve injury	<5%	<5%	NVD-should pt be seen by neurologist?
	8	Proportion of patients who return to theatre within 30 days following surgery	<5%	<5%	NVD
	9	Total length of hospital stay	Monitor	Monitor	NVD

**Limb revascularisation quality markers (all targets monitor unless specified)**

Area	No.	Standard description	Target		Comments
			Claudication	Critical limb ischemia	
Pre-operative	1	Proportion of arterial bypass operations compared to angioplasty procedures	Monitor	Monitor	Angioplasties not on NVD. ?ask to inc or local collection
	2	Pre-operative length of stay to be kept below 1 day for elective patients	Target: 100%	100%	NVD
Operative & in-hospital	3	Primary amputation rate (i.e. amputations without prior attempt at revascularisation)	Monitor	Monitor	NVD
	4	Secondary amputation rate below the knee (i.e. amputations following previous revascularisation)	Monitor	Monitor	NVD
	5	Secondary amputation rate above the knee (i.e. amputations following previous revascularisation)	Monitor	Monitor	NVD
	6	Amputation for Critical Limb Ischaemia 30 day mortality – casemix adjusted	Monitor VS risk adjusted funnel plots	Monitor VS risk adjusted funnel plots	NVD



	7	30 day mortality following infrainguinal bypass	Monitor VS risk adjusted funnel plots	Monitor VS risk adjusted funnel plots	NVD (Nat Av = 4.2% 4 <sup>th</sup> National VD Report)
	8	In hospital graft occlusion rate Diabetic Non diabetic	Monitor	Monitor	NVD
Post-operative	9	30 day re-admission rate for patients who have undergone surgery	Monitor	Monitor	NVD
	10	Total length of hospital stay	Monitor	Monitor	NVD

**Process for failure to meet standards.**

Should the unit fail to reach the above standards; an internal review would take place in the first instance, with an external review undertaken by a nominee from the Vascular Society in the second.

**Process Indicators**

Domain of practice:	Data Source	Rationale	Target/norms/tolerance level
<b>Carotid endarterectomy:</b>			
1. Time from first event (stroke or TIA) to carotid endarterectomy (percentage of appropriate symptomatic cases operated on within 2 weeks) Change to London stroke standard	NVD	Maximum benefit of operation derived from early intervention 1,2	100% (tolerance 90% to allow for patient choice)
2. Pre-operative length of stay	HES/NVD	Shorter stay indicates good use of resources	< 24 hours – target 100% (tolerance level 95% to account for emergency)

<b>Domain of practice:</b>	<b>Data Source</b>	<b>Rationale</b>	<b>Target/norms/tolerance level</b>
			surgery)
3. Post-operative length of stay	HES/ NVD	Shorter stay indicates good use of resources	< 3 days (median from UK Carotid interventions audit 5)
4. Carotid endarterectomy rate per 100,000 population	HES	Appropriate rate indicates good referral mechanisms and access to recommended treatment	100% patient having suffered a TIA (with 50% stenosis) should have been considered for surgery
5. Number of carotid endarterectomies performed per unit per year	HES	Higher volumes associated with improved outcomes	Carotid endarterectomies should be performed where there is evidence of neurological back up.
<b>Aortic surgery:</b>			
6. Length of pre-operative stay (elective repair)	HES	Shorter stay indicates good use of resources	< 24 Hours – At least night before
7. Length of stay (elective and emergency)	HES	Shorter stay indicates good use of resources	Elective - <9 days –median from HES Emergency -< 10 days- median from HES
<b>Amputation for critical limb ischaemia:</b>			
8. Below knee to above knee revision rate	NVD/H ES	Low rate indicates good decision making	Revision of amputation to higher level < 13.5% when compared to below knee amputation rate (HES)
9. Post-operative length of stay – casemix adjusted	HES/N VD	Shorter stay indicates good use of resources and appropriate discharge to rehabilitation facilities	Median 25 days (HES)
10. Amputation rate per 100,000 population – casemix adjusted	HES	Appropriate figures demonstrate good limb salvage rates and adequacy of care for patients with diabetes or CLI	Rates for Type 2 Diabetes = 7 to 36 per 10000 diabetic population

Domain of practice:	Data Source	Rationale	Target/norms/tolerance level
<b>Lower limb ischaemia: infrainguinal bypass</b>			
11. Rate of operative revascularisation per 100,000 population (casemix adjusted)	HES	Appropriate figures demonstrate a proactive approach to revascularisation	Range 22-83 per 100,000 depending on casemix 11
12. Rate of endovascular revascularisation per 100,000 population (casemix adjusted)	HES	Appropriate figures demonstrate a proactive approach to revascularisation	Range 10-91 per 100,000 depending on casemix 11
13. Pre-operative length of stay (infrainguinal bypass/ angioplasty)- -Case mix adjusted	HES	Shorter stay indicates good use of resources, timely imaging and decision making	Target: Elective - <1 day Emergency -< 3 days
14. Post-operative length of stay (infrainguinal bypass/ angioplasty) -Casemix adjusted	HES	Shorter stay indicates less complications, good use of resources and appropriate rehabilitation	Norms: Elective – median 8 days Emergency – median 14 days (HES)
15. Ratio of prosthetic to vein grafts used in preference – as clinically appropriate	HES/ NVD	Vein graft associated with better outcomes	
<b>Global measures:</b>			
16. Completeness of data submission to NVD (percentage) & BSR registries	NVD / HES	Indicates engagement with clinical governance and quality improvement	Target 100% completion

## 7. Relevant Guidance

Year	Title	Published by
July 2010	UK Audit of Vascular Surgical Services & Carotid Endarterectomy	The Vascular Society of Great Britain and Ireland

November 2009	Interventional Radiology: Improving Quality and Outcomes for Patients.	Department of Health. Gateway Ref: 12788
September 2009	At a Glance Guide to the current Medical Standards of Fitness to Drive	Drivers Medical Group, DVLA, Swansea
August 2009 (Version 2.1)	Essential Elements in Developing an Abdominal Aortic Aneurysm (AAA) Screening and Surveillance Programme	UK National Screening Committee/ NHS Screening Programmes Abdominal Aortic Aneurism
August 3rd 2009, (Version 1.1)	NHS Abdominal Aortic Aneurysm Screening Programme - Quality Standards and Service Objectives	UK National Screening Committee/ NHS Screening Programmes Abdominal Aortic Aneurism
July 2009 (Version 2.0)	NHS Abdominal Aortic Aneurysm Screening Programme – Guidance for Public Health and Commissioners	UK National Screening Committee/ NHS Screening Programmes Abdominal Aortic Aneurism
May 2009 (Final Version)	Framework for improving the results of elective AAA repair	Council of the Vascular Society of Great Britain and Ireland
November 2008	The Provision of Services for Patients with Vascular Disease 2009 – “Patients with a vascular emergency should have rapid access to a specialist vascular team in all parts of the UK”	The Vascular Society of Great Britain and Ireland
2007	The Provision of Emergency Vascular Services 2007	The Vascular Society of Great Britain and Ireland
August 2006	The Organisation and Delivery of the Vascular Access Service for Maintenance Haemodialysis Patients – Report of a Joint Working Party	The Renal Association The Vascular Society British Society of Interventional Radiology

## Appendix 2: NCL Vascular Service Activity and Outcome Data 2010 (Annual Year)

1) AAA Repairs N= 222, Elective = 184, Emergency = 38

Area	No.	Standard description	Target		
			Elective	Unplanned	Emergency
Pre-operative	1	Proportion of patients who are operated on who came in from screening programme?	Monitor NCL: 1%	n/a	n/a
	2	Proportion of patients with a known un-ruptured AAA of at least 5.5cms that are declined surgery	Monitor NCL: 6.5%	n/a	n/a
	3	Pre-operative length of stay for elective patients to be kept below 1 day average.	NCL: 1.1	n/a	n/a
	4	On the day cancellation rate for elective AAA procedures	Monitor NCL: 0%	n/a	n/a
	5	Number of patients who suffer a ruptured AAA whilst on the elective AAA waiting list	Monitor NCL: 2	n/a	n/a
Operative & in-hospital	6	Proportion of AAA procedures performed using EVAR	Target: 60% NCL: 89.7%	n/a	Monitor NCL: 63.2%
	7	Crude in-hospital mortality rate	Target: 4% NCL: 2.7%	n/a	40% NCL:13.2%
Post-operative	8	Crude 30 day mortality rate	Target: 4% NCL: 1.7%	n/a	40% NCL: 9.1%
	9	Proportion of patients discharged to level 3 critical care/ITU bed immediately following surgery	Monitor NCL: 38%	Monitor	Monitor NCL: 73.7%
	10	30 day re-admission rate for patients who have undergone AAA surgery	Monitor NCL: 5.4%	Monitor	Monitor NCL: 13.2%
	11	Total length of hospital stay	Monitor NCL: 7.7 days	Monitor	Monitor NCL: 14.1 days

## 2) Carotid Endarterectomies

N = 99, Symptomatic = 82

Area	No.	Standard description	CAROTID ENDARTERECTOMY	
			Symptomatic	Asymptomatic
Pre-operative	1	Proportion of patients treated within two weeks	Target: 70% NCL: 91%	Monitor NCL: 0%
	2	Pre-operative length of stay to be kept below 1 day for elective patients	Target: 1 day NCL: 1.6 days	Target: 1 day NCL: 1 day
Operative & in-hospital	3	Crude in-hospital stroke rate	Target: 6% NCL: 2.4%	Target: 3% NCL: 0%
	4	Crude in-hospital mortality rate	Target: 6% NCL: 0%	Target: 3% NCL: 0%
	5	Proportion of procedures undertaken using a carotid artery stent	NCL: 3.7%	NCL: 0%
Post-operative	6	30 day re-admission rate for patients who have undergone CEA surgery	Target: <5% NCL: 3.7%	Target: 5% NCL: 0%
	7	30 day persistent evidence of cranial nerve injury	Target: <5% NCL: 4.9%	Target: <5% NCL: 0%
	8	Proportion of patients who return to theatre within 30 days following surgery	Target: <5% NCL: 4.9%	Target: <5% NCL: 5.9%
	9	Total length of hospital stay	2.5 days (median)	7 days (median)

3) **Limb Revascularisation.** N = 628, Bypass Procedures = 137, Angioplasties = 523

	No.	Standard description	LIMB REVASCULARISATION	
			Claudication	Critical limb ischemia
Pre-operative	1	Proportion of arterial bypass operations compared to angioplasty procedures	Monitor NCL: 19%	Monitor NCL: 21%
	2	Pre-operative length of stay to be kept below 1 day for elective patients	100%	100%
Operative & in-hospital	3	<i>Primary amputation rate (i.e. amputations without prior attempt at revascularisation)</i>	Monitor	Monitor
	4	<i>Secondary amputation rate below the knee (i.e. amputations following previous revascularisation)</i>	Monitor	Monitor
	5	<i>Secondary amputation rate above the knee (i.e. amputations following previous revascularisation)</i>	Monitor	Monitor
Post-operative	6	30 day re-admission rate for patients who have undergone surgery	Monitor NCL: 2.1%	Monitor NCL: 2.8%
	7	Total length of hospital stay	Monitor NCL: 3.42	Monitor NCL: 19





### **Appendix 3: Description of Vascular Procedures.**

**(1) Abdominal aortic aneurysm repair.** The aorta runs down the back of the abdomen, and is the most common location for an aneurysm to develop. Around half of the people with ruptured abdominal aortic aneurysm die before getting to hospital for treatment. Of the patients that make it to hospital, half do not survive the operation or the immediate post-operative period. An abdominal aneurysm can be surgically repaired in two ways – an open repair or an endovascular aneurysm repair. The open repair technique replaces the aortic aneurysm with an artificial artery (prosthesis). An endovascular aneurysm repair uses a minimally invasive technique to access the artery, which is less invasive than open repair. During the procedure, an incision is made in the groin and a stent graft (an artificial, metal reinforced, fabric tube) is fed to the site of the aneurysm and deployed. The stent graft takes the pressure off the site of the aneurysm preventing any subsequent rupture. This type of endovascular procedure may be performed in association with interventional radiology. The need for emergency stenting demands that specialist radiologists should be available 24 hours a day.

**(2) Carotid endarterectomy surgery.** Carotid arteries are the main vessels through which oxygenated blood is transported to the brain. Any narrowing of these arteries is particularly serious as it can lead to a stroke or death. Carotid endarterectomy is an operation that removes fatty deposits or plaques that narrow these arteries and thus improves the blood flow to the brain. During the procedure, the inner lining of the affected region of the artery is removed. The artery is then widened with a patch to prevent it narrowing again in the future. This procedure reduces a patient's risk of stroke or death.

**(3) Lower extremity arterial bypass** Peripheral arterial disease in the legs, sometimes known as peripheral vascular disease, is caused by fatty deposits (atheroma) in the walls of the arteries leading to insufficient blood flow to the muscles and other tissues. The most common symptom, intermittent claudication, is characterised by leg pain and weakness brought on by walking. Patients diagnosed with peripheral vascular disease, including those who do not have any symptoms, have an increased risk of mortality, myocardial infarction and stroke. If surgery is required, one of the options is a lower extremity arterial bypass. This procedure aims to reroute blood flow around the blocked artery by grafting a transplanted piece of blood vessel from another part of the body.

**(4) Limb angioplasty.** Limb angioplasty is another, less invasive, technique that can be used to treat peripheral vascular disease. A small inflatable balloon, sometimes with a stent (cylinder of stainless steel mesh) mounted on it, is inflated in a narrowed artery, compressing the fatty tissue and allowing the blood to flow more easily. As the balloon is inflated, the stent expands so that it holds open the narrowed blood vessel. The balloon is then deflated and removed, leaving the stent in place.

**Acknowledgements and Authorship**

The North Central London Cardiac & Stroke Network would like to thank those who have contributed to and who continue to work on the Vascular Project.

We would like to thank the following people for their help and expertise and Dr Nick Losseff for his clinical leadership of the overall project.

**Communication Meeting Thursday 7<sup>th</sup> April, 2011**

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<b>Camden and Islington NHS Foundation Trust</b>	<b>BOROUGHS:</b> CAMDEN, ISLINGTON <b>WARDS:</b> ALL
<b>REPORT TITLE:</b> Quality Accounts 2010/11: Camden and Islington NHS Foundation Trust	
<b>REPORT OF:</b> Claire Johnston (Director of Nursing and Performance, Camden and Islington NHS Foundation Trust)	
<b>FOR SUBMISSION TO:</b> North Central London Joint Health Overview & Scrutiny Committee	<b>DATE:</b> 27 May 2011
<p><b>SUMMARY OF REPORT:</b></p> <p>Provided in Appendix 1 is the draft Quality Accounts for 2010/11 for Camden and Islington NHS Foundation Trust. This is a mandatory document for NHS trusts in England produced annually to allow trusts to provide a public account of work towards improving the quality of service provision. There are several mandated sections within the document template but trusts are also able to provide additional narrative information on key quality improvement initiatives.</p> <p>Key stakeholders are invited to contribute to the production of the report and also to comment on final account document. The final report will be submitted to Monitor on 7 June 2011.</p> <p><b>CONTACT OFFICER:</b> Ian Diley Head of Performance and Regulation 020 3317 3098 <a href="mailto:ian.diley@candi.nhs.uk">ian.diley@candi.nhs.uk</a></p>	
<b>RECOMMENDATIONS:</b> The Committee is invited to comment on the Quality Accounts. Formal comment can be included in the Quality Accounts document if desired.	
<p style="text-align: center;"></p> <p><b>SIGNED:</b> Ian Diley (Head of Performance and Regulation)</p> <p><b>DATE:</b> 19<sup>th</sup> May, 2011</p>	

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**QUALITY ACCOUNTS 2010/11**

## Quality Accounts 2010/11

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## **1.0 Statement on quality from the Chief Executive, Wendy Wallace**

Camden and Islington NHS Foundation Trust is proud of its achievements in improving a wide range of aspects of the quality and safety of care we deliver to our service users and their families. As part of our drive for Excellence, the first of the Trust's strategic goals is to continuously improve the quality and safety of service delivery, improve service user and carer experience and improve outcomes. The work to deliver this derives from many programmes within the Trust. A principal pillar of the Trust's strategy to improve quality is the Clinical Strategy which sets out the principles of service delivery and the structures governing care. It also sets out for the Trust and its stakeholders annual objectives which drive our delivery of excellent mental health and substance misuse services.

During the past year we have reorganised the services so that management is on the basis of clinical care pathways. Each pathway will have quantitative outcome measures which we will be able to compare over time and which will measure the recovery made by service users. During the past year we have also introduced local patient experience tracking systems, enabling us to get feedback on specific areas rapidly and improve the service as a result. Throughout the services there are numerous quality initiatives, which improve services at the frontline on a day to day basis.

In late 2010/11 the Trust received its first inspection by the Care Quality Commission (CQC) as part of its new assessment processes. The CQC inspected services based in or linked to Queen Mary House; all being services for older adults. I am delighted that not only did the CQC find that the Trust was fully compliant with all standards, but they made no recommendations at all for improvement and quoted many complements about the service from service users and carers.

We had set an ambitious list of quality targets with our commissioners for 2010/11, through the CQUIN process. These targets covered important areas, such as improving our vigilance and oversight of physical health issues (with which mental health service users disproportionately suffer). The Trust is reporting full achievement against these targets in this year's Quality Accounts. Further regional and local quality indicators and targets have been set for 2011/12 and we are committed to achieving good results against these targets in the coming months.

The Board of Directors established a new Quality subcommittee of the Board during 2010/11. This committee, chaired by the Deputy Chair of the Trust gives enhanced oversight and assurance on quality issues for the Board.

The Board is satisfied that the data contained in these quality accounts are accurate and representative.

## 2.1 Priorities for improvement

### 2.1.1 Priority area 1 – Quality of response to service user requests for information and assistance

#### Rationale

This is a quality area priority suggested by the Trust's governors. A "mystery shopper" programme will help examine levels of customer care at initial contact with service users and the public and establish a baseline for performance that can then be developed. Other Trust's have successfully conducted similar programmes with the aim of improving service user and carer experience of services.

#### Key improvement initiatives

This initiative will complement the established and expanding Patient Experience Tracking (PET) programme and it is hoped that service user representatives will be able to help undertake the surveys in a similar manner to past successful user focussed monitoring programmes.

#### Key performance indicator

The survey will examine the accuracy of information provided in response to set queries and the performance of the responder in relation to set expectations of politeness and timeliness. The details of the questions, standards and targets are still to be developed.

### 2.1.2 Priority area 2 – CQUIN 1: Physical health

#### Rationale

This is a key priority nationally and for our local stakeholders. Research data has consistently shown that mental health service users suffer significantly worse physical health outcomes than the national average. This includes a higher risk of high mortality physical health diagnoses such as diabetes, cardio-vascular disease and respiratory diseases. This priority area will look to better identify physical health diagnoses in our service users and improve physical health care in Trust hospital and community settings.

#### Key improvement initiatives

The key initiatives in this area relate to improved information sharing between primary and secondary care. In 2010/11, the physical health CQUIN indicators related to building better systems for ensuring that service user information stores in both care settings are populated with key data fields for mental and physical health diagnoses and ensuring that service users are helped to access primary physical health care for high mortality diagnoses. In 2011/12, this will be further developed with the addition of work to ensure key information about medication in the primary care setting is relayed to secondary care settings.

### Key performance indicators

There are four key indicators for this priority:

- Service users to have a complete set of mental and physical health high mortality ICD10 codes recorded for their episode of care;
- Support of inpatients and service users on CPA to access relevant physical health checks and/or screening;
- To improve the medicines reconciliation of service users admitted to mental health inpatient units;
- Provision of discharge letters to GPs on discharge from secondary mental health care

### **2.1.3 Priority area 3 – CQUIN 2: Patient Reported Experience Measures (PREMs)**

#### Rationale

This is a key priority nationally and for our local stakeholders. Key ratings from the annual CQC survey indicate that trusts in London score relatively poorly for service user satisfaction compared to the national average. Camden and Islington NHS Foundation Trust performed strongly in relation to other London trusts at the 2010 survey but results still indicated an unsatisfactory level of satisfaction for some of our service users. In 2010/11, the Trust undertook a Patient Experience Tracking (PET) programme that allowed us to monitor service user feedback much more dynamically than the previous reliance on the CQC annual survey could allow. Commissioners have identified this area as a key priority for improved Trust performance, including particular questions from the annual CQC survey as indicators in the 2010/11 CQUIN list.

#### Key improvement initiatives

The Trust will continue to use the handheld electronic PET devices to collect service user satisfaction data throughout 2011/12. The devices will be used in community settings in addition to the inpatient use of 2010/11. The surveys will be run at the beginning and end of the year with an action plan being developed in response to any areas of weakness in the first survey.

#### Key performance indicators

Responses to four key questions will be monitored for this CQUIN:

Inpatient:

- The proportion of service users answering “good” or “excellent” when asked about the care they received;

- Proportion of service users answering “yes” to the question, “Were you involved as you wanted to be in decisions made about your care?”;
- Proportion of service users answering “yes” to the question, “Were you treated with respect and dignity?”;
- Proportion of service users answering “yes” to the question, “During your most recent stay, did you feel safe?”;

#### Community:

- The proportion of service users answering “good” or “excellent” when asked about the care they received;
- Proportion of service users answering “yes” to the question, “Do you think your views were taken into account when deciding what was in your care plan?”;
- Proportion of service users answering “yes” to the question, “Have you been given (or offered) a written or printed copy of your care plan?”;
- Proportion of service users answering “yes” when asked if they had the number of someone from their local NHS Mental Health Service that they could phone out of hours;

### **2.1.4 Priority area 4 – CQUIN 3: Development of personalisation in care plans**

#### Rationale

This is a key priority nationally and for our local stakeholders. The Trust ascribes to the promotion of sustainable recovery and increased self esteem in its Recovery Model approach to care delivery but fidelity to this model so far has not been widely measured. Recovery based services need to measure how they are promoting service user involvement in setting meaningful goals in care plans that promote recovery and improved quality of life outcomes.

#### Key improvement initiatives

This CQUIN aims to develop the recovery model culture in care planning by ensuring ownership of a care plan by the service user rather than the clinical team. This cultural change will be driven through service user ownership of the practical goal setting work in care planning and of the language used in its formalisation.

#### Key performance indicators

The Trust will need to demonstrate that at least 30% of care community based care plans are written in the first person singular and have at least two service user defined recovery goals.

### **2.1.5 Priority area 5 – CQUIN 4: Patient Reported Experience Measures (PREMs) in dementia services**

#### Rationale

This is a key priority nationally and for our local stakeholders. In line with established work in relation to certain physical health areas, nine statements have been proposed by the Department of Health which capture what people with dementia say they aspire to in terms of their expectations of the health and social care system. It is proposed that the Trust prioritise work towards ensuring these particular aspirations and expectations are met.

#### Key improvement initiatives

As with priority area 3, the Trust will monitor its performance against this area through service user surveys. Compliance with one of the nine key statements will be monitored in the Trust's dementia services at two points in the year with an action against any weak areas being developed and implemented in between the two surveys.

#### Key performance indicator

The key questions to be asked for this CQUIN indicator are:

- “Have you been treated with dignity and respect?”;
- “Do you know what you can do to help yourself and who else can help you?”

## 2.2 Quality of services provided

### 2.2.1 Statements of assurance from the Board

The Board is able to provide the following statements of assurance:

#### 2.2.1.1 Review of services

During 2010/11, Camden and Islington NHS Foundation Trust provided and/or sub-contracted the following 4 NHS services:

- Adult Mental Health
- Mental Health Care of Older People
- Substance Misuse
- Learning Disability

Camden and Islington NHS Foundation Trust has reviewed all the data available to it on the quality of care in all 4 of these NHS services

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2009/10.

The Trust has been able to review data for each of these services in the areas of patient safety and clinical effectiveness. It has also been able to review data relating to patient experience for Adult Mental Health, Mental Health Care of Older People and Substance Misuse through the use of the Trust's Patient Experience Tracking programme.

#### 2.2.1.2 Participation in clinical audits and national confidential enquiries

During 2010/11, one national clinical audit and one national confidential enquiry covered the NHS services that Camden and Islington NHS Foundation Trust provides.

During that period, Camden and Islington NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Camden and Islington NHS Foundation was eligible to participate in during 2010/11 are as follows:

- National audit for psychological therapies for anxiety and depression (NAPT)

- Confidential enquiry into suicide and homicide by people with mental illness (CISH)

The national clinical audits and national confidential enquiries that Camden and Islington NHS Foundation Trust participated in during 2009/10 are as follows:

- National audit for psychological therapies for anxiety and depression (NAPT)
- Confidential enquiry into suicide and homicide by people with mental illness (CISH)

The national clinical audits and national confidential enquiries that Camden and Islington NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

	Cases submitted	% of cases required
National audit for psychological therapies for anxiety and depression (NAPT)	545	93%
National confidential enquiry into suicide and homicide by people with mental illness (CISH)	18	100%

No reports of national clinical audits were reviewed by the provider in 2010/11. The report of the National audit for psychological therapies for anxiety and depression will be reviewed when published.

Results from the national clinical audit programme administered by the Healthcare Quality Improvement Partnership (HQIP) are available at the HQIP website:

<http://www.hqip.org.uk/national-clinical-audit/>

The reports of 260 local clinical audits were reviewed by the provider in 2009/10 and Camden and Islington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (examples):



- A best practice flow chart is to be developed to assist clinical staff in reviewing service users who are on antipsychotic medication or service users where an antipsychotic medication is being considered. This flow chart will prompt the care coordinator to consider other ways of managing challenging behaviours such as behavioural interventions and additional carer support,
- Develop a safeguarding clinical dashboard to ensure the successful implementation of all safeguarding best practice,
- Work with well-being champions across services to help service users access smoking cessation services and advice,
- Ensure relevant yet comprehensive physical health diagnostic information is recorded for mental health service users,
- Implement evidence based process improvements to nursing handovers on inpatient wards.

The Trust has worked diligently in 2010/11 to further develop its programme of clinical audit and augment clinician participation in this audit work. All professions and disciplines contribute to clinical audit across all services through the balanced scorecard programme and the healthy programme of local audit in both boroughs. Structures are in place locally in both boroughs to encourage audit projects, monitor their progress and analyse and share their results. The findings and information accrued by these local groups is then shared with the Trust Quality Committee. The trust-wide remit for centrally co-ordinating audit lies with the Clinical Governance and Performance Team.

Since 2006, the Trust has organised biannual Audit Forums where clinicians can present the findings of their audits to their peers. In 2010/11 a prize-fund element was introduced to the two audit forums whereby the author of the best audit presentation, as agreed by a judging panel, was awarded a grant of £300 towards their personal professional development.

#### 2.2.1.3 **Participation in clinical research**

The number of patients receiving NHS services provided or sub-contracted by Camden and Islington NHS Foundation Trust that were recruited in 2009/10 to participate in clinical research approved by a research ethics committee was 786 (992 less than in 2009/10).

The Trust participated in 88 research projects in 2010/11. This is an increase on the 77 active studies in which the Trust participated in 2009/10.

Participation in clinical research demonstrates Camden and Islington NHS Foundation Trust's commitment to improving the quality of care we offer and to making our

contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. Additionally, since 2009, 118 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

#### 2.2.1.4 The CQUIN framework

A proportion of Camden and Islington NHS Foundation Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Camden and Islington NHS Foundation Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The six quality areas included in the CQUIN framework for **2010/11** were:

1. Improving the physical health care of patients with mental health problems,
2. Establishing baseline information on prescribing of antipsychotics for people with dementia,
3. Improving the collection and reporting of currency data which will inform future service improvements,
4. Improving patient reported measures of care,
5. Dual diagnosis and substance misuse,
6. Facilitating smoking cessation.

CQUINs 1-3 are all regionally agreed across NHS London while CQUINs 4-6 were agreed on a local basis between provider and commissioner agencies. Further details of the 2010/11 agreed goals and new goals agreed for 2011/12 are available on request from the Trust Performance Manager, Ian Diley ([ian.diley@candi.nhs.uk](mailto:ian.diley@candi.nhs.uk)) or at [www.candi.nhs.uk](http://www.candi.nhs.uk)

The monetary total for the amount of income in 2010/11 conditional upon achieving quality improvement and innovation goals was £1,281,485 of which 100% was accrued.

For **2011/12**, CQUINs have been agreed with commissioners covering the following areas:

- Improving the physical health care of patients with mental health problems,
- Improving patient reported measures of care in inpatient and community services,
- Ensuring fidelity to the recovery model of care,
- Improving patient reported measures of care in dementia services,
- Improving rates of planned treatment exit from substance misuse services.

### 2.2.2 Statements from the Care Quality Commission (CQC)

- Camden and Islington NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditionally registered.
- The Care Quality Commission has not taken enforcement action against Camden and Islington NHS Foundation Trust during 2010/11.
- Camden and Islington NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
- The Care Quality Commission has externally assessed one of the Trust's registered locations in 2010/11; Queen Mary's House. The CQC provided an extremely positive assessment report and made no recommendations for improvement.

The Trust has worked throughout 2010/11 to implement a robust self assurance framework for compliance with CQC essential quality outcomes across all its locations and services. It was very pleasing to receive such a positive report for its first location assessment and the Trust can look forward with confidence to further positive assessments of its other locations in 2011/12. The overall findings of the report noted:

*"All the people who we talked to were positive about their treatment and care at this location both as users of the day hospital and the wards. We received many positive comments from relatives, one of whom described this service as "a gem". Patients and relatives were very satisfied with staff attitudes and care and patients reported that they felt safe and [were] treated with dignity and respect..."<sup>1</sup>*

The most pleasing aspect of the report was the inclusion of positive complementary quotes from the service users and carers.

*"They don't just treat us as a group, they take time to get to know us as individuals and find out about our individual needs"<sup>2</sup>.*

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<sup>1</sup> CQC Review of compliance: Queen Mary's House, March 2011

<sup>2</sup> Ibid.

### 2.2.3 Data quality

Camden and Islington NHS Foundation Trust will be taking the following actions to improve data quality:

Action	Rationale	Deadline
A set of data quality indicators has been agreed for quarterly monitoring with the lead commissioner	These key data quality indicators are linked to CQUIN targets and key national indicators	Quarterly monitoring
The Trust Data Quality Strategy will be revised	This will take account of key quality priorities and improved monitoring facilities for 2011/12	July 2011
Further development of data quality dashboards	These will be developed to include the new indicator targets and monitoring of use of dashboards will continue.	June 2011
The Trust will address as an information governance priority issues regarding clinical coding audit and pseudonymisation	These are the areas assessed as weaknesses within the Trust's Information Governance Toolkit return in 2010/11	September 2011

Camden and Islington NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data<sup>3</sup>.

The percentage of records in the published data which included the patient's valid NHS number was:

- 100% for admitted patient care;

The percentage of records which included the patient's valid General Medical Practice code was:

- 100% for admitted patient care;

In 2010/11, the Trust established the Data Quality Group which meets on a monthly basis to monitor data quality issues and develop systems for ensuring optimal performance. This group reports to the overall Trust Performance Group and the Quality Committee.

To enable effective monitoring of performance against data quality standards and targets, 2010/11 saw the successful introduction of intranet-based data quality

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<sup>3</sup> Correct as at Month 10. Official year-end figures are available at the end of May.

dashboards providing current performance and trend information. These dashboards are one element in a suite of performance dashboards that will greatly assist service lines in ensuring that the high standards of care expected of Trust services are met.

Examples of particular areas of Trust services where data quality improvement programmes have been successfully implemented include the mental health services at HMP Pentonville where data collection processes have been improved to meet the new facilities provided by new national administration software in prisons (with enhanced monthly performance reporting now possible) and substance misuse services where enhanced data assurance processes have been introduced.

#### **2.2.4 Information Governance Toolkit attainment levels**

Camden and Islington NHS Foundation Trust's Information Governance Assessment Report score overall score for 2010/11 was 70% and was graded not satisfactory<sup>4</sup>. However, the Trust has achieved a score that compares favourably with many other trusts whose annual scores have also reduced with amendments to the assessment toolkit in 2010/11. These attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation. The Trust has put an action plan in place to ensure a achievement at a higher level at the next self assessment. The specific actions are outlined in the table in 2.2.3.

#### **2.2.5 Clinical coding error rate**

Camden and Islington NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

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<sup>4</sup> This score relates to four specific areas of the toolkit for which the Trust scored a 0 when the expected standard score was 2.

## 3.1 Review of quality performance

The Quality Accounts process requires that trusts identify three key quality performance indicators for each of three quality domains; safety, effectiveness and patient experience. The Trust's performance on each of these indicators during the financial year (and in previous years where available) is set out below, along with a description of the construction of the indicator.

### 3.1.1 Safety

The Trust has selected the following three indicators to represent the safety domain:

- i. The proportion of Trust inpatient service users (Services for Ageing and Mental Health) who received assessment through the Malnutrition Universal Screening Tool (MUST) within 72 hours of admission;
- ii. The proportion of service users receiving physical health assessments in line with Trust policy for inpatient, community and residential and rehabilitation based services;
- iii. The proportion of Serious Untoward Incident recommendations completed to timescale.

#### **i. Compliance with standards of MUST policy**

The 'Malnutrition Universal Screening Tool' ('MUST') is a validated, evidence based tool designed to identify individuals who are malnourished or at risk of malnutrition (under-nutrition and obesity). The use of MUST is included in NICE guidelines to tackle the issue of malnutrition and its use is particularly important for services such as those providing services to older people. The Trust has an agreed Balanced Scorecard and Service Quality Improvement Plan measure for monitoring implementation of Trust policy in its application of the MUST in inpatient sites.

Numerator

All service users admitted to inpatient services at the time of the (quarterly) audit receiving a MUST assessment within 72 hours of admission<sup>5</sup>.

Denominator

All service users admitted to inpatient services at the time of the (quarterly) audit.

Reporting

This is audited and reported internally through the balanced scorecard process with results provided to commissioners as part of the Service Quality Improvement Plan.

**Performance figures:**

	Q1	Q2	Q3	Q4
2008/09	89%	89%	77%	95%
2009/10	80%	76%	96%	94%
2010/11	73%	78%	92%	78%

2009/10 Target = 80%

Note: Previous year's audits had looked solely at whether a MUST tool had been completed during the admission. This was changed to include the issue of timeliness in 2009/10. When the 72 hour aspect is disregarded, quarterly scores in 2010/11 range from 85% to 90%.

**ii. Compliance with physical health assessment policy**

The association between severe mental illness and physical health problems is well established with the life expectancy of people with severe mental illness being nine years less than that of the general population (Disability Rights Commission 2006). Therefore people with a mental illness are at a greater risk of premature mortality than the general population. The physical health care needs of people with a mental illness are as important as the individual's mental health care and must be part of a holistic package of care. The Trust has agreed policies and protocols for ensuring our service users receive effective physical

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<sup>5</sup> This figure includes all service users receiving a MUST assessment within 72 hours and those for whom a transfer to/from general acute care necessitated a clinically acceptable deferment of assessment.

health assessment and the implementation of these policies is measured through the balanced scorecard process. Measures for monitoring liaison between primary and secondary care in relation to physical health care are also included in the CQUIN indicator set.

Numerator A

Number of current service users in Residential & Rehabilitation services at the time of the (quarterly) audit with evidence of physical assessment being offered in the preceding 12 months.

Numerator B

Number of service users currently admitted to inpatient services at the time of the (quarterly) audit receiving a physical assessment (or refusal noted) within 24 hours of admission.

Numerator C

Number of service users from audit sample having received a physical health assessment in line with current Trust Policy.



Denominator A

Number of service users in Residential & Rehabilitation services at the time of the (quarterly) audit.

Denominator B

Number of service users admitted to inpatient services at the time of the (quarterly) audit.

Denominator C

Sample of service users allocated to community mental health teams within the quarter<sup>6</sup>.

Reporting

This is reported internally through the quarterly balanced scorecard process.

Action plan

Further work needs to be undertaken to ensure full compliance in community based teams with the physical health assessment policy. There have been significant improvements in areas relating to CQUIN physical health targets since the agreement of these targets on a London-wide basis in Q3. Physical health care for mental health service users remains on the CQUIN list for 2011/12 so this will be maintained as a significant priority area.

See table below for performance figures.

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<sup>6</sup> This sample equates to up to 12 service users per Community Mental Health Team (CMHT) for all CMHTs.

**Performance figures:**

		Q1	Q2	Q3	Q4
2008/9	Inpatient services	88%	93%	80%	82%
	Residential & Rehabilitation services	78%	73%	74%	93%
2009/10	Inpatient services	67%	73%	72%	84%
	Residential & Rehabilitation services	86%	91%	94%	95%
2010/11	Inpatient services	93%	90%	96%	87%
	Residential & Rehabilitation services	N/A <sup>7</sup>	N/A	77%	83%
	Community Mental Health Teams <sup>8</sup>	50%	73%	64%	66%

Targets for 2010/11: 85%

**iii. Completion of Serious Untoward Incident investigations**

In response to the occurrence of any Serious Untoward Incident (SUI), the Trust completes an internal investigation to ascertain the learning that can be accrued to inform any steps that can be taken to reduce the risk of similar incidents re-occurring. The Trust follows the NHS policy for this process. It is important that these investigations are conducted to the agreed timescales. The inclusion of this measure was requested by our Trust governors.

Numerator

The number of SUI investigations completed to agreed timescale for incidents occurring in the year.

Denominator

The number of SUI investigations for incidents occurring in the year

<sup>7</sup> A different measure was audited in Q1 and Q2: *If the service user has identified physical health needs, do they have a current support plan addressing these needs?*

<sup>8</sup> Note, this was only monitored in CMHT balanced scorecards from 2010/11

**Performance:**

In September 2010, the Trust implemented the new National Patient Safety Agency (NPSA) policy for investigation and response to Serious Untoward Incidents (SUIs). The Trust has conducted five SUI investigations of the most serious type (level 2) during the this period and all were completed to the timescales agreed with its commissioners.

**3.1.2 Effectiveness**

The Trust has selected the following three indicators to represent the effectiveness domain:

- iv. The proportion of service users receiving a weekly review of their inpatient care plan;
- v. The proportion of service users receiving early discharge from inpatient care to Crisis Resolution Team home treatment;
- vi. Recovery rate in Improving Access to Psychological Therapies (IAPT).

**i. Frequency of review of care plans in inpatient services**

It is important for services to react swiftly to changes in our service users' mental and physical state and to their personal circumstances and we must be quick to review and amend care plans to reflect these changes. The Trust Care Programme Approach (CPA) Policy outlines the standards expected of our care teams in this area. A measure to monitor this is included in the balanced scorecard process for inpatient services.

**Numerator**

All service users currently admitted to inpatient services at the time of audit with evidence that their care plan has been reviewed in the seven days preceding the audit.

**Denominator**

All service users currently admitted to inpatient services at the time of audit.

Action plan

Trust-wide performance has been consistently slightly under target in 2010/11 and the prioritisation of this area (as part of the balanced scorecard programme) will continue in 2011/12.

**Performance figures:**

	Q1	Q2	Q3	Q4
2008/09	76%	87%	77%	82%
2009/10	67%	61%	76%	76%
2010/11	80%	75%	80%	85%

Target for 2010/11: 85%

**ii. Early discharge to Crisis Resolution Team home treatment**

A crisis resolution team (sometimes called a crisis resolution home treatment team or CRT) provides intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. The Trust has a target that 25% of CRT caseloads are service users who have received early discharge from inpatient services. This indicator measures fidelity to the model of providing care in community based services wherever this is possible.

Numerator

Number of service users allocated to CRT caseloads directly from inpatient care in the quarter.

Denominator

Number of service users allocated to CRT caseloads in the quarter.

**Performance figures:**

	Q1	Q2	Q3	Q4
2008/09	18%	22%	13%	29%

2009/10	31%	29%	40%	45%
2010/11	46%	46%	48%	47%

Target 2010/11: 25%

### iii. The number of people who have recovered in IAPT services

The Improving Access to Psychological Therapies (IAPT) programme is based upon the commitments the Government made in their General Election manifesto 2005. The programme was launched in May 2007. It aims to investigate ways to improve the availability of psychological therapies, especially relating to people with depression or anxiety disorders. It also aims to promote a more person-centred approach to therapy. This measure aims to assess the rate of successful treatment outcomes for the services.

#### Numerator

Number of service users completing treatment with IAPT services in the quarter who had recovered (who no longer met the criteria for depression or anxiety) at final treatment session.

#### Denominator

Number of service users completing treatment with IAPT services in the quarter who at assessment had scores indicative of clinical caseness.

#### **Performance figures:**

2010/11	Numbers	Percentage
Camden	631 / 1706	37%
Islington	675 / 1740	39%

### 3.1.3 Patient experience

The Trust has selected the following three indicators to represent the patient experience domain:

- i. the number of carers receiving advice or services following a carer's assessment;
- ii. the proportion of service users in inpatient services (and particularly Psychiatric Intensive Care Units or PICU) being offered at least 4 activities per week;
- iii. Patient Environment Action Team (PEAT) assessment scores.

**i. Advice and services to carers**

The needs of carers to Trust service users are of paramount importance. Ensuring the well-being of carers is a significant factor in also ensuring the well-being of the people for whom they care.

Numerator

The number of carers receiving a 'carer's break' or other specific carers service, or advice or information, during the year following a carer's assessment or review.

Denominator

The number of adults receiving a community- based service during the year.

(Performance is provided in the table below)

**Performance figures:**

	Target	Performance
Camden 2008/9 (Adults)	90 carers	93 carers
Camden 2008/9 (Older People)	16%*	17.4%*
Islington 2008/9 (Adults)	161 carers	109 carers
Islington 2008/9 (Older people)	15%*	16.8%*
Camden 2009/10	394 carers	458 carers
Islington 2009/10	23%**	19%**
Camden 2010/11	320	462 carers
Islington 2010/11	32%	23%

Targets: Please note that targets for this measure are set for each borough by separate commissioners and have been set as absolute numbers or as percentages for different services at different times.

While Islington's target was not met for 2010/11, this was the only Local Authority set target not met and performance showed a considerable improvement over 2009/10.

\* % of clients receiving a community based service

\*\* The target was raised mid-year (Nov) from 15% to 23%

## **ii. Provision of activities in inpatient teams (with particular reference to PICU)**

The provision and encouragement of occupational therapy and leisure activities are a vital component of recovery within mental health inpatient services. This provision has been monitored by the Trust through its balanced scorecard process for several years and quarterly audits check to see whether individual service users have been offered or taken up at least four activities per week. The Trust Governors particularly requested that the Quality Accounts review provision of activities in the Trust's PICU ward, Coral.

Numerator

The number of service users currently admitted to inpatient services at the time of audit with evidence that they had been offered or taken up at least four occupational therapy or other leisure activities in the seven days preceding the audit.

Denominator

The number of service users currently admitted to inpatient services at the time of audit.

**Performance figures:**

	Q1	Q2	Q3	Q4
Trust 2008/09	35%	72%	59%	52%
PICU 2008/09	N/A	90%	100%	91%
Trust 2009/10	80%	60%	67%	86%
PICU 2009/10	56%	90%	82%	100%
Trust 2010/11	88%	79%	85%	79%
PICU 2010/11	100%	100%	100%	100%

Target for 2010/11: 75%

**iii. Patient Environment Action Team (PEAT) assessment scores**

PEAT is an annual assessment of NHS inpatient services in England<sup>9</sup>. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of service user care including environment, food, privacy and dignity. The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England. There are 9 Trust sites included in the assessment. Inclusion of scores against this measure were requested by the Trust Governors.

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<sup>9</sup> And of residential and rehabilitation services with more than 10 beds



**Performance figures:**

Percentage of Trust sites rated as "Good" or "Excellent"	Environment	Food	Privacy and dignity
2008	100%	86%	100%
2009	78%	100%	100%
2010	100%	100%	100%

The assessment uses a 5 point scale: unacceptable, poor, acceptable, good and excellent. In the past five assessments, the Trust has not had any sites rated as unacceptable or poor. Trust performance is appreciably above the national average.

**3.1.4 Review of monitoring processes**

- Balanced scorecard process

The Trust completed its ninth year of balanced scorecard service improvement work. The balanced scorecards for services are developed on an annual basis with performance indicators being amended to follow Trust and service need and targets being stretched. Balanced scorecards are produced for the vast majority of clinical teams with aggregated scorecards for service types and boroughs providing an overall summary of Trust performance. The measures chosen for inclusion reflect both national and local priority and are categorised into four domains; service user outcomes, service user processes, resources and lifelong learning. Many of the quality indicators included in these Quality Accounts are monitored quarterly through the balanced scorecard process. Similarly, many of the agreed CQUIN targets for the year have their data collated and monitored through this process. The completed scorecards for each quarter are discussed at trust-wide and local forums and action plans are produced at a team-level to address any concerns raised in each report.

The balanced scorecard process is a key part of the Trust's commitment to encouraging and monitoring multi-disciplinary participation in audit and reflective practice.

- Quarterly performance reports  
The Trust Board receives a quarterly performance monitoring report covering all national indicators and assessment processes, agreed quality indicator sets for commissioning bodies and locally derived quality measures. This information is shared publicly with performance reports being published on the Trust website and information from the performance report is shared at Trust Governor Board meetings.
- Electronic performance dashboards  
In 2010/11, the Trust has produced a set of on-line quality and performance management dashboards available to staff to allow them to monitor performance in a more dynamic way than ever before. Information is updated daily to allow more responsive management of service line activity, performance against national targets and data quality. As these dashboards develop, the facility will increase for reviewing performance against further locally derived indicators such as those included in the balanced scorecards.
- Quality reports to commissioners  
In addition to the activity reports provided to commissioners, 2010/11 saw the introduction of quarterly quality meetings and quality reports to the Trust's lead commissioners. Performance against CQUIN targets and other quality indicators is monitored along with reviews of learning from incidents and complaints. The different commissioning bodies have significant input into deciding priorities for quality improvement and in setting quality indicator targets.

### 3.1.5 Key quality initiatives in 2010/11

The Trust has further developed its Acute Care Forum structure in each borough in 2010/11 with a well received and extremely well attended launch event being held in February 2011. These multi-disciplinary forums will define the therapeutic philosophy for acute care and guide and promote excellence in acute care services and monitor and report on the many strands of quality improvement work scheduled to begin or continue in 2011/12. The forums aim to integrate acute care into a whole-systems approach and anticipate and implement national quality guidance.

The Trust has worked hard in 2010/11 to implement the best practice guidelines provided through the national *Triangle of Care* initiative. Audits of performance against *Triangle of Care* standards have been carried out within inpatient services with many positive findings. Any areas of weakness that have been identified are being addressed at ward level and through the Acute Care Forums.

2010/11 has seen further development work on implementing *Productive Wards*; part of the NHS Institute for Innovation and Improvement's *Releasing Time to Care* programme. National guidance has been provided to help clinical staff make changes to the physical clinical environment and working processes to improve the quality of service user care. The programme is designed to create calmer wards, increase safety and morale and give back to nursing staff more time to spend on patient care. Implementation of the programme has continued throughout the year on Trust inpatient sites with the evaluation process ongoing with measures developed to assess the effectiveness of steps implemented. The programme is to be extended to community services in 2011/12.

The Trust is currently working towards AIMS accreditation with the Royal College of Psychiatry for a number of its acute and rehabilitation inpatient wards and expects to complete this process in 2011/12. In addition, a project team within the Trust has been tasked with developing national AIMS accreditation standards for Crisis Resolution Teams with the ultimate aim being to develop standards across the whole acute care pathway.

### 3.1.6 Patient Reported Experience Measures (PREMs)

In 2010, the CQC annual service user survey covered people who use community mental health services. A highlight summary of results is provided below<sup>10</sup>:

#### Positives (top 20% of Trusts nationally)

- Were the purposes of medication explained to you?
- Were you told about the possible side effects of medications?
- Do you know who your care co-ordinator (or lead professional) is?
- Can you contact your care co-ordinator (or lead professional) if there is a problem?
- Does your care plan cover what you should do if you have a crisis?
- In the last 12 months have you had a care review meeting to discuss your care plan?

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<sup>10</sup> Please note, a full summary of the Trust's results can be found at the CQC website; [http://www.cqc.org.uk/publications.cfm?fde\\_id=16103](http://www.cqc.org.uk/publications.cfm?fde_id=16103)

- Before the review meeting, were you given a chance to talk to your care co-ordinator about what would happen?
- Did anyone in mental health services ask you about any physical health needs you might have?
- Did mental health services give you enough support getting help for any physical health needs?
- Did mental health services give you enough support with your care responsibilities?
- Have you received enough help from anyone in mental health services with finding or keeping work?
- Overall, how would you rate the care you have received from mental health services in the last 12 months?

Negatives (bottom 20% of trusts nationally)

- Did [your allocated health and social care worker] take your views into account?
- In the last 12 months, did the provision of talking therapies meet your requirements?
- Were you given the chance to express your views at the [care review] meeting?

In 2010/11, the Trust further developed its facility to monitor PREMs. In addition to the annual CQC survey of community based service users, the Trust implemented its Patient Experience Tracking (PET) system across inpatient and substance misuse services. The PET system is delivered through hand-held touch-screen devices that ask a brief set of questions for both service users and or carers with free-text areas allowing comment on anything the respondent wishes to share. Service users now have more opportunity than ever before to tell the Trust how it can improve their experience of care and treatment. In 2011/12, implementation of the PET system is also being rolled out to community based mental health services.

In addition, specific teams have continued to carry out service user satisfaction surveys independent of the PET system in areas such as crisis services and memory services.

The Trust has also implemented the new national model for advice and complaints services in 2010/11, ensuring that all service users and carers have access to a professional and responsive service. Complaints analysis reports are shared with commissioners and stakeholders and these will be further developed in 2011/12 with improved trend analysis.

#### Response to complaints - timeliness

Complaints category – required response times <sup>11</sup>	Q1	Q2	Q3	Q4
48 hours	N/A	N/A	N/A	N/A
10 days	100%	100%	100%	100%
25 days	92%	76%	83%	52%
Total	94%	86%	87%	69%

### 3.1.7 Performance against key national indicators

#### Care Quality Commission (CQC)

As of 2010/11, the CQC's primary tools for monitoring healthcare providers are the biennial individual location assessments and the monthly updates to the Quality Risk Profiles. As noted above (2.2.2), the CQC assessed one of the Trust's locations (Queen Mary's House) in 2010/11 and provided an extremely positive review. It found there were no recommendations for improvement required at all.

The Trust's monthly Quality Risk Profile updates have similarly been extremely positive since their introduction in September 2010. This document is updated using over 600 individual quality indicators and as is categorised into five key

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<sup>11</sup> Please note the timescale standards have been set locally (in line with Department of Health guidance) as there are no national timescale reporting requirements.

areas with a performance rating assigned to each: green being performing better than expected, amber being performing as expected and red being performing worse than expected. As of March 2011, the Trust is performing better than expected in two areas and as expected in three.

### Monitor

Mental health Foundation Trusts are assessed on a quarterly basis by Monitor through seven distinct performance indicators<sup>12</sup>. Trust performance against these is provided below:

	Target	Q1	Q2	Q3	Q4
CPA – having formal review in the last 12 months	95%	95.5%	96.1%	96.0%	>95%
CPA – follow up within 7 days of inpatient discharge	95%	96.6%	97.1%	95.7%	95.2%
Admissions to inpatient care having access to Crisis Resolution Home Treatment Teams	90%	91.0%	90.5%	92.5%	92.6%
Minimising delayed transfers of care	<7.5%	1.0%	1.4%	4.3%	3.3%
Meeting commitment to serve new psychosis cases by Early Intervention Teams	95%	100%	100%	100%	100%
Mental Health Minimum Data Set: data completeness - identifiers	99%	98.7%	99.3%	99.2%	99.2%*
Mental Health Minimum Data Set: data completeness – outcomes	50%	N/A	N/A	61.7%	64.3%*
Certification against compliance with requirements regarding access to healthcare for people with learning disability	N/A	Met	Met	Met	Met

\* MHMDS figures as at February submission. Next submission due May 2011.

<sup>12</sup> For Q1 and Q2 there were only six. A seventh (MHMDS outcomes) was introduced from Q3.

## **3.2 Stakeholder involvement in Quality Accounts**

### **3.2.1 Trust staff**

Trust staff were invited to contribute suggestions for areas of inclusion within the priorities for 2011/12 and the review of 2010/11. Input was received from all clinical disciplines in the Trust and from supporting staff in ICT, clinical governance and Human Resources.

### **3.2.2 Local Involvement Networks (LINKs)**

An invitation to contribute to the planning process of the Quality Accounts was taken up by Camden LINKs who provided several suggestions for areas of priority and review. Several of these are included in these Quality Accounts.

### **3.2.3 Trust Governors**

The Trust Governors have similarly provided input to the Quality Accounts development and again, their suggestions have been included in these Quality Accounts. The Governor body is made up of representatives from staff, service users and the public.

### **3.3 Stakeholder statements**

#### **3.3.1 Statement from Camden LINKs**

Draft to be sent for comment

#### **3.3.2 Statement from Islington LINKs**

Draft to be sent for comment

#### **3.3.3 Statement from lead commissioner**

Draft to be sent for comment

#### **3.3.4 Statement from Overview and Scrutiny Committee**

Draft to be sent for comment