A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality report 2017-18

Contents

About the Trust's quality report

About the Trust

Royal Brompton & Harefield NHS Foundation Trust is the largest specialist heart and lung centre in the UK and amongst the largest in Europe. We work from two sites, Royal Brompton Hospital in Chelsea and Harefield Hospital near Uxbridge. As a specialist trust our doctors, nurses and other healthcare staff are experts in their chosen fields and we are known throughout the world for our expertise, standard of care and research success.

We offer some of the most sophisticated treatment that is available anywhere in the world and treat patients from all over the UK and around the globe. Over the years our experts have been responsible for several major medical breakthroughs – such as performing the first combined heart and lung transplant procedure in Britain, implanting the first coronary stent (to unblock an artery) and founding the largest centre for cystic fibrosis in the UK.

Some useful facts about the Trust:

- In 2017-18 we cared for over 200,000 patients at our outpatient clinics and over 37,500 patients of all ages on our wards[1].
- We are Europe's top-ranked respiratory research centre and our cardiac, cardiovascular and critical care teams are rated in the top three most highly cited health research teams in England.
- Our Heart Attack Centre at Harefield has pioneered the use of primary angioplasty for the treatment of heart attacks and has one of the fastest arrival-to-treatment times in the UK (23 minutes compared to a national average of 56), a crucial factor in patients' survival.
- Europe's largest unit for the treatment of cystic fibrosis is based at Royal Brompton Hospital.
- During 2017/18, the Trust was successful in winning a tender to provide Extracorporeal Membrane Oxygenation (ECMO) Services in conjunction with Guy's and St Thomas' NHS Foundation Trust.
- Our on-site foetal cardiology service enables clinicians to begin caring for babies while still in the womb; some are scanned at just 12 weeks, when the heart measures just over a centimetre.
- The Ventricular Assist Device (artificial heart) programme at Harefield Hospital is one of the world's most established programmes with a long history of clinical and scientific excellence.
- We are the country's largest centre for the treatment of adult congenital heart disease, staffed by a specialist team including four full-time specialist consultants.
- Harefield has one of the most advanced cardiac catheterisation laboratories of its kind in Europe. The state-of-the-art equipment includes a remote-controlled robot that uses high-tech 3D mapping enabling precise catheter manipulation and the reduction of exposure to X-rays for patients and staff.

[1] In 2016-17 we cared approximately 200,000 patients at our outpatient clinics and approximately 39,000 patients of all ages on our wards.

- In 2017-18 we helped 11,670 adults who have breathing problems caused by diseases such as COPD (chronic obstructive pulmonary disease) and severe asthma.

- We provide specialised care for patients with suspected or diagnosed cancer affecting the chest (thoracic oncology). A specialist 'lung laser' device with a wavelength laser beam is used to help surgeons remove tumours from patients' lungs with minimal damage to neighbouring healthy lung tissue.

- We are one of only three centres diagnosing and caring for patients with Primary Ciliary Dyskinesia, a rare inherited multisystem lung disease.

What is a quality report?

A quality report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. All NHS providers strive to achieve high quality care for all, and the quality report provides the Trust an opportunity to demonstrate our commitment to quality improvement and show what progress we have made in 2017-18. The quality report is a mandated document which is laid before parliament before being made available to the public on NHS Choices website.

What is included in a quality report?

The quality report is a mandated document that contains specific mandatory statements and sections. These statements cover areas such as our participation in national audits, research activity, and our registration as a healthcare provider with the Care Quality Commission (CQC).

Since an inspection by the CQC in June 2016, the Trust has been addressing quality improvement objectives as part of its CQC action plan. These objectives have been adopted as quality priorities for both 2017/18 and 2018/19. Hence, section 2 of this report is structured to provide an update on progress during 2017/18 for each objective and the plan for continued work in 2018/19.

There is a glossary at the back of the report which lists all abbreviations included in the document with a brief description of the term. You will also find text boxes throughout the report with additional explanations.

This is a "what is?" box.
It explains or describes a term or abbreviation found in the report

Statement of directors' responsibilities

The directors of the Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare a Quality Report for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

a) the content meets the requirements set out in the NHS foundation trust annual reporting manual 2017-18 and supporting guidance;
b) the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to March 2018
    - papers relating to quality reported to the board over the period April 2017 to March 2018
    - feedback from commissioners
    - feedback from governors
    - feedback from local Healthwatch organisations,
    - feedback from Overview and Scrutiny Committees
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2017 national staff survey
    - the 2016 national inpatient survey
    - the head of internal audit's annual opinion over the Trust's control environment, dated 22/05/2018
    - CQC Inspection Report, dated 10/01/2017

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

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

By order of the Board:

Baroness (Sally) Morgan
Chair 24th May 2018

Robert J Bell
Chief Executive 24th May 2018

Part 1: Chief Executive Statement

The period from 1 April 2017 to 31 March 2018 has been the eighth full year in which the organisation has operated as a Foundation Trust. During the year, the Trust has achieved the governance targets and indicators set out in the Single Oversight Framework issued by NHS Improvement, apart from the indicator relating to the 62 day cancer wait target and the 18 week referral to treatment time target for incomplete pathways. Data from the Lorenzo PAS system showed that the 18 week referral to treatment time target for incomplete pathways was met for eleven out of twelve months. However, there have been concerns about the quality of the data used to report against this target.

The Trust was inspected by the CQC in June 2016 and the inspection report was published on 10 January 2017. Overall, the Trust was rated by the CQC as 'Requires Improvement'. Within this rating Harefield Hospital was rated as 'Good' and Royal Brompton Hospital as 'Requires Improvement'. An action plan was developed and is currently being implemented prior to re-inspection by the CQC. The majority of the Trust's services were rated as 'Good', with a number being identified as 'Outstanding'.

During the course of 2017/18, the Trust has worked closely with its commissioners at both local and national level. There is a Clinical Quality Review Group in place, where information about the quality of our services is discussed in an open and transparent manner with commissioners on a regular basis.

The Trust remains committed to the provision of high quality services for patients of all ages and will take whatever action is necessary to ensure on-going delivery of this commitment.

The organisation's impressive record on quality and safety is supported by a culture of transparency where weaknesses are dealt with promptly and openly, so that better and safer systems of care can be developed. An ongoing quality improvement programme operates across the Trust.

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.

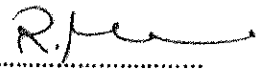
- Data is collected by a large number of teams across the Trust, alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust, its Board and management team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognise that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate with the exception of the matters identified in respect of the 18 week referral to treatment incomplete pathway indicator as described on page 41 of this report.

Signed:



Robert J Bell
Chief Executive
Royal Brompton & Harefield NHS Foundation Trust **24th May 2018**

Part 2: Review of quality priorities for improvement 2017-18 & Plan for 2018-19

For 2017-18, the following five quality priority projects have been developed. Building on previous quality priorities, areas for improvement highlighted by the CQC inspection process, and areas which we feel will have the greatest impact on patients; they have been chosen to embrace the breadth and depth of our services and to ensure as many staff as possible will be actively contributing to their success.

Managing the Acutely Ill Patient

An improved, holistic approach to the management of all aspects of the acutely ill patient has been introduced. Overseeing this project is the newly formed Response Escalation And Co-ordination Taskforce (REACT) which includes senior clinical staff from all disciplines and is widely supported. The taskforce's objective is to focus on implementing real-time, local improvement initiatives based on the latest research, and sharing best practice across the organisation. The focus in 2018-19 and continuing into 2019-20 is in three keys areas: the National Early Warning System (NEWS); sepsis recognition and management; and acute kidney injury recognition and management.

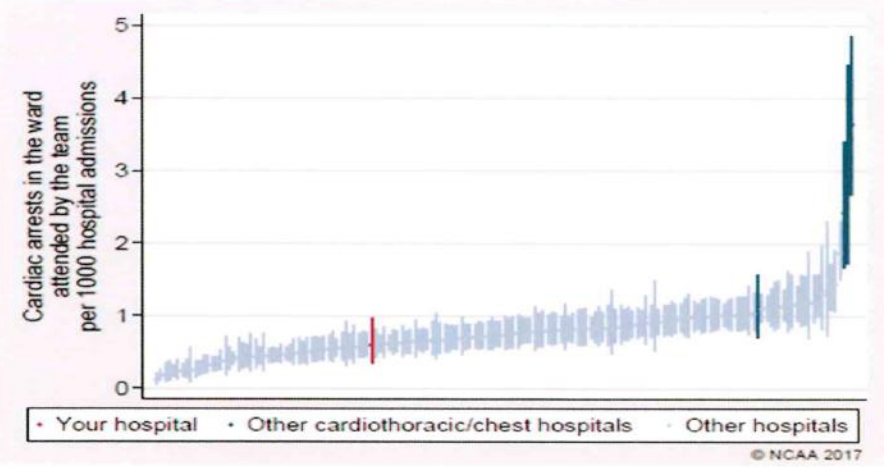
1. **National Early Warning System implementation (NEWS).**

   This system covers any inpatient care (adults and children) outside the intensive care environment. It is a national tool to record key patient observations, along with an algorithm to identify quickly and simply when patients may be deteriorating, enabling clinical teams to escalate the level of care appropriately. We routinely monitor the number of cardiac arrests which happen outside the critical care environment.

   The chart below is produced by the National Cardiac Arrest Audit, and shows we have one of the lowest rates in the country for cardiac arrest on our wards (i.e. outside critical care).

Rate of cardiac arrests - ward

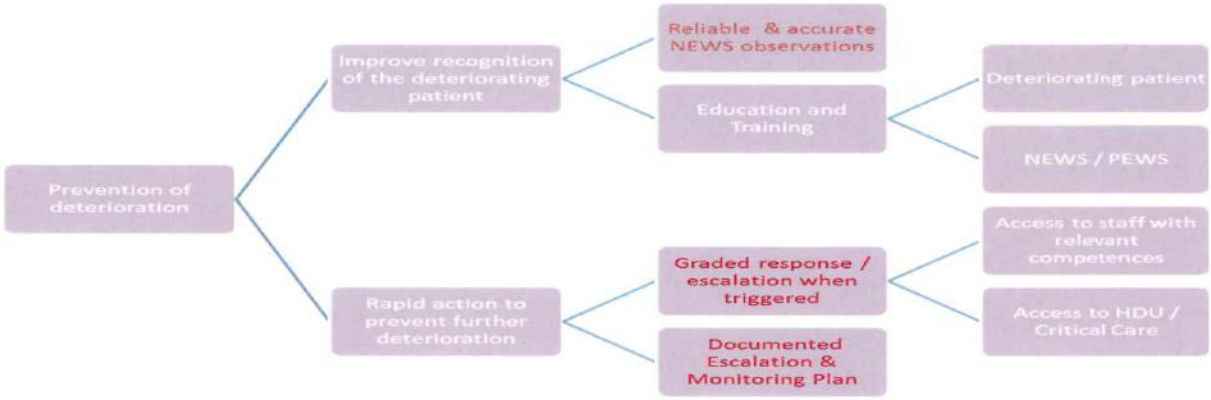
The following graph presents the reported number of in-hospital cardiac arrests attended by the team where the location of arrest was ward per 1,000 hospital admissions for adult, acute and cardiothoracic/chest hospitals in NCAA.



Current position at start of 2017-18: A new tool, bespoke to the Trust, was rolled out across all clinical areas, with appropriate training and education for staff.

The aim for 2017-18 was routine auditing on every ward/clinical unit, with prompt feedback of any errors found. Audit to include checking that documentation was being completed correctly, escalation was occurring appropriately, and that where care was escalated patients were reviewed promptly by a more senior colleague. The aim was for 90% compliance on all wards/clinical units by year-end.

The aims for this 3 year project are summarised in the driver diagram below. The focus in the first year, 2017-18, has been on monitoring the elements in 'red'.



Progress in 2017-18:

a) The appropriate use of NEWS charts to guide escalation of care has been a real focus on all wards across the Trust in 2017-18. There has been significant input and support from senior clinical staff to ensure the importance of both completing the observations correctly and ensuring documentation is complete and accurate for every patient every time.

b) Despite this support, engagement and enthusiasm, the results from the early part of 2017-18 remained disappointing and were mostly below the 90% target. This prompted wards to engage in a quality improvement approach to identify locally what were the specific issues and find ways to address them.

c) On Harefield's Oak ward it was identified that staff working predominantly on night shifts were missing out on the daytime training sessions. Additional sessions were arranged in the evening to ensure these staff received the appropriate training.

d) At Royal Brompton, the ward sisters undertook real-time reviews of patient notes during every shift, and were then able to provide immediate feedback to staff who had not completed the NEWS tool correctly.

e) Junior doctor training already had a focus on NEWS but as a result of feedback from nursing staff, this aspect of the training has been updated.

f) These local improvements have resulted in real change with all wards achieving the target score of 90% in the monthly audits at some points in the year. However, sustaining this consistently has proved challenging. A key contributing factor has been the use of temporary or agency staff, where training on the Trust's specific NEWS tool may not always be feasible within the time period of their employment.

g) The latest results are shown below. Whilst the aim of 90% has not been achieved, the results have improved significantly; as has awareness amongst staff of the importance of completing the

documentation appropriately. The challenge that remains is to ensure temporary and agency staff adhere to the same high standards as permanent staff. NEWS 2 will be introduced in 2018-19, a newly developed national tool designed to be identical in every Trust. This should overcome this particular problem.

Indicator	Q1	Q2	Q3	Q4
All NEWS observations completed and correctly scored	77%	79%	83%	87%
NEWS observation completed correctly	67%	70%	84%	89%
Individual escalation plan completed (if appropriate)	80%	82%	70%	85%

Plan for 2018-19:

i. Implement NEWS 2 across the organisation with an ambition to move to electronic recording of NEWS. This will significantly reduce the opportunity for errors of completion to be made and will allow for more rapid auditing and feedback of results to frontline staff

ii. Aim for > 95% compliance with NEWS/ PEWS for all relevant patients with >95% accuracy in scoring , documented escalation and management plans

iii. Continue to implement quality improvement ideas in local teams to ensure the Trust builds on the work undertaken in 2017-18 and has a consistently high level of focus on the recognition and management of deteriorating patients.

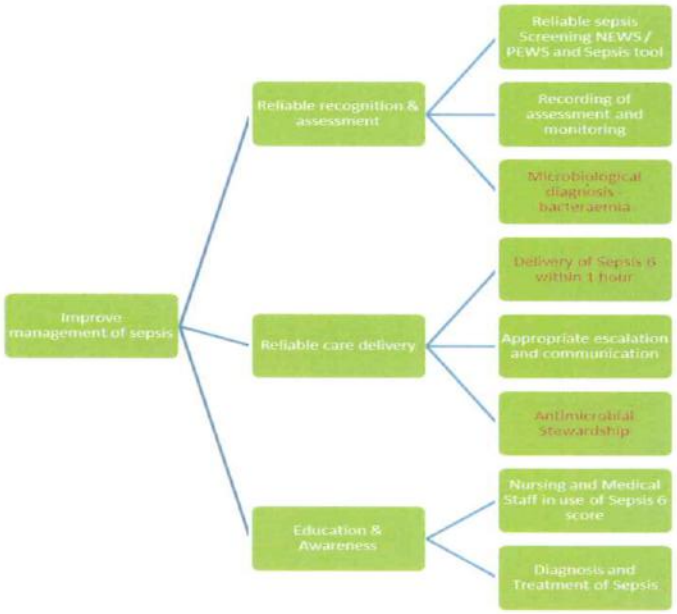
2. Implement Sepsis Six. This covers all inpatient care for both adults and children.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Due to the specialist work undertaken at the Trust, we have very few patients who are at risk of, or develop, multi-organ sepsis.

Position at the start of 2017-18: tools to identify possible sepsis have been incorporated into NEWS2, rolled out across all clinical areas with appropriate training and education to staff.

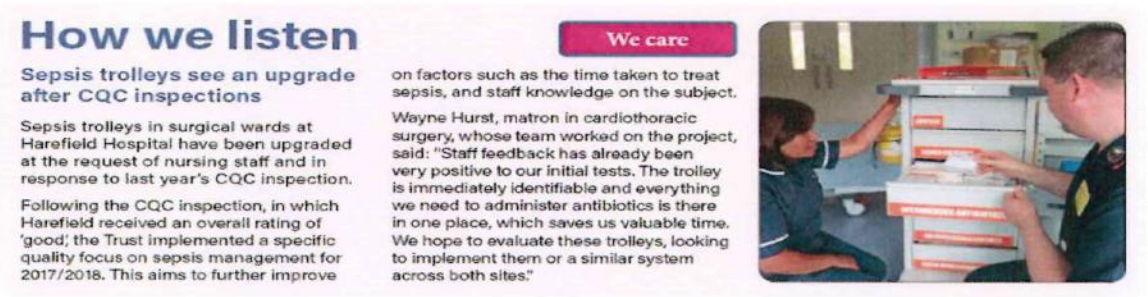
Aim for 2017-18: routine auditing on every ward/clinical unit, with prompt feedback of any errors found. Audit to include checking that documentation is being completed correctly, escalation is occurring appropriately, and that where care has been escalated patients are reviewed promptly by a more senior colleague. Aim for 90% in all areas of audit on all wards/clinical units by year-end.

The aims for this 3 year project are summarised in the driver diagram below. The focus in the first year, 2017-18, has been on monitoring the elements in 'red'.



Progress made in 2017-18:

a) Following the CQC inspection in 2016, and after listening to feedback from nursing staff, Harefield teams upgraded sepsis trolleys so that everything required for sepsis care is in one place and is easily identifiable. A similar approach, but using boxes, is being rolled out across the rest of the Trust in 2018.



How we listen

We care

Sepsis trolleys see an upgrade after CQC inspections

Sepsis trolleys in surgical wards at Harefield Hospital have been upgraded at the request of nursing staff and in response to last year's CQC inspection.

Following the CQC inspection, in which Harefield received an overall rating of 'good', the Trust implemented a specific quality focus on sepsis management for 2017/2018. This aims to further improve on factors such as the time taken to treat sepsis, and staff knowledge on the subject.

Wayne Hurst, matron in cardiothoracic surgery, whose team worked on the project, said: "Staff feedback has already been very positive to our initial tests. The trolley is immediately identifiable and everything we need to administer antibiotics is there in one place, which saves us valuable time. We hope to evaluate these trolleys, looking to implement them or a similar system across both sites."

b) Sepsis cards have been developed by the critical care outreach team; these can be made available on the ward or staff can keep in a pocket. They remind staff of the key signs and symptoms of sepsis and how to react appropriately.

c) Regular ward rounds with pharmacists and microbiologists are held to specifically discuss appropriate antimicrobial usage for each patient.

d) After disappointing results in quarter 2; the first of a regular newsletter was published reminding staff of the importance of recognition and management of sepsis, the correct protocol is and how it is assessed. This acted as a reminder to staff and has resulted in improved results for the rest of the year. In addition, changes to how antibiotics are prescribed have made a significant difference in ensuring they are administered within an hour.

Indicator	Q1 results	Q2 results	Q3 results	Q4 results
% of potentially septic patients who have been screened for sepsis according to local protocol	94%	80%	88%	95%
% of patients with sepsis treated within 1 hour	58%	27%	62%	66%
% of antibiotic prescriptions reviewed at 24-72 hours in patients with sepsis	94%	92%	96%	97%

e) The key elements of Sepsis Six were incorporated into the latest version of the NEWS chart; which was rolled out across the Trust at the end of 2017-18. Monitoring of the NEWS chart, including Sepsis Six elements, is reported above in the 'NEWS implementation' section.

Plan for 2018-19:

a) Aim for > 95% compliance with the Sepsis Six System for the identification and management of sepsis in adult and paediatric patients.

b) Continue to implement local innovations to ensure the Trust builds on the work undertaken in 2017-18 and has a consistently high level of focus on the recognition and management of sepsis in all areas. The focus will specifically be around:

i. The appointment of a Trust lead for sepsis
ii. Creation of a specific work stream for sepsis, as part of the REACT taskforce, with core members of staff tasked with delivering change. The sepsis work stream includes the antimicrobial pharmacists, consultant microbiologist, nurse educator and a ward based doctor.
iii. Education, training and increasing awareness of the use of the sepsis scores, our current baseline data and the treatment of sepsis, with nursing and medical staff. This will include the development of new teaching materials and specific training competencies for sepsis.
iv. Appointment of sepsis champions on each ward.
v. Redesign of the Sepsis Six document with an associated teaching package.

3. Acute Kidney Injury (AKI).

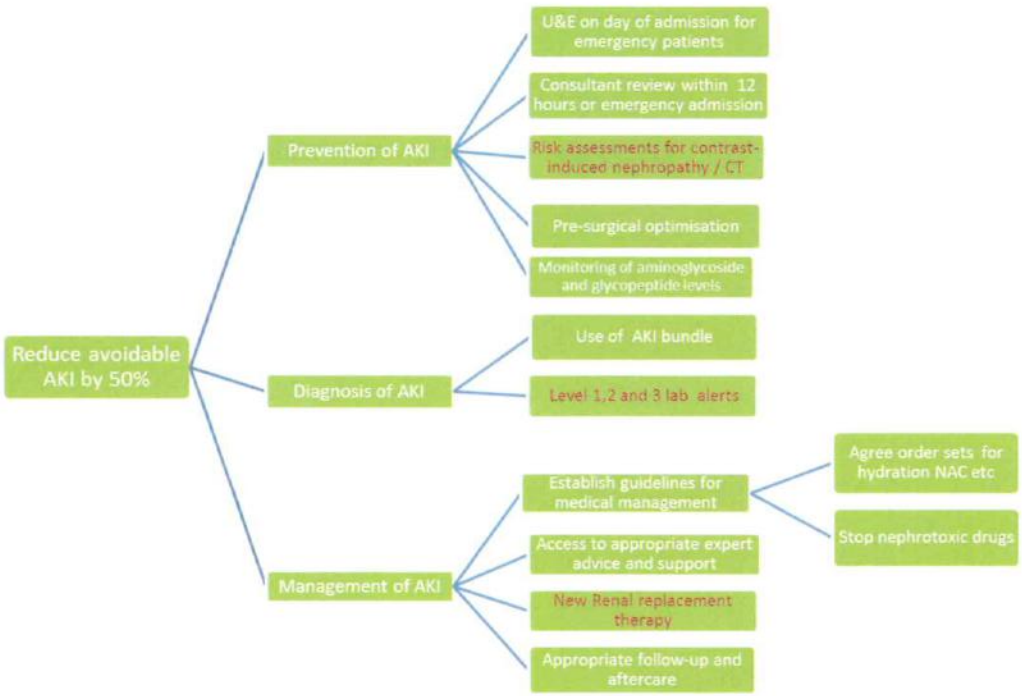
It is four years since the National Patient Safety team, now part of NHS Improvement, decided to prioritise a programme of work to improve the management of AKI. During this time the Think Kidneys AKI national programme has created the platform for significant improvement in the management of AKI at a local level, and has raised awareness with staff and the public on the importance of keeping kidneys healthy.

One of the other key ambitions of the programme is to establish national data collection to allow successful audit and quality improvement. The Trust has been proactive in submitting data to the UK Renal Registry throughout 2017-18.

Position at end of 2016-17: A new system has been implemented to ensure that abnormal results are easily identified and can be quickly highlighted to the clinical team.

Aim for 2017-18: Start producing a monthly report to look at the incidence of: Renal Replacement Therapy (RRT); readmission rates; % risk assessments completed; % risk assessment pre CT scan; % appropriately monitored and adjusted aminoglycosides and glycopeptides. Produce an audit of laboratory alerts leading to change in patient management.

The aims for this 3 year project are summarised in the driver diagram below. The focus in the first year, 2017-18, has been on monitoring the elements in 'red'.



Progress made in 2017-18:

a) Achieved 100% completeness in submission of key data to UK Renal Registry; with the exception of a metric relating to filtration rates (eGFR).

b) The AKI warning level has been routinely monitored for all patients throughout the year. Only a very small number of patients are triggering an AKI warning at all, and the majority of these are a level 1 warning and do not escalate to a level 2 or 3 - indicating that the risk of AKI is being recognised at an early stage and managed effectively.

Month	AKI warning level 1	AKI warning level 2	AKI warning level 3	Missing	Total
APR17	157	39	10	0	206
MAY17	211	81	64	0	356
JUN17	184	81	29	0	294
JUL17	171	48	20	0	239
AUG17	153	28	15	0	196
SEP17	132	27	20	0	179
OCT17	164	43	29	0	236
NOV17	248	70	33	0	351
DEC17	234	57	42	0	333
JAN18	259	61	26	0	346
FEB18	246	79	31	0	356
MAR18	212	49	31	0	292

Plan for 2018-19:

a) To reduce the incidence of avoidable new onset AKI by 50%.

b) To improve recording of estimated glomerular filtration rates (EGFR) and submission of this to the UK Renal Registry.

c) To better understand which patients are triggering an AKI warning and put in place local improvements to reduce this.

d) Continue to implement local innovations to ensure the Trust builds on the work undertaken in 2017-18 and has a consistently high level of focus on the recognition and management of acute kidney injury in all areas.

Developing Our Culture

1. **Implementation of 5 Steps to Safer Surgery and Other Procedures.**

Current position: The middle 3 steps to safer surgery are already embedded into everyday practice, with routine auditing and feedback. The CQC inspection found no concerns with this part of the process. However, the inspection found the approach to steps 1 and 5 (briefing and de-briefing) could be improved. These 2 steps very much focus on teamwork and the culture with the theatre environment – planning for the day ahead with the whole team, so everyone knows what to expect (briefing) and then reflecting both on what went well and why and any actions that need to be taken (de-briefing).

Aim for 2017-18: All theatres to roll out a programme of briefing and debriefing for all surgeries. Auditing to ensure this happens, but the focus to be on the quality of both steps - ensuring both briefings and debriefings are meaningful and supported by the whole, multidisciplinary team. To this end, part of the aim was to ensure 50% of staff across all grades and staff groups have attended human factors training. Dependent on the success of the programme in the theatre environment, work could also start to roll out a similar programme in other procedure-based areas of clinical practice.

Progress in 2017-18

a) Surgical theatres and the cardiology catheter laboratories on both sites have had a systematic programme of ensuring all 5 steps to safer surgery/procedure are being followed at all times; and have had a routine programme of auditing this and feeding back to local teams. The latest results are shown below:

	Royal Brompton	Harefield
The 5 steps are being recorded in both theatres and cath labs. Compliance is monitored and regular reports are presented at the monthly Q&S Group meetings for discussion The March 2018 audit showed the following completion rates for all five steps:	Cath Labs - 98% Theatres – 97%	Cath Labs - 98% Theatres – 96%

b) In addition to the regular, monthly human factors training session offered on each site; specific 'theatre staff only' sessions have been trialled in the latter part of 2017-18. These were extremely well attended and received and following this success, this approach will continue in 2018-19. In hindsight, the target for training 50% of theatre staff in human factors by the end of 2017-18 was perhaps overly ambitious; but the number of staff from all disciplines working in the theatre environment who have been through this pivotal training has increased notably. Whilst exact numbers are difficult to provide given staff turnover and shift patterns; it is estimated that approximately 30% on any given day have had human factors training.

Plan for 2018-19:

a) To sustain the commitment to the 5 steps for safer surgery programme through maintaining the current audit programme, overseen by the Divisional Quality & Safety Groups
a) Continue to provide human factor training to as many staff as possible but with a particular focus on the highly complex, high risk environments of theatres and catheter laboratories.

2. **Bullying and Harassment.**

Current position: The CQC report highlighted that some staff had reported concerns around the team environment in which they worked.

Aim for 2017-18: To appoint a Freedom to Speak Up Guardian and develop the roles of the bullying and harassment ambassadors; to work with the Imperial College Healthcare Partnership to share ideas across the Northwest London area; to increase the staff survey response rate to allow greater confidence that feedback was representative; to improve staff survey results in this area.

Progress in 2017-18

Staff Survey:

The 2017 national NHS Staff survey is key in enabling Trusts to see how they are performing in key areas such as staff wellbeing, training and development, and shows how staff feel about the organisation. One of the key achievements this year was improving the response rate from 39% in 2016, to 54% in 2017.

In 2016/17 64 per cent of staff who said they had experienced bullying or harassment did not report it. Over the past year, the HR team has been working with areas that reported bullying, to run listening groups and drop in sessions, giving people a place where they can freely air any worries.

In April 2017, a freedom to speak up guardian was appointed, with a remit to promote an open and honest reporting culture within the Trust. In addition, our policy and procedures on bullying have been rewritten to make it easier to raise an issue. A new employee assistance programme has been started to provide counselling to staff 24 hours a day, and a new "time to change" pledge underlines the Trust's commitment to mental health.

The new Optimising Strength and Resilience Programme supports patients, carers and staff to take steps to look after their mental wellbeing. Its first event – a mindfulness lecture with international expert Dr Maura Kenney – was attended by more than 100 staff, keen to learn techniques that can help with stress, depression and even pain management.

In Royal Brompton's heart division, a new traffic light system monitors how people feel about their day, enabling managers to address any issues straight away.

Plan for 2018-19:

In 2017-18, a large number of new initiatives were launched to provide better support and listen to staff. The early results after just a few months have been encouraging with ad-hoc feedback from staff suggesting that the cumulative effect of these initiatives is positive. However, to fully embed change and see behaviour and culture adapt as a result takes time. Therefore the plan for 2018-19 is to continue to support the initiatives started in 2017-18, ensuring there is good awareness of them and to provide access to support for all staff. This will be tracked predominantly through the NHS staff survey but also through a number of other local measures specific to individual teams. For further information please see page 21 of this report which sets out further details of the Staff Survey 2017.

Learning from Deaths

From April 2017, the NHS has been required to both standardise and formalise the arrangements for reviewing and learning from deaths in hospital; and to publish specified information on deaths which should be brought to a Board meeting every quarter from September 2017 onwards[2]. The Trust has had a strong programme of mortality review of all in-hospital deaths in place for many years. In 2017-18, the trust undertook a review of the processes in place, and published a Mortality Review policy to ensure all areas of the Trust were following best practice, and the new national guidance. For this year, individual clinical areas have continued to use their existing mortality review tools provided they comply with the national guidance; and the learning points and actions are documented on the Trust's mortality database. In addition, several areas have piloted using the new Structured Judgement review tool. In 2018-19, the plan is to improve the current mortality database to accommodate the structured judgement tool, and to allow for reports to be more easily produced, and particularly to allow quicker and easier correlation of learning and actions from mortality review, complaints, incidents and claims.

Learning from Deaths data is now routinely reviewed at the Divisional Directors and Governance & Quality Committee meetings, prior to review at the Risk & Safety Committee. This allows for sharing of learning points from mortality across the Trust, not just within the clinical team. The data included in this Quality Report was reviewed at the Risk and Safety Committee on 10th April 2018 prior to presentation to a public meeting of the Trust Board which was held on 25th April 2018.

The following table shows Trust data on Learning from Deaths for the period 1st April 2017 – 31st March 2018 and is published here in order to comply with the detailed requirements for quality reports 2017/18. This shows that there 394 in-hospital deaths in 2017-18, of which 386 were reviewed by the end of 201-18; and the remaining 8 which occurred at the end of the financial year, have been reviewed subsequently.

2017-18	Number of in-hospital deaths	Number undergoing mortality review	Number where death is more likely than not to have been due to problems in care provided to the patient
Apr-Jun	100	99	0
Jul-Sep	96	95	0
Oct-Dec	99	97	1
Jan-Mar	99	95	0
Total	**394***	**386**	**1****

*One patient with Learning Disabilities died was an in-patient. The death was reviewed in accordance with the Learning From Deaths methodology for these patients; and found that their learning disability had no bearing on the cause of death.

**There was a drug administration error for one patient, and this may have contributed to the patient's deterioration and death. This has been fully disclosed to the family as part of the Duty of Candour process, and has been fully investigated and reported as a Serious Incident to NHS England.

[2] National Guidance on Learning from Deaths, National Quality Board, March 2017.

Royal Brompton & Harefield NHS Foundation Trust: Learning from Deaths Dashboard - March 2017-18

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Please note: deaths are being graded according to Bristol Mortality Grading System, and then this grades are being retrospectively fitted to the new RCP methodology score

Bristol Scale Grade 1: < adequate care - different management would have made a difference to outcome = RCP Score 1 or 2 or 3: Definitely avoidable; Strong evidence of avoidability; Probabably avoidable (more than 50:50)

Bristol Scale Grade 2: < adequate care - but different management might have made a difference to outcome = RCP Score 4: Probably avoidablebut not very likely

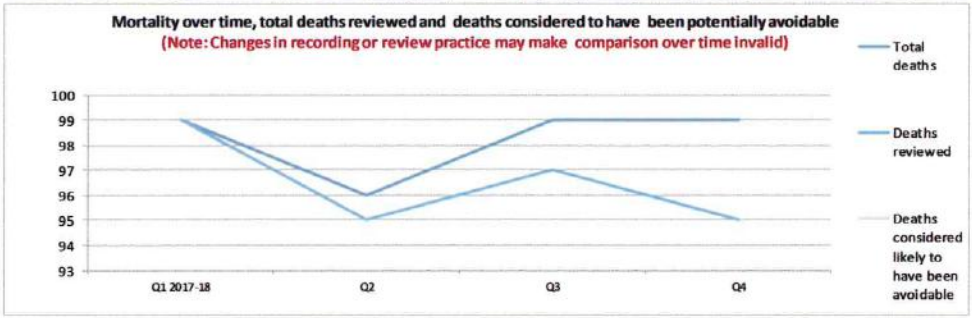
Bristol Scale Grade 3: < adequate care - but different management would have made no difference to outcome = RCP Score 5: Slight evidence of avoidability

Bristol Scale Grade 4: Adequate Care = RCP Score 6: Definitely not avoidable

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
29	38	30	37	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
99	99	95	97	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
393	387	386	387	1	0

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.3%	This Year (YTD)	0	0.0%

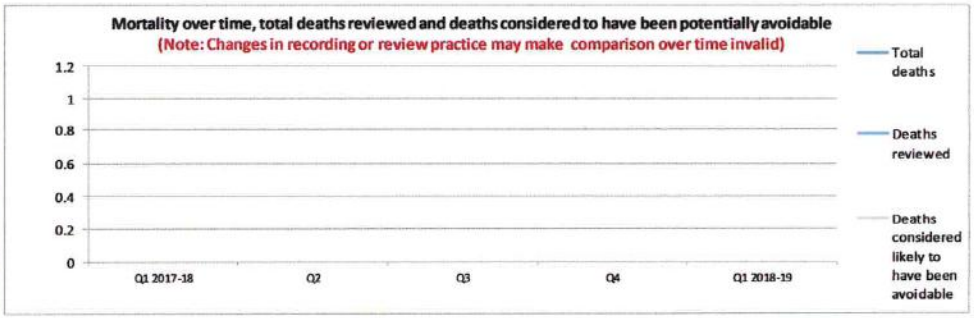
Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	1	3.3%	This Month	29	96.7%
This Quarter (QTD)	1	1.1%	This Quarter (QTD)	6	6.3%	This Quarter (QTD	88	92.6%
This Year (YTD)	5	1.3%	This Year (YTD)	24	6.2%	This Year (YTD)	355	92.2%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	0	1	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Seven day Hospital Services

The following statement explains how the Trust is implementing the priority clinical standards for seven day hospital services.

The Trust has continued its participation in national audits for the required standards with the following results (March 2017) as follows:

- **Clinical Standard 2** – Time to 1st Consultant Review - patients reviewed within 14 hours of admission to hospital: The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was 90% compared to 69% in September 2016. This places the Trust above the national mean and local mean of 72%. The most recent survey data for September 2017 has not be released.

- **Clinical Standard 5**- Access to Diagnostics: The Trust provided 4 of 6 consultant-directed diagnostics, on-site or by formal arrangement, seven days each week except CMR and Upper GI endoscopy. To improve access, the CMR unit has extended its services which started July 2017.

- **Clinical Standard 6** – Access to Interventions: The Trust provided 9 of 9 consultant-directed interventions on-site or by formal arrangement.

- **Clinical Standard 8** – Consultant Review: the overall proportion of patients who required and got twice daily consultant reviews was 100% with 92% for patients needing and receiving once daily consultant reviews. This is higher than the national and local level mean.
  Patient Involvement - patient are informed within 48 hours of admission to hospital: the overall proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission, was 94%. This is higher than the national and local mean.

Duty of Candour

The lead for Duty of Candour is Elizabeth J Haxby, Lead Clinician in Clinical Risk. The Adverse Incident policy makes specific reference to Duty of Candour (DoC). Training in Being Open and the Duty of Candour occurs on both sites and remains advisory but is open to any member of staff. All relevant policies contain reference to the Duty of Candour requirements.

For the period April 2017 – March 2018

- 44 incidents were reported within the Trust which appeared to meet the DoC. 7 DoC episodes were reported on the Harefield site and 37 on the Royal Brompton site.
- A documented apology to and discussion with the patient / family occurred at the time of the incident in 87% (38/44) of cases. In all cases this was a consultant, senior nurse or lead clinician in clinical risk.
- In 4% (2/44) the patient had been repatriated overseas or transferred to another hospital before this discussion could occur and in 2% (1/44) the patient arrived from another hospital with an undetected fracture. In 7% (3/44) the error was noted sometime after the event and the patient was then contacted.
- In 74% (28/38) of cases an initial Duty of Candour letter was sent (63% Q3 2016).
- In 58% (22/38) cases a final Duty of Candour Letter was sent including details of an investigation where relevant (74% Q3 2016).

Actions in 2017

- Dedicated incident reporting and investigation training, 24 sessions cross site, (in addition to monthly induction session for all staff which include incident reporting) includes the DoC and was attended by 41 staff in 2017 / 18.
- Being Open and Duty of Candour training sessions (15 across the Trust 2017/18) were attended by 59 staff.
- All materials and tools used during the Being Open & Duty of Candour training are hosted on the Quality and Safety pages of the intranet. Being Open and the Duty of Candour features in many other for a including Divisional Quality & Safety Meetings, Complaints Working Group, Root cause analysis and Mortality Structured Judgement Review training.
- Data collection for the DoC process is collated into a central spreadsheet by the Divisional Q&S leads.

Summary

Compliance with statutory obligations and national guidance on the DoC has improved in relation to initial DoC documentation and letters since the previous audit in 2016 but further work on understanding the reason for not sending a second letter is required. This may reflect the fact that all information is provided in the first letter but also since 11 / 38 DoC incidents are linked to surgical site infection (SSI) in some cases the RCA is yet to be completed and a letter has yet to be sent. Staff are aware of their obligations and senior clinicians engage promptly with patients and families to offer an apology and explanations where possible. Work is on-going to ensure appropriate documentation and that letters are sent when required and within the requisite timescales or there is improved documentation as to why DoC letters (1st and 2nd) are not required. The latter will be a focus of attention in 2018.

Staff Survey

In the 2017 staff survey 15% staff surveyed reported harassment or bullying by a manager, and 24% by another colleague, an increase of 1% since 2016. 40% of these staff stated that they reported the issue, compared to 36% in 2016. Ten bullying and harassment grievances were raised with HR in 2017, compared to five in 2016.

Data suggests some of the challenge lies in the capability of managers to have skilled and sometimes difficult conversations with their teams. Initial feedback from staff has confirmed this. In June 2018 a new Trust wide manager coaching programme will launch, enabling managers to have better, more productive coaching conversations and ensuring employees derive developmental benefit from the appraisal programme.

In a number of areas that report higher levels of harassment and bullying, Listening Groups have been facilitated by a qualified member of the HR team. These are a means for staff to raise their concerns in an informal, safe and comfortable way. They are often run for different bandings, staff groups, supervisors or management and allow staff to speak freely and openly about topics such as culture, management style or working environment. Comments surrounding the chosen topics are then collated and fed back to the line manager, general manager and HR director for discussion. Actions to address any concerns raised are then put in place and updates on the progress of these actions are then fed back to staff.

A 'Freedom to Speak Up Guardian' has now been appointed and staff are encouraged to speak to this impartial advisor with any issues they are experiencing

A new bullying and harassment policy was launched in December 2017, designed so that all cases are dealt with swiftly and consistently, keeping stress and disruption to a minimum. These cases are managed by an independent case management team, experts in the fair and swift resolution of such complaints. To date 56 managers from all parts of the Trust have been trained to impartially investigate complaints to ensure a wide pool of managers capable and competent in dealing with these complex issues. A Trust-wide mediation service has been established and all staff will receive a specially designed 'How we work together' training looking at healthy converstations and relationships between staff.

A key finding shows 82% of staff believes the Trust provides equal opportunities for career progression, 2% below the national average for acute specialist trusts.

The Trust offers all full time permanent staff up to £2,000 per annum as a study budget for courses relevant to their post or career development. The learning and development department also run a variety of courses cross site. The nursing development team also runs a large range of courses, including professional development study days, critical care courses, clinical skills courses and many more. The learning management system will be changed in 2018 to support easier, more effective learning, as well as redesigned courses with further e-learning opportunities. Appraisal procedures and design will also be revaluated, as well as further training for managers to ensure learning opportunities are supported and appraisals are implemented.

Workforce Race Equality Standard

The Trust completed its 2016/17 WRES submission in August 2017 which was published on the Trust's website in autumn 2017 with an accompanying action plan. For 2017 more focus has been placed on the WRES and on developing an action plan to support key targets. Whilst the data itself showed some improvement against some of the indicators when compared at a regional and national level, compared to the previous year some of the indicators had deteriorated slightly. To this end, an action plan was developed to focus specifically on those areas where results were not as the Trust expected, including investigation training for managers, introduction of a simplified grievance and bullying and harassment policy, trained mediators with a view to launching a mediation service and the continuation and expansion of listening groups for staff. This action plan is being continually reviewed and it is expected that the Trust's 2018 submission will be particularly representative given the increased return rate on the 2017 Staff Survey. The WRES is a useful tool, helping to shine a light on the Trust's own data therefore providing an opportunity to improve the employment experience for BME staff.

Care Quality Commission Inspection

CQC ratings for Royal Brompton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	☆ Outstanding	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

CQC ratings for Harefield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	☆ Outstanding	☆ Outstanding	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Good	Good	Good	Good	Good	Good

CQC ratings for Royal Brompton & Harefield NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

The Trust was inspected by the CQC in June 2016 and the inspection report was published on 10 January 2017. Overall, the Trust was rated by the CQC as 'Requires Improvement'. Within this rating Harefield Hospital was rated as 'Good' and the Royal Brompton Hospital as 'Requires Improvement'.

During 2017/18 the Trust worked to deliver its action plan following the inspection. Regular engagement meetings were held with the CQC Inspectors allocated to the Trust and a focus group was held in February 2018. This enabled CQC Inspectors to hear the views of nursing staff. Further focus groups are planned so that the CQC can hear the views of medical staff and administrative staff.

Section 2 of this report provides information on progress with quality improvements associated with the CQC Action Plan during 2017/18 and plans for further work during 2018/19.

Performance against national quality indicators

Royal Brompton & Harefield NHS Foundation Trust considers this data is as described because it is data from our HES (Hospital Episode Statistics) submitted data. Due to our processes around this data, we believe the data reported back to us to be accurate. We have checked the figures (where possible) with our own internal data and we believe it to be accurate. Domains 1 & 2 are not applicable to the Trust.

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons					Data Source
	2015-16	2016-17	2017-18		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	
Domain 3: Helping people recover from episodes of ill health or following injury										
Percentage of emergency readmissions to our own hospitals occurring within 28 days of the last, previous discharge from hospital after admission.[3]										
% of patients aged 0-15 readmitted within 28 days	1.75%	1.08%	1.01%[4]	In accordance with NHS Digital definitions.	1.01%	Apr17-Dec17	0.51%	8.42%	3.81%	https://my.drfoster.co.uk/users/account/accessdenied?ReturnUrl=%2F
% of patients aged over 15 readmitted within 28 days	2.28%	1.76%	1.78%		1.78%		0.58%	9.25%	5.12%	
Domain 4: Ensuring that people have a positive experience of care										
Percentage of Inpatients who would recommend the provider to friends or family needing care	96.98%	96.89%	95.68%	In accordance with NHS England guidance.	95.68%	Apr17-Mar18	99.81%	72.53%	95.59%	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Percentage of staff who would recommend the provider to friends or family needing care.	91%	92.57%	94.86%		94.86%	Apr17-Mar18	100.00%	42.86%	79.87%	https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/data/
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm										
Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)	95.59%	95.29%	95.88%	In accordance with NHS England guidance.	95.88%	Apr17-Mar18	100.00%	71.88%	95.21%	https://improvement.nhs.uk/resources/vte/
Rate of *clostridium difficile* (number of infections/100,000 bed days)	0.73	0.68	0.79	In accordance with DH guidance.	0.79	Apr17-Mar18	No benchmark available			
Patient safety incidents reported to the National Reporting & Learning System							Benchmarked against Acute Specialist NRLS Cluster			http://www.nrls.npsa.nhs.uk
Number of patient safety incidents	3,857	3,925	3,956[5]	In accordance with National Patient Safety Agency guidelines.	1,932	Q1+Q2 17/18	2814	294	1447	Benchmark based on NRLS Q1 +Q2 2017/18
Rate of patient safety incidents (number/1000 bed days)	19.9	17.52	18.47		32.23		174.59	31.76	Cluster median = 41.06	
Percentage resulting in severe harm or death	0.054%	0.04%	0.07%		0.1%		0%	0.5%	0.1%	

[3] Financial years 15/16 + 16/17 figures have been updated due to revised Dr Foster methodology

[4] Dr Foster data is based on HES data and therefore there is a 3-6 month lag in data publication

[5] Local trust data represents the full financial year 2017-18. Publication of Q3 + Q4 NRLS benchmark data is 6 months behind.

Friends and Family test

The Friends and Family Test was introduced in May 2012. All hospital trusts are mandated to ask all inpatients: "How likely are you to recommend our ward/clinic to friends and family if they needed similar care or treatment?"

The Friends and Family Test (FFT) provides a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and make improvements where necessary to ensure that patients have a positive experience of care. Results of the test are published every month on the NHS England and NHS Choices websites.

The Trust started using the Friends and Family Test in December 2012. The data is collected by various methods; paper questionnaires given to all patients on the day of discharge, online via tablets, or as a response to a text message sent 48 hours post discharge. The FFT target score first set by the Department of Health was 15%, this was increased to 25% in April 2014 and the Trust has managed to achieve and exceed these targets. As from 1st January 2015 the FFT target increased to 30% and this was achieved consistently throughout the year (see Chart 1 below).

Chart 1: FFT response scores for 2017-18 (Source: Healthcare Communications UK Ltd)

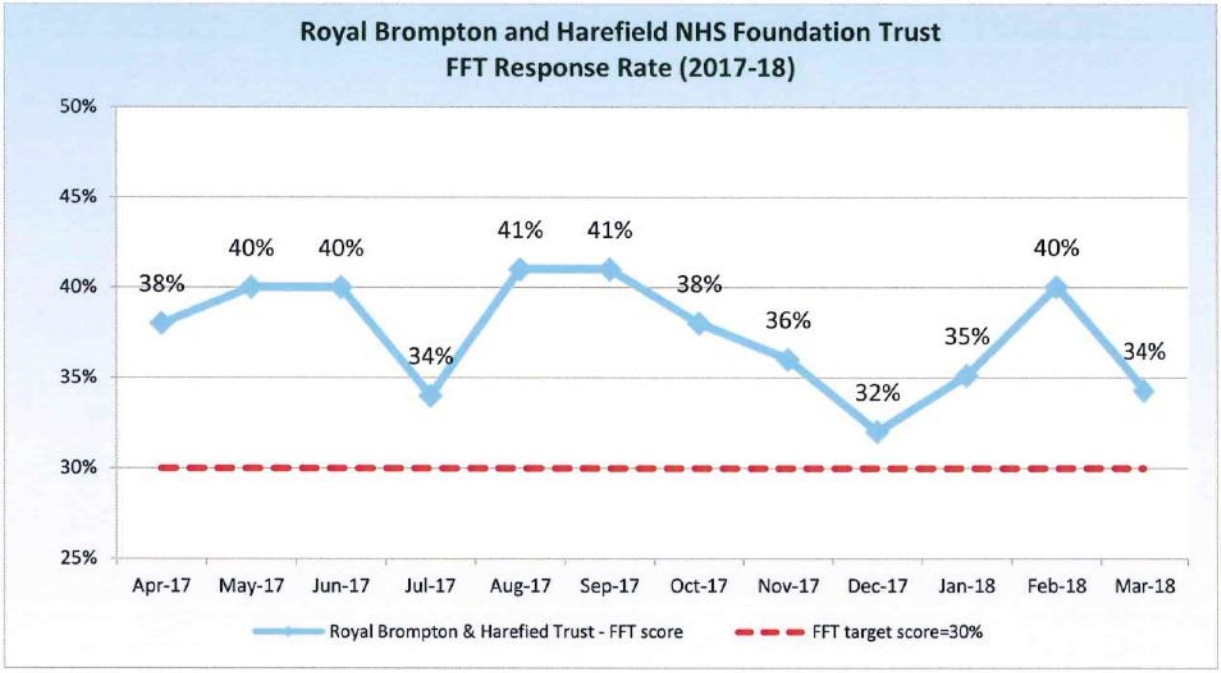
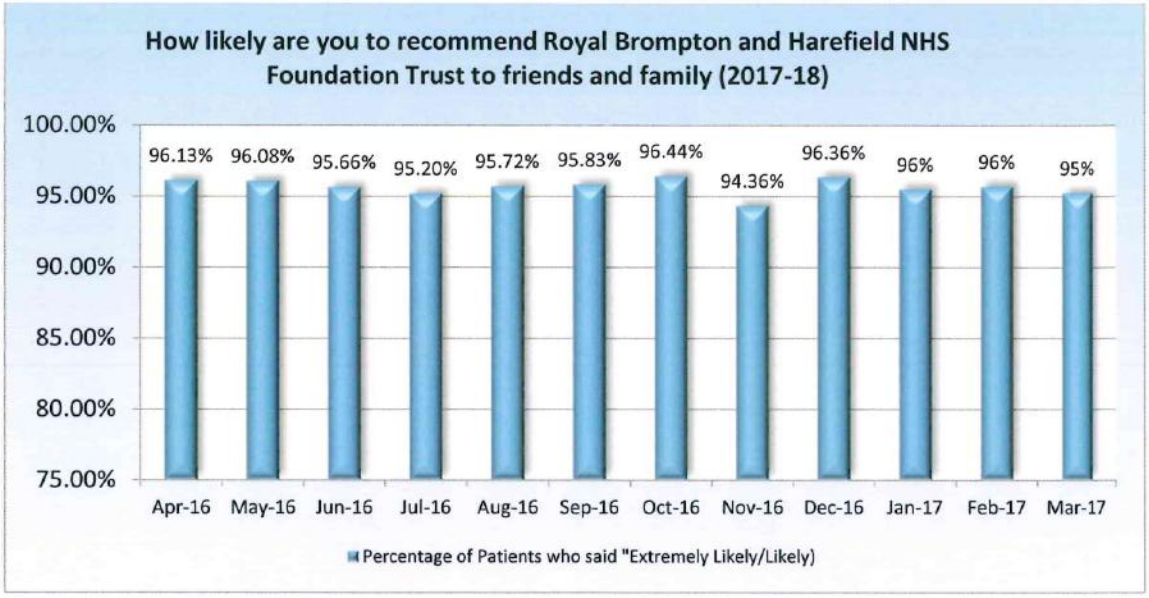


Chart 2: FFT recommend scores for 2017-18 (Source: Healthcare Communications UK Ltd)



The FFT recommend scores (See Chart 2 above) for Royal Brompton & Harefield NHS Foundation Trusts has been consistently high = >90%.

The negative response rating has consistently been 2% throughout 2017 -2018

Friends Family Test Benchmarking – March 2018 (Source NHS England)

a) National Benchmarking – 153 trusts in England
   - Royal Brompton & Harefield Trust FFT response rate = 34% (ranked 28th).
   - 95% of patients would recommend the Trust to friends and family.

b) Local Benchmarking – 57 hospitals in London
   - Royal Brompton FFT response rate = 32% (ranked 20th).
   - Harefield Hospital FFT response rate = 40% (ranked 13th).

Patient feedback comments:

Sample of patients' comments why they are "Extremely Likely" to recommend our wards/hospitals:

"I always have the best service from Harefield hospital. Extremely like it and recommend to everyone. I do like to help Harefield hospital."

"Thank you so much for your wonderful service | Thank you so much for your wonderful care and attention. I could not fault the service the staff absolutely fantastic."

"All the staff have been amazingly friendly, cheerful, knowledgeable and professional. They work extremely hard and made my stay as comfortable as possible."

"The attention to medical care was second to none, nothing was too much trouble and you knew at all times You were in the hands of well trained and professional people, thank you."

"All of the staff who dealt with me were capable patient and professional. What I saw was that all patients got equal levels of care and attention across the spectrum from the high levels of activity on admission through to the little things like a request for a bowl of cereal. In my opinion the NHS at its absolute best"

"All the staff were extremely kind and friendly which makes such a difference if you are feeling nervous or apprehensive"

"I am always treated with dignity and respect and I feel very safe! Even when there has been a problem - like today, obtaining the product. I needed to wait for the product to be obtained and written up. The staff made sure they got this done as soon as they could, and commenced as soon as it was brought to the ward."

Actions taken as a result of patient feedback in 2017-2018

The Friends and Family Test (FFT) enables trusts to respond to patients' feedback and make changes and/or improvements where necessary.

1. Facilities
Broken Toys have been mended or replaced as new in Children's Outpatients.
Refurbishment of Maple and Acorn wards at Harefield Hospital.

2. Compassion in Practice
As part of the Darwin transformation programme a new pre-admission unit has been implemented so these patients can be seen quickly and efficiently prior to their procedure taking place.

3. Information and Communication
Various complaints were received about the reception staff on a specific ward. This area is now under new management and more favourable comments have been received.

A pilot is being undertaken to offer electronic appointment letters to outpatient clinics. Findings will be reviewed after 3 months.

A pilot is being undertaken so patients can share their medications with GPs/DGH electronically.

4. Patient Experience
Local surveys have been implemented in PICU and AICU to gain patient and visitor feedback. These areas are not covered as part of the Friends and Family Test as patients are not discharged home from these wards.

Complaints

The following information about formal complaints received by the Trust is reviewed on a monthly basis by the operational management team Complaints performance is measured against the timescale agreed with the complainant and is usually reported for the month that the complaints are actually closed, not when they are received

Period	1st April 2017 – 31st March 2018		
	Complaints responded to Within agreed timescales	Total Number of Complaints	%
Royal Brompton Hospital	43	52	83%
Harefield Hospital	22	23	96%
Trust Total	**65**	**75**	**87%**

Amendments to the NHS complaints regulations removed the stipulation to respond to complaints within set timescales, allowing organisations to individually negotiate response dates with complainants, ensuring that they are kept informed of any delays in the investigation. During the year 2017/2018 this Trust, in line with many others, retained an internally set standard which aims for 25 working days from receipt of a formal complaint to a response being sent from the chief executive. The exception to this is where a different timescale is negotiated with the complainant in recognition of a particularly complex investigation. Setting an achievable deadline at the outset and allowing time for a comprehensive response is preferable to complainants.

16 complaints (21%) had extended agreed timescales negotiated at the outset.

Current performance is that 87% of complaints were responded to within agreed timescales. However the Trust is working towards a target of 95% for all complaints to be responded to within agreed timescales.

The Trust received a total of 75 new complaints during the year 1st April 2017 to 31st March 2018. This included complaints from 8 private patients (11%) and 8 complaints (11%) being led by other organisations.

Managers speak directly to complainants once a complaint letter is received to discuss the complaint in more detail and agree a timescale in which to provide a written response. Following a discussion some complainants are happy for the manager to handle their complaint informally, and in the year 2017/2018 6 complaints were handled directly in this way, with 1 re-opened complaint also being closed informally. This may mean the complainant receiving a written response directly from the manager instead of the chief executive or attending a meeting with clinical staff. However these complaints are still included in the total number of complaints received, lessons are learned and outcomes are recorded.

Following the investigation, complaint outcomes are described as Complaint Upheld (the majority of the complaint is justified), Complaint Partially Upheld (some aspects of the complaint are justified) or Complaint Not Upheld.

Site	Complaints Closed 2017/2018				Number of complaints re-opened
	Upheld	Partially Upheld	Not Upheld	Total Complaints Received	
Royal Brompton Hospital	25	13	14	52	9
Harefield Hospital	8	5	10	23	3
Trust Total	**33**	**18**	**24**	**75**	**12**

*Table represents the status of complaints closed during the year 1st April 2017 to 31st March 2018. As new complaints received in March 2018 are not expected to be closed until April/May 2018 at the earliest and therefore their outcomes are currently unknown.

Of the 52 new complaints closed at Royal Brompton Hospital during the year 2017/2018 73% were upheld or partially upheld and 27% were not upheld. Of the complaints closed 9 complaints were reopened at the complainant's request (17%) which included 2 private patient complaints and a further written response or meeting was provided.

Of the 17 complaints received at Harefield Hospital during the year 2017/2018 57% were upheld or partially upheld and 43% not upheld. 3 complaints were reopened at the complainant's request (13%) and a further written response or meeting was provided.

Private patient complaints at the Trust are treated under the same Trust policy as NHS complaints and are therefore included in the number of complaints received and responded to for internal reporting purposes.

The complaints data return to the Health and Social Care Information Centre is submitted quarterly. These figures will NOT include complaints received from private patients as this return is only for patients receiving NHS funded treatment. NHS complaints led by other organisations or reopened complaints are also NOT included, so that complaints about NHS care do not get counted twice.

The Trust continues to improve its care and service delivery through regular review of complaints, and identification of learning via the divisional and Trust-wide governance processes.

Although most complaints in the Trust revolve around individual complex care issues, there are some broad themes that have been identified over the past year. These include;

- **Communication** – in particular, the issue of how we manage patient and family expectations, ensuring that messages are consistent when given by different staff. It is also clear that listening to the details that matter to complainants is vital, and that documentation needs to capture conversations more clearly.
- **Waiting** – ensuring that realistic waiting times are discussed with patients, being clear about communication between teams, and ensuring that this does not cause delays in the system.
- **Discharge** – processes are not always smooth, causing delays, and errors can occur in the discharge information given.
- **Specific learning** – for example although it is thought important to encourage patients or family members to raise concerns if they are not happy with their experience, some find this feels like the burden of improving care is transferred to the family, which is just an additional stress for them.

Staff undertaking investigations continue to be supported through regular case review meetings and learning events.

Part 3: Formal statements of assurance

CQC registration

Royal Brompton & Harefield NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

Royal Brompton & Harefield NHS Foundation Trust was inspected by the CQC in June 2016 and the inspection report was published on 10 January 2017. Overall, the Trust was rated by the CQC as 'Requires Improvement'. Within this rating Harefield Hospital was rated as 'Good' and the Royal Brompton Hospital as 'Requires Improvement'.

An action plan has been developed and is currently being implemented prior to re-inspection by the CQC.

Royal Brompton & Harefield NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Provision of NHS services

During 2017-18 Royal Brompton & Harefield NHS Foundation Trust provided 37 Commissioner Requested Services. Royal Brompton & Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 37 of these NHS services.

The income generated by the NHS services reviewed in 2017-18 represents 100% of the total income generated from the provision of 37 NHS services by Royal Brompton & Harefield NHS Foundation Trust for 2017-18.

Use of the CQUIN Payment Framework

There were two CQUIN schemes in place for 2017/18, one applying to NHS England contract work and the other to Clinical Commissioning Groups.

NHSE CQUIN

The Trust has submitted evidence to commissioners and is negotiating to a maximum 96.5% achievement of the CQUIN. The Trust will not have confirmation from commissioners as to the value of the final payment until the evidence has been reviewed by commissioners. However, to date, the Trust has received full payment for Q1 and Q2 NHSE CQUIN submissions and anticipating full payment for Q3. Commissioners will request clarification on the evidence submitted at year end and value during May 2018. If there is 100% achievement for all NHSE CQUINS this will generate a total income of £3,365,877. Achievement of 96.5% would generate income of £3,248,168. The tables below show confirmed income received up to the end of Q3. The final Q4 position is currently (15th May 18) subject to confirmation by commissioners.

Commissioner: NHS England

Scheme	Weighting	Total value £	Annual Achievement (estimated)	Total claimed to end of Q3
Clinical Utilisation Review	0.65	£1,093,010	100%	£765,737
Severe Asthma	0.20	£336,588	100%	£100,976
Complex Devices	0.26	£437,564	100%	£131,269
Shared Decision Making	0.12	£201,953	100%	£60,586
Paediatric Networked Care	0.15	£252,441	100%	£75,732
CF Adherence	0.10	£168,294	100%	£126,220
Medicine Optimisation	0.52	£875,128	100%	£422,249
Total	**2.00**	**£3,365,877**		**£1,683,107**

Commissioner: Clinical Commissioning Groups

Scheme	Weighting	Total value £	Annual Achievement (estimated)	Total funding received to Q3
Improving staff health and wellbeing:		**£139,727**		**Q4 CQUIN only**
(i) improvement in the annual staff survey	0.10%	£46,576	0%	£0
(ii) Healthy food for NHS staff, visitors and patients	0.10%	£46,576	100%	£0
(iii) Improving uptake of flu vaccination for frontline clinical staff	0.10%	£46.576	25%	£0
Sepsis:		**£139, 727**		
(i) Timely identification of patients with sepsis in emergency departments and acute inpatient settings	0.075%	£34,932	50%	£15,719
(ii) Timely treatment of sepsis in emergency departments and acute inpatient settings	0.075%	£34,932	50%	£17,466
(iii) Assessment of clinical antibiotic review between 24-72 hours	0.075%	£34,932	100%	£26,199
(iv) Reduction in antibiotic consumption per 1,000 admissions (Q4 only)	0.075%	£34,932	100%	£0
Advice & Guidance	0.30%	£139,727	75%	£104,795
NHS e-referrals	0.30%	£139,727	75%	£104,795
Preventing ill health by risky behaviour:		**£139,727**		
(a) Tobacco Screening	0.015%	£6,986	100%	£6,986
(b) Tobacco brief advice	0.06%	£27,945	100%	£27,945
(c) Tobacco referral and medication	0.075%	£34,932	50%	£17, 476
(d) Alcohol screening	0.075%	£34,932	100%	£34,932
(e) Alcohol brief advice or referral	0.075%	£34,932	12%	£4,367
Sustainability and Transformational Plans (STP):		**£465,757**		
(i) Engagement in the NWL STP	0.50	£232,878	100%	£232,878
(ii) STP - Risk Reserve	0.50	£232,878	100%	£232,878
Total	**2.50**	**£1,164,393**		**£541,447**

What is clinical audit?
Clinical audit is a quality improvement process that seeks to improve patient care and outcomes. This is done through a systematic review of care against specific criteria followed by implementation of change, if required.

Participation in clinical audit

During 2017/18 financial year 17 national clinical audits covered relevant health services that Royal Brompton & Harefield NHS Foundation Trust provides. During that period Royal Brompton & Harefield NHS Foundation Trust participated in 88.24% of the national clinical audits relevant to the Trust as listed below:

Clinical Audit Topic	National clinical audit	Did the Trust participate in 2017-18	Clinical Audit Lead
Perinatal mortality	MBRRACE-UK	√	Val Hedley
Children			
Paediatric intensive care	PICANet / Specialised services quality dashboards	√	Dr Sandra Gala-Peralta
Paediatric cardiac surgery/cardiology/Adult Congenital Heart Disease	NICOR Congenital Heart Disease Audit	√	Dr Rodney Franklin and Mr O Ghez
Congenital Heart - Adult	Specialised services quality dashboards	√	Dr Rodney Franklin and Mr O Ghez
Congenital Heart - Paediatrics		√	
Fetal Medicine		√	
Acute care			
Cardiac arrest	National Cardiac Arrest Audit	√	Richard Young
Adult critical care	Intensive Care National Audit & Research Centre Case Mix Programme	√	Dr TC Aw
Emergency Laparotomy	NELA	√	Lakshmi Kaupparao Tom Pickering
Elective procedures			
Coronary angioplasty	NICOR Adult cardiac interventions audit	√	Charles Ilsley Simon Davies
CABG and valvular surgery	Adult cardiac surgery audit	√	Neil Moat / Rashmi Yadav Fabio de Robertis
Thoracic Surgery	Society of Cardiothoracic Surgery	√	Eric Lim
Cardiovascular disease			
Acute Myocardial Infarction & other ACS	MINAP	√	Rob Smith Simon Davies
Heart failure	Heart Failure Audit	√	Rakesh Sharma
Cardiac arrhythmia	Cardiac Rhythm Management Audit	√	Tom Wong
Vascular Procedures	National Vascular Registry	X	Nick Cheshire
Cancer			
Lung cancer	National Lung Cancer Audit	√	Eric Lim
Blood transfusion			
Re-audit of patient blood management in audit surgery	National Comparative Audit of Blood Transfusion	√	Ketan Patel
End of life			
Care of dying in hospital	National Care of the Dying Audit for Hospitals	x	Lauren Berry

National Confidential Enquiries

The Trust was eligible for and took part in two NCEPOD studies in 2017/18:

a) Acute Heart Failure. The aim of this study is to identify and explore avoidable and remediable factors in the process of care for patients admitted to hospital with acute heart failure. The study includes all adult patients (aged 16 and over) that were admitted as an emergency between 1st January 2016 and 31st December 2016 inclusive, and died in hospital with a primary diagnosis of Heart Failure. The Trust submitted a full dataset, and the final report is now awaited - due to be published in summer 2018.

b) Perioperative Diabetes. The aim of this study is to identify and explore remediable factors in the process of care in the perioperative management of surgical patients with diabetes across the whole patient pathway from referral to surgery (elective) or admission to hospital (emergency) to discharge from hospital. The Trust submitted a full dataset, and the final report is now awaited - due to be published in winter 2018.

The report for Acute Non-Invasive Ventilation: Inspiring Change was published in July 2017.

This NCEPOD report focuses on the quality of acute non-invasive ventilation clinical care, for patients aged 16 years or older who are admitted to hospital. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

Although not listed here, each clinical care group is also expected to take an active role in local clinical audit. In addition to participation in the relevant national audits, each care group will review, and where appropriate audit compliance with NICE guidance, and conduct a number of clinical audits identified as a local priority. These projects are supported by the Divisional Quality & Safety teams and monitored through the Divisional structure

The data submitted to the national clinical audits, the national confidential enquiries and the local clinical audit reports, is reviewed by the Trust's Clinical Effectiveness and Standards Oversight Committee, chaired by the Deputy Medical Director. The actions taken as a result of the audit work are also kept under review by the Committee. Consideration is being given to producing an annual report on the work of the Committee and the associated learning.

Participation in research

As a specialist tertiary centre focussing on heart and lung disease across the whole age spectrum, staying at the forefront of research and innovation is vital to the delivery of our services. Part of the overall mission of the Trust is to;

"undertake pioneering and world class research into heart and lung disease in order to develop new forms of treatment which can be applied across the NHS and beyond".

From 1 April 2017, the Trust no longer has designated NIHR Biomedical Research Units for Respiratory or Cardiovascular research. The Trust was successful in its application for a NIHR Clinical Research Facility which supports our continued engagement with the NIHR to facilitate the delivery of world-leading research of direct benefit to our patients. The Trust has now fully integrated research with clinical activity and is working on the development of a new research strategy in collaboration with clinical divisions. Each clinical care group now has an appointed research leader whose role is to support activity in line with the Trust's four strategic research goals:

- To support and develop research-active staff – increasing critical mass and productivity of research leaders and ensuring that all staff are appropriately trained and supported.
- To exploit opportunities to attract and retain research funding – diversifying and increasing the value of research funding coming to the Trust and ensuring high quality delivery of studies, to time and on target.
- To promote and increase engagement in Trust research – by raising awareness of research activities amongst all staff and patients/carers.
- To provide effective and well managed research facilities, research resources and administrative support.

These objectives map on to all areas of research activity within the Trust and will be achieved by working in collaboration with a wide range of partners (including academic, commercial, charity, funding bodies and government agencies).

Research income

The Trust has raised £7.2m in research income during 2017/18, exceeding the income target for research by £230k, specifically achieving £2.7m in research grant income and £2.1m in commercial funding for clinical trials. Trust researchers have submitted 85 grants with a total value of over £46m (£16.5m to the Trust) and have been awarded 27 grants with a total value of over £10m (£3m to the Trust).

Participation in clinical research

The number of patients recruited to participate in research approved by a research ethics committee was 2,284. At the end of the financial year, the Trust was participating in 230 actively recruiting studies, 102 that are continuing to follow up patients after a research intervention, with another 85 in set-up. This includes global studies sponsored by industry, trials involving new medicines or devices and international registry studies, compiling research data for better patient outcomes.

Of our active studies in 2017-18, 1,098 patients were recruited into NIHR portfolio studies (commercial and non-commercial) and 539 patients were consented to donate their tissue for retention within the Trust's ethically approved biobanks (Respiratory Biobank, Cardiovascular Biobank and Diagnostic Archive). In addition, 145 patients have consented to participate in the National 100k Genome project for rare diseases and cancer. We consistently perform well in the sector against our national objectives, consistently ranking second to Imperial College Healthcare NHS Trust for number of open commercial clinical trials in North West London (32) and exceeding the target set by the NIHR for recruiting to time and on target (72% of our commercial studies and 100% of our non-commercial studies achieving or surpassing their recruitment target).

Data quality

Statement on relevance of data quality and actions to improve data quality

The Trust uses the following initiatives to maintain and improve data quality, thereby ensuring a high quality of service to all service users:

- Patient demographic details are sourced directly from the Patient Demographics Service (PDS)
- Prompt reporting and investigation of all data quality issues
- Regular briefing of frontline staff at team meetings
- Routine checking and updating of service user information with service users.

Secondary Uses Service

Royal Brompton & Harefield NHS Foundation Trust submitted records during 2017/18 financial year to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The NHS contract target for completion of valid general medical practice code and NHS number is 99%. This standard has not been met for the inclusion of patients' valid NHS Numbers for inpatients and for inclusion of patients' valid general medical practice codes for admitted patients.

The percentage of records in the published data[6]:

- which included the patient's valid NHS number was:
  - 97.5% for admitted patient care;
  - 99.0% for outpatient care.
- which included the patient's valid General Medical Practice Code was:
  - 95.4% for admitted patient care;
  - 96.0% for outpatient care.

Information governance toolkit attainment levels 2017-18

The Information Governance Toolkit for acute trusts consists of 45 individual requirements, each assessed between Level 0 and Level 3.

The Trust's information governance toolkit submission for 2017-18 achieved a 'Satisfactory' grade (all requirements met at Level 2 or better).

The Trust had an overall score of 79% for 2017/18. This compared to 78% for the previous year (2016-17). 100% represents all requirements scored at Level 3.

What is the information governance toolkit? Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The toolkit provides NHS organisations with a set of standards against which we declare compliance annually.

[6] Data Source: NHS Digital (April 2017 - December 2017)

Clinical coding error rate

Royal Brompton & Harefield NHS Foundation Trust carried out an internal audit during February 2018. This was based on 200 randomly selected records from June 2017 to August 2017

The results of the clinical coding audit are below.

Clinical Coding Audit Results

Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct	Unsafe to audit
98.5%	98.7%	98.8%	97.6%	0%

Royal Brompton & Harefield NHS Trust Reference cost audit was carried by KPMG in May 2017 which included overview of clinical coding internal audits too, no concerns were raised.

PricewaterhouseCoopers audited the coded data in May 2016 indicated that RBHT demonstrated good practice in complying with costing guidance.

Royal Brompton & Harefield NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18

Performance against key healthcare targets 2017-18

There are national healthcare targets that enable the regulators and other institutions to compare and benchmark the performance of organisations. Trusts are required to report against the targets that are relevant to them. The table below shows the key healthcare targets that this Trust reports to the Trust board and also externally.

Single Oversight Framework

Indicator	National Target/ Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017/18
Clostridium difficile - Cases due to lapses of care	23	0	1	0	0	0	0	0	0	0	0	0	0	1
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Maximum time of 18 weeks from point of referral to treatment (RTT)	92%	92.42	92.20	92.71	92.71	92.67	93.29	94.08	93.31	92.93	93.41	92.51	91.89	92.85%
Cancer - 62 day Urgent GP referral to first definitive treatment	85%	93.33	33.33	81.82	70.0	64.29	63.64	70.83	84.62	100	100	62.50	75.00	75.17%[7]
Maximum 6 – week wait for diagnostic procedures	1%	0.	0	0	0	0	0	0	0	0	0	0	0	0.0%
Never Events	0	0	0	0	1	0	0	0	0	0	0	0	0	1

[7] This differs to the average figure of 74.84% reported during financial year 17/18 because of changes that were made to the Open Exeter system for patients in some months after the publication date.

The Single Oversight Framework was operated by NHS Improvement throughout 2017/18.

During this period:

- All of the reviews were carried out by the end of April and out of 17 cases only one lapse of care was found. This was due to delay in transferring a patient to an isolation room.
- There were no cases of MRSA during 2017/18.
- 18 week waiting time target (from GP consultation to first definitive treatment) – data from the Trust's PAS system indicates that this target was met up to M11, but not met for M12. However, significant data quality concerns persist. More detail is provided in the next section of this document.
- The 62 day cancer target (for the time from GP consultation to first definitive treatment) did not meet the national standard of 85% for 9 months of the financial year. It should be noted that this national standard is designed for use in hospitals delivering a broad range of cancer services involving both long and short pathways. The 85% standard is intended to be an average set across both long and short pathways. The Trust is a specialist centre providing surgical treatment for lung cancer patients. This is an inherently long pathway, the diagnostic portion of which is carried out in secondary care. Although the national standard was not met, the requirements of the improvement trajectory agreed with NHS Improvement were met for 8 out of 12 months.
- 6 week wait for diagnostic procedures. The Trust met the standard for 6 week diagnostic waits throughout the period
- Never Events, these was one never event during the year. This involved the retention of a surgical swab.

18 Week Referral to Treatment Time Data Considerations

Background

In July 2016, the Trust's Patient Administration System (PAS) was changed from the original iexpress PAS to the new Lorenzo PAS system. Data was migrated from iexpress to Lorenzo and the staff who enter data were provided with training on how to use the new system.

From October 2016, the PAS Board which had overseen the implementation of the new PAS was transformed into the PAS Implementation Group (PIG) in order to provide continuing executive oversight for the project following the initial deployment. The PIG was chaired by the Chief Operating Officer and brought together personnel from IT, Performance and Information and from the operational teams. Initially, the PIG met fortnightly and then moved to monthly meetings throughout 2017.

2017/18

During the summer of 2017, the Trust took part in a national audit of data quality, carried out by NHS Improvement. The data audited was that underpinning the management of all elective care including planned care, patients waiting for Out-patient follow up / diagnostic tests as well as the reporting of the referral to treatment time (RTT) target. This audit raised questions about the integrity of the data within the Trust's Lorenzo PAS system and NHS Improvement issued a report which set out matters that needed to be investigated and addressed.

In November 2017, the Chief Operating Officer invited the Elective Care Intensive Support Team (IST) of NHS Improvement to get involved in the work required to take forward the report's recommendations. An Action Plan was developed in conjunction with the IST and work began in January 2018 on what is expected to be a programme of work extending over twelve months.

Although a better understanding of the data quality position has been achieved during 2017/18, significant numbers of RTT pathways continue to be started on the Lorenzo PAS for patients who are not on an RTT pathway and there is uncertainty as to whether clock stops are being applied correctly. The presence of these pathways within the reports means that the Trust has been unsighted on the correct numbers of patients on RTT pathways and this could be obscuring performance issues. Deloitte LLP has undertaken testing of RTT data in line with the requirements for external assurance for Quality Report. This testing resulted in a qualified conclusion with regards to RTT.

The current validation process involves a team of validators based in the Divisions. Every month 750 – 800 records of patients who have waited over 18 weeks are checked. As a result of this validation process around 300 – 400 pathways are closed every month. The main reason for closing these pathways is that patients should not have been started on an 18 week pathway in the first place. The other main category of error discovered at validation is that a clock stop has not been applied when it should have been.

The continual opening of new pathways with data quality errors, followed by their closing after validation has meant that overall, for the past year, the Trust has been in a position of stasis. The total number of open pathways was 5,725 at M12.

The report issued by the IST, its recommendations and the resulting action plan identify improvements that need to be made to break out of this cycle. Chief amongst these is the need to

retrain operational staff in data entry to the Lorenzo PAS so that the data is entered correctly at source and the provision of patient tracking information which covers the whole of elective care.

Patients on an RTT Pathway who waited more than 52 weeks

Five patients on RTT pathways waited more than 52 weeks for treatment during 2017/18.

Four of these cases involved patients under the care of the Heart Division at Harefield Hospital. Three of these cases were due to incorrect data entry to the Lorenzo PAS system and one case involved paper records being filed rather than being acted upon.

One case involved a patient under the care of the Heart Division at Royal Brompton Hospital. In this case, incorrect data entry to the Lorenzo PAS was a contributing factor to the delayed treatment.

In all five cases, a clinical review will be undertaken six months after treatment has been completed in order to determine whether any harm resulted from the long waiting time. These clinical reviews will be reported through the Divisional Quality and Safety meetings and then to the Governance and Quality Committee.

Plan for 2018/19

On 3rd April 2018 a Programme Director for RTT and Planned Care came into post for an initial six month secondment from the Intensive Support Team.

A programme to retrain operational staff in data entry to the Lorenzo PAS system has been designed and delivery of the training is expected to commence during May 2018.

As part of the Operational Plan for 2018/19, the Trust has been required to submit a trajectory for RTT 2018/19. A Trajectory has been submitted based upon the information available at the time. The trajectory shows performance beginning at 90% in April 2018 and rising to 92% by the end of the year (31st March 2019). The assumptions behind this trajectory are that a combination of training and validation is expected to remove around 1,500 shorter patient pathways that should either not be classified as RTT, or should have been clock stopped. At the same time increased productivity and efficiency during 2018/19, driven through the Darwin Programme, is expected to release capacity which will enable the Trust to treat more patients who have waited over 18 weeks which will bring the target back into compliance by year end. It should be noted at as progress is made with the data quality improvement plan, a better understanding of the underlying position will be achieved and it may be necessary to revisit this forecast.

62 day Urgent GP Referral to first definitive treatment Data Considerations

During 2017/18 preparations began to ensure that by the time that the new national cancer waiting times system went live on 1st April 2018, processes were in place to capture the additional data required in order to meeting the requirements set out in the new guidance[8].

The introduction of the new CWT dataset v2.0 dataset consists of 54 data items (previously 42). These items ensure that the key events and descriptors of cancer waiting times pathways are captured. The data set includes:

- 24 existing data items
- 16 changes to data items
  - Data item changes to align with the data dictionary and/or COSD
  - Data item changes required to be consistent with SCCI0090 Health and Social Care Organisation Reference Data
- 14 new data items
  - 9 items for Faster Diagnosis Standard
  - 5 items on Inter-Provider Transfers (IPTs)
- 2 data items retired
  - Metastatic site
  - Radiotherapy intent

The implementation is planned for July 2018 so that submission of data for April 2018 patients can be sent in the new format.

This new dataset links directly into the Breach Allocation Guidance 2016. This guidance was introduced to promote collaboration and provide a more refined approach to allocating breaches of the 62 day standard.

Inter-Provider Transfer date will be clarified in the CWT system as:

- referral request received date, as well as;
- agreed minimum clinical data set received

Both 62 day activity as well as 38/24 day activity will be reported.

The new web based database for CWT reporting (which replaces Open Exeter) has new functionality which will eradicate the issue of our own data being changed by other Trusts. A notification email will provide an alert to the MDT team and Cancer Manager if any data is changed for patients attributable to RBH, thus allowing real time action to be taken to address the detail of the change and confirm accuracy.

The consideration for the Trust is that we will need a lead in time to be ready for our Infoflex system (cancer patient tracking and reporting database). CIMS the IT provider of the software has already tested the new data module in January 2018 with a further test planned for May 2018, with test uploads in May and June to ensure the system can go live for July 2018.

[8] Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0, NHS England April 2018

An overview of the quality of care

This overview refers back to indicators presented previously in this Quality Report. It is largely based on the quality priorities which were selected by the Board in consultation with stakeholders. These have been augmented by other indicators and grouped under three themes:

Patient Safety

- Five steps to safer surgery (see page 15)
- Sepsis (see page 10)
- Acute Kidney Injury (see page 13)

Clinical Effectiveness

- National Early Warning Scores (NEWS) (see page 8)
- Participation in Clinical Audit (see page 33)
- Seven day hospital services (see page 19)

Patient Experience

- Complaints (see page 29)
- Ensuring that people have a positive experience of care (see page 25)
- Friends and Family Test; for patient feed-back comments (see page 27)

In addition, a summary of our performance against key national healthcare targets are given on page 39 of this report.

Part 4: Statements from our stakeholders

Statements from Healthwatch

Healthwatch Hillingdon's response to Royal Brompton and Harefield NHS Foundation Trust Quality Report 2017-2018

Healthwatch Hillingdon wish to thank the Royal Brompton and Harefield NHS Foundation Trust (the Trust) for the opportunity to comment on the Trust's 2017-18 Quality Report.

We are pleased to see the progress being by the Trust on this year's priorities. The work carried out on "Managing the Acutely Ill Patient", around the National Early Warning System and Sepsis are particularly positive. Targets may not have been fully met for every workstream, but the Trust has clearly demonstrated their commitment to continuous quality improvement and improving the patient's experience of care.

Public Accessibility

The Trust's Quality Account has always been a document that has been written in a clear format. This format has helped the public clearly understand how the Trust is meeting its current priorities, how the Trust has identified its future priorities and the plans it has in place to meet these over the coming year. We were slightly disappointed to note that the account this year is not as clearly formatted as in previous years. This is partly because the Trust has chosen to repeat all of its priorities for another year and partly because the lack of clarity in some of the diagrams and tables included in this year's account due to font size.

After realigning the original 2016-2019 priorities last year, the public were informed that the new priorities were for 2017-18. We do not feel there is sufficient explanation within this report for the public to understand why the decision was taken by the Trust to concentrate on lasts years priorities for a further year and not to identify any new priorities. It has also led us to question why some of the priorities have been continued. For example, there has been good progress on NEWS and sepsis during 2017-18 which has seen targets reached, or even exceeded. The new targets for 2018-19 are generally only slightly more than last year and it could be argued that these would be achieved by embedding the 2017 progress through business as usual. This would allow the Trust to concentrate upon a new priority to improve the quality of its care in another area.

The information provided for the public feels a little incomplete in the document. For example, in the Learning from Deaths section the table shown gives no explanation as to what the learning is from the review the Trust has carried out and what is being put in place due to this learning.

The report does not always provide an explanation for the public on how the aims, or targets, set for the 2018-2019 priorities will be achieved. The 2018-2019 section for Acute Kidney Injury is a prime example of this, for example, no explanation or methodology is outlined as to how incidences of avoidable new onset AKI will be reduced by 50%.

Conclusion

The Report undoubtedly indicates the Trust is committed to the delivery of high quality care. The Trust may wish to reflect on this year's presentation and look to see how this may be enhanced, to give a greater assurance to the public of the quality and safety of the services it provides and a more comprehensive understanding of how it will meet its set priorities.

Should the Trust require any further information or clarification on the content of our response please contact Mr Graham Hawkes, Chief Operating Officer.

Healthwatch Hillingdon

15th May 2018

Statement from Healthwatch Central West London

Healthwatch Central West London (HWCWL) welcomes the opportunity to provide this statement on the draft Royal Brompton Hospital and Harefield Quality Account for 2017-18, and to comment on the quality of the services commissioned locally to meet the needs of residents in Kensington & Chelsea, Hammersmith & Fulham and in Westminster.

Our members welcome the opportunity to provide comments on the Trusts Draft Quality Account.

National Early Warning System Implementation (NEWS)
The descriptive paragraph may need rewording We routinely monitor the number of cardiac arrests which happen outside of the critical care environment; which is (the)where patients recognised as being at risk of cardiac arrest should be cared for.

Members welcome the progress concerning staff training and addressing bullying at work. However, they asked for greater clarity on which areas are still struggling and if there is a working plan of action to address the higher levels of bullying. Could there be clarification as to what is meant by 'higher levels' i.e. persistence or volume and how this might sit within the Trusts approach to culture change, organisational development or quality. Although the report notes 64% of staff a detail of area or grade level would be appreciated, members were concerned about the knock on to safe wellbeing and patient care.

Is there internal assurance in regard to:
1) % of staff who feel pressure to come into work when unwell
2) % of staff who have experienced bullying and harassment
3) % who have experienced work-related stress'

Secondary Uses Service.
What measures are being taken in regard to meeting the NHS contract target for completion of valid general medical practice code and NHS number?

Positive feedback
AKI diagram – very clear and effective, the majority of diagrams in the report are clear and comprehensive.

Looking forward
Although not mentioned in the quality account specifically members were concerned about sluice room control and asked for assurance on process and procedure dealing with clutter and cleaning.

Information on any programmes for the updating of wards was requested, communication with patients to advise if this is taking place or planned.

HW CWL and our members look forward to working with the Royal Brompton Hospital & Harefield over the coming year.

Healthwatch Central West London
info@healthwatchcentralwestlondon.org

22nd May 2018

Statements from Local Authority Oversight and Scrutiny Committees

Statement from Councillor Catherine Faulks (Chairman, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea) on the Royal Brompton and Harefield NHS Foundation Trust's Quality Account 2017/18

I am pleased to provide this brief statement for the Royal Brompton and Harefield NHS Foundation Trust's Quality Account for 2017/18. The Quality Account gives a useful overview of the work and performance of trusts. The Royal Borough of Kensington and Chelsea continues to have a good working relationship with the Royal Brompton and Harefield NHS Foundation Trust.

It can be more difficult for a scrutiny committee to scrutinise with a specialist trust, such as the Royal Brompton and Harefield because only a small proportion of the Trust's patients are from the scrutiny committee's borough. However, having said this, we are most proud of having the Royal Brompton based in the Borough.

Of particular relevance, we recall in the recent past the NHS England consultation period on the future of congenital heart disease (CHD) services. Royal Brompton together with senior representatives of NHS England attended the Scrutiny Committee meeting at Chelsea Old Town Hall on 11 July 2017. We remain grateful for the participation of the Royal Brompton officers in this consultation process.

Following the Scrutiny Committee meeting last July then Chairman (Councillor Charles Williams) wrote to confirm that the Scrutiny Committee was very concerned about the effect on the Royal Brompton of the decommissioning of the CHD service which forms a significant part of what is provided at the hospital. We believe then and now that this would not only impact on the financial position of the Trust but would adversely affect other services including those for chest and respiratory conditions.

The Scrutiny Committee considered that no evidence has been presented to justify the new requirement for co-location of services which leads NHS England to recommend the de-commissioning of CHD services from the Royal Brompton. For these reasons the Scrutiny Committee was opposed to the proposal to de-commission Level 1 CHD services from the Royal Brompton Hospital.

The last Care Quality Commission (CQC) inspection report on the Royal Brompton published on 10 January 2017 had an overall summary rating of Requires Improvement. We remain interested to hearing from the Royal Brompton its plans to address the issues identified by the CQC.

We look forward to working more closely with colleagues at the Royal Brompton and Harefield NHS Foundation Trust over the coming year to better understand the priorities and issues covered in the Quality Account 2017/18.

In general terms we are interested to hear the Brompton's future plans for the Hospital. Perhaps to cover the solution for the continuing treatment of CHD and the long term future of The Brompton in Chelsea. We are also interested in the Brompton's interrelationships with the Royal Marsden and Chelsea and Westminster Hospital.

Councillor Catherine Faulks

Chairman,
Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea
18th May 2018

Response on behalf of the External Services Scrutiny Committee at the London Borough of Hillingdon

Response on behalf of the External Services Scrutiny Committee (2017/2018) at the London Borough of Hillingdon

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2017/2018 Quality Account report and acknowledges the Trust's continued commitment to attend its meetings when requested.

The inclusion of explanatory text boxes in the report have been very useful. However, the report, whilst easy to read, lacked comparative data and targets which made meaningful comparison difficult. Although there is some comparative data within the report, this was not always located near to the relevant commentary.

Staff should be commended for working hard to improve the Trust's performance in relation to the appropriate use of NEWS charts on the wards. Although the 90% target has not been achieved, results have improved and awareness amongst staff regarding the importance of completing the documentation appropriately has also increased. The Committee would have liked to have seen evidence of this comparison in the report and, given the increased staff awareness, looks forward to seeing further improvement in this area in the future.

The Trust has listened to feedback from nursing staff and upgraded sepsis trolleys at Harefield Hospital as a result, with a similar approach planned for roll out across the rest of the Trust during 2018. Whilst the sepsis achievements have been included in the report, it is difficult to assess these as there is no information included in relation to the targets or previous years' achievements or explanation as to why Q2 results for patients with sepsis being treated within 1 hour was so noticeably lower than other quarters. However, the actions planned for 2018/2019 appear robust and the Committee looks forward to receiving an update on the impact that these actions have had at a future meeting.

The Committee is pleased to see the positive steps taken to address bullying and harassment. The increase in the response rate to the NHS Staff Survey from 39% in 2016 to 54% in 2017 is even more representative and the new traffic light system to monitor how staff feel about their day is an interesting idea. Action being taken to help staff feel more confident in speaking up about bullying and harassment (such as the appointment of a freedom to speak up guardian) and the training and development opportunities available to staff are also welcomed. As these initiatives will be continued into 2018/2019, Members look forward to receiving an update on their impact.

With regard to complaints, it is noted that the deadline for a response to be provided is agreed with the complainant to allow timing negotiations for more complex investigations. However, consideration needs to be given to the length of this deadline as there is a significant difference between Harefield Hospital and Royal Brompton in their achievements. With regard to whether or not the complaint was upheld (fully or in part) also differs significantly between the two hospitals and the Committee is aware that action is being taken to address this.

It is recognised that staying at the forefront of research and innovation is vital to the delivery of the Trust's services. As such, the Trust should be commended on achieving £1.9m in research grant income (exceeding the target by £460k) and £1.6m in commercial funding for clinical trials.

Members note that performance in relation to the Cancer - 62 day Urgent GP referral to first definitive treatment target of 85% has not been met (74.84%) but that the requirements of the improvement trajectory agreed with NHS Improvement have been met. It is also noted that the Trust

has been experiencing some data quality issues but that an action is in place to address the matter. The Committee would like to be updated on this matter at a future meeting.

Overall, the Committee is pleased with the continued progress that the Trust has made over the last year but notes that there are a number of areas where further improvements still need to be made. We look forward to receiving updates on the progress of work to support the priorities outlined in the report over the course of 2018/19.

20th May 2018

Statement from NHS England

Statement from NHS England to Royal Brompton and Harefield foundation trust quality account 2017-2018

NHS England is happy to receive and comment on this year's quality report and see the progress that the trust has made.

Over the year NHS England has enjoyed working in a closer fashion with the Trust, incorporating site visits that offer the opportunity to strengthen this working partnership. We have been pleased to gain a greater understanding of the intricacies of the trusts services and care delivered in different settings.

NHS England had an opportunity to attend the Trust's annual quality improvement competition and it was inspiring to see trust staff demonstrate their ethos of continuous improvement. This has been further demonstrated in the Trust's engagement with CQUIN schemes such as incorporating shared decision making into services, improving severe asthma care and utilising clinical utilisation review.

The Trust have also utilised their CQUIN schemes to demonstrate clinical leadership, increasing quality across London through network working in areas such as arrhythmia management and paediatric networks. The Trust has also worked closely this year with partners within the North West London Sustainability and Transformation Partnerships, working towards improving health and services for the local population.

NHS England recognises that significant efforts have been made this year towards improving the culture within the organisation, offering wellbeing and resilience initiatives for its staff. This year has seen the appointment of a "Freedom to Speak-up Guardian" and an emphasis within the Trust to reduce bullying and harassment as a result of feedback from the staff survey.

Significant improvements within the year include 5 steps to safer surgery initiatives to improve safety, together with scheduling initiatives to reduce cancellations within theatres. The Trust have made efforts to maintain good infection control processes, thus no concerns regarding infection rates during the year have been noted. There has been transparent reporting of incidents within the year and NHS England feels the Trust works hard to continuously identify areas for improvement.

We look forward to continuing to work with the Trust to maintain and improve statutory metric achievements and local priorities that lead to improvements in quality of service provision.
The Trust in addition continues to work towards their aspiration to become recognised as an "outstanding" organisation by the CQC that we applaud and will continue to support.

Michael Marsh - Medical Director
On behalf of NHS England
18 May 2018

Statement from Hillingdon Clinical Commissioning Group

NHS Hillingdon CCG, on behalf of all CCGs in England has welcomed the opportunity to review your Quality Account for 2017/18.

We confirm that we have reviewed the information contained within the Account and it is compliant with the Quality Account guidance for NHS Trusts as set out by the Department of Health and NHS Improvement.

We note the quality improvements the Trust set itself for 2017/18 which were based on previous priorities, areas highlighted by the CQC and where you felt there would be the greatest impact. However, we would like to see the Trust engage with stakeholders when developing future quality priorities.

The priorities are well documented and your progress against these is noted. Where the Trust has not met their target, we look forward to seeing the work undertaken to improve through 2018/19. Particularly, in relation to NEWs compliance, in light of the recent patient safety alert; Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) published on 28th April 2018. We are aware the Trust has incorporated elements of the sepsis 6 bundle into the NEWs charts. However, the CCGs are disappointed by the level of CQUIN achievement in relation to percentage of patients who are identified with suspected or confirmed sepsis receiving antibiotics in an hour (Q4 – 66%). The Trusts plans for 2018/19 in relation to NEWs implementation and monitoring are acknowledged and we look forward to seeing progress against these in the coming months.

There is evidence in the account of the work is doing to address the issues highlighted in the CQC findings from 2016 in relation to the culture and bullying and harassment. We note that patients rate the Trust highly from the numbers of responses to the Friends and Family Test and the low level of formal complaints that the Trust receives.

The performance against the 62 day urgent GP referral to first definitive treatment has not been met (74.8% vs target of 85%). We note the specialist nature of the cases the Trust receives; however, we would like to see the plans the Trust are making in order to improve the timeliness of treatment to these patients. We will monitor this with our specialist commissioning colleagues from NHS England via our monthly clinical quality review group meetings.

The Trust has a strong mortality review process and has been able to embed the learning from deaths guidance. We note the Trust has performed well against the national quality indicators.

We welcome the continuing work the Trust is undertaking to improve the quality of care to the patients and the experience of staff working within the Trust. We look forward to working with the Trust to monitor the progress against the 2017/18 priorities and the improvements set out in your 2018/19 quality priorities.

Diane Jones - Director of Quality & Safety
NHS Brent, Harrow & Hillingdon Clinical Commissioning Groups
21st May 2018

Statement from our Governors

The Council of Governors chose the local indicator, the six week diagnostic wait, for review by the Trust's external auditors, Deloitte LLP. Elections to the Council of Governors were held during April / May 2018 with the results of the elections being declared on 31st May 2018. The Annual General Meeting of the Council of Governors will be held on 25th July 2018 and will consider the report provided by Deloitte LLP on the Trust's Quality Report at this meeting. The membership of the Patient and Quality Working Group of the Council of Governors will be refreshed following the elections and this group will receive updates on the work carried out by the Trust in order to implement the recommendations made by Deloitte LLP.

Glossary

A	
Adult Intensive Care Unit (AICU or ICU)	A special ward for people who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.
Atrial fibrillation (AF)	An abnormal heart rhythm in which the atria, or upper chambers of the heart, "quiver" chaotically and are out of sync with the ventricles, or lower chambers of the heart.
AKI	Acute Kidney Injury.
B	
Biobank	A storage facility used to archive tissue samples for use in research.
Biomedical research unit (BRU)	A nationally recognised and funded unit to provide the NHS with the support and facilities it needs for first-class research.
C	
Cancelled operations	This is a national indicator. It measures the number of elective procedures or operations which are cancelled for administrative reasons e.g. lack of time, staffing, equipment etc.
Cardiac surgery	Heart surgery.
Cardiac valve procedures	A type of heart surgery, where one or more damaged heart valves are repaired or replaced.
Cardiomyopathy	Disease of the heart muscle.
Care Quality Commission (CQC)	The independent regulator of health and social care in England. www.cqc.org.uk
Chronic Obstructive Pulmonary Disease (COPD)	Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.
Clostridium difficile infection	A type of infection that can be fatal. There is a national indicator to measure the number of *C. difficile* infections which occur in hospital.
Commissioning for Quality and Innovation (CQUIN)	A payment framework enabling commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

Coronary artery bypass graft (CABG)	A type of heart surgery where the blocked or narrowed arteries supplying the heart are replaced with veins taken from another part of the patient's body.
CoG	Council of Governors. The council of governors exists to represent the views of foundation trust members, to hold the board of directors to account, and advise on the Trust's future direction. The governors are elected by our foundation trust members which currently stands at approximately 10,000 made up of patients, carers, the public and staff. All Trust members are eligible to stand for election
D	
Department of Health (DH)	The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk
Duty of Candour (DoC)	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
DATIX	Datix is an information system used by the Trust to enable incident reports to be submitted from clinical and non-clinical areas, greatly improving rates of reporting & promoting ownership of risk. The system utilises an online incident reporting form that has been designed in consultation with the Trust so that it is simple to use and suitable for both clinical and non-clinical incident reporting. Incidents can be submitted by anyone in your organisation with access to a computer.
E	
Eighteen (18) week wait	A national target to ensure that no patient waits more than 18 weeks from GP referral to treatment. It is designed to improve patients' experience of the NHS, delivering quality care without unnecessary delays.
ECMO	Extracorporeal membrane oxygenation (ECMO) is a technique of providing both cardiac and respiratory support oxygen to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function.
Elective operation/procedure	A planned operation or procedure. It is usually a lower risk procedure, as the patient and staff have time to prepare.
Emergency	An unplanned operation or procedure that must occur quickly as the patient

operation/procedure	is deteriorating. Usually associated with higher risk, as the patient is often acutely unwell.
Expected death	An anticipated patient death caused by a known medical condition or illness.
F	
Foundation trust (FT)	NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Royal Brompton & Harefield became a Foundation Trust on 1st June 2009.
(FFT) Friends & family Test	A questionnaire that service users and carers are asked to complete on discharge and within 48 hours of discharge about their experience of the care they have received and whether they would recommend the organisation to others. In addition, staff are asked to complete the questionnaire about whether they would recommend the organisation to others and be happy to receive care by the organisation.
G	
Governors	Royal Brompton & Harefield NHS Foundation Trust has a council of governors. Most governors are elected by the Trust's members but there are also appointed governors. http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/
H	
Hospital episode statistics (HES)	The national statistical data warehouse for the NHS in England. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations.
Healthwatch (Formally LINks)	Healthwatch are made up of individuals and community groups working together to improve health and social care services. http://www.healthwatch.co.uk/
Hospital standardised mortality ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares trusts against a national average.
I	
Indicator	A measure that determines whether the goal or an element of the goal has been achieved.
Inpatient	A patient who is admitted to a ward and staying in the hospital.
Inpatient survey	An annual, national survey of the experiences of patients who have stayed in

	hospital. All NHS trusts are required to participate.
K	
KDIGO	Kidney Disease: Improving Global Outcomes. A global organization developing and implementing evidence based clinical practice guidelines in kidney disease. It is an independent volunteer-led self-managed charity incorporated in Belgium accountable to the public and the patients it serves.
L	
Local clinical audit	A type of quality improvement project involving individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team.
Local Authority Scrutiny Committee	These look at the question of health care delivery and act as a 'critical friend' by suggesting ways that health-related services might be improved. They also look at the way the health service interacts with social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to meet the diverse needs of the area.
M	
MINAP	**M**yocardial **I**schaemia **N**ational **A**udit **P**roject. A national registry of patients admitted in England and Wales who have had a heart attack or have severe angina and need urgent treatment.
Multidisciplinary team meeting (MDT)	a meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients.
Multi-resistant staphylococcus aureus (MRSA)	A type of infection that can be fatal. There is a national indicator to measure the number of MRSA infections that occurs in hospitals.
MHRA	The **M**edicines and **H**ealthcare products **R**egulatory **A**gency regulates medicines, medical devices and blood components for transfusion in the UK.

N	
National clinical audit	A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and all NHS trusts are expected to participate in the national audit programme.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death (NCEPOD). NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. http://www.ncepod.org.uk/
National Institute for Health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. http://www.nice.org.uk/
National Early Warning Score (NEWS)	National Early Warning Score – a score that indicates deteriorating physical condition of the patient and a trigger for escalation taken from patient clinical observations such as pulse, blood pressure, oxygen levels, temperature and urine output.
Never events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Trusts are required to report nationally if a never event does occur.
NHS Improvement	NHS Improvement brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. NHS Improvement is an operational name for the organisation which formally comes into being on 1 April 2016.
NHS number	A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
NICOR - National Institute for Cardiovascular Outcomes Research	NICOR is part of the Centre for Cardiovascular Preventions and Outcomes at University College London.
NED	Non-Executive Director. A member of the Trust board of directors who does not form part of the **executive** management team, who act in an advisory capacity only.

O	
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but is not admitted to a ward and is not staying in the hospital.
Outpatient survey	An annual, national survey of the experiences of patients who have been an outpatient. All NHS trusts are required to participate.
P	
PAS – Patient Administration System	The system used across the Trust to electronically record patient information e.g. contact details, appointments, admissions.
Patient record	A single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information.
Paediatric Intensive Care Unit (PICU)	A special ward for children who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.
Pressure ulcers	Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients than in people who are fit and well, as patients are often not able to move about as normal.
Primary coronary intervention (PCI)	Often known as coronary angioplasty or simply angioplasty. A procedure used to treat the narrowed coronary arteries of the heart found in patients who have a heart attack or have angina.
Priorities for improvement	There is a national requirement for trusts to select three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and patient outcomes.
Paediatric early Warning Score (PEWS)	A modified paediatric early warning score to trigger alerting of physical deterioration in a similar manner to the NEWS.
R	
Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge.
Risk Assessment framework	The Risk Assessment Framework sets out the approach used by NHS Improvement prior to the Single Oversight Framework to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.
RRT	Renal replacement therapy.
RTT	Referral to treatment.

S	
Safeguarding	Safeguarding is a new term which is broader than 'child protection' as it also includes prevention. It is also applied to vulnerable adults.
Secondary uses service (SUS)	A national NHS database of activity in trusts, used for performance monitoring, reconciliation and payments.
Serious Incidents	An incident requiring investigation that results in one of the following: • Unexpected or avoidable death • Serious harm • Prevents an organisation's ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern • Never events
Surgical Site Infection	An infection that develops in a wound created by having an operation.
Single sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender.
Society of Cardiothoracic Surgeons (SCTS)	http://www.scts.org/
Standard contract	The annual contract between commissioners and the Trust. The contract supports the NHS Operating Framework.
SSKIN	**SSKIN** is a five step model for pressure ulcer prevention: **Surface**: make sure your patients have the right support. **Skin inspection**: early inspection means early detection. Show patients & carers what to look for.
T	
TAVI	Transcatheter aortic valve implantation (**TAVI**) is a non-surgical alternative to open heart surgery. **TAVI** is carried out in a cardiac catheterisation laboratory, also known as a cath lab, and normally takes one to two hours to complete.