# M12 Clinical Quality Report

## Introduction

This report details the Trust's M12 2018/19 position against key quality and performance measures.

The report also provides an overview on initiatives happening across the Trust to maintain high standards of clinical care with a focus on patient experience.

The report continues to be structured around the five Care Quality Commission (CQC) domains:

- Safe — Protecting patients from abuse and avoidable harm;
- Effective — Ensuring care, treatment and support achieves good outcomes, helps patients to maintain quality of life and is based on the best available evidence;
- Caring — Staff involve and treat patients with compassion, kindness, dignity and respect;
- Responsive — Services are organised so that they meet patient needs.
- Well led — The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around a patient's individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

## Section 1: Safe

### 1.1 Infection Prevention and Control

#### HCAI mandatory surveillance

The Trust continues to comply with the Public Health England Mandatory surveillance programme which requires reporting of incidence of the following infections:

- MRSA (meticillin-resistant Staphylococcus aureus)
- MSSA (methicillin-susceptible Staphylococcus aureus)
- Gram negative bacteraemia
- Clostridium difficile infection surveillance.

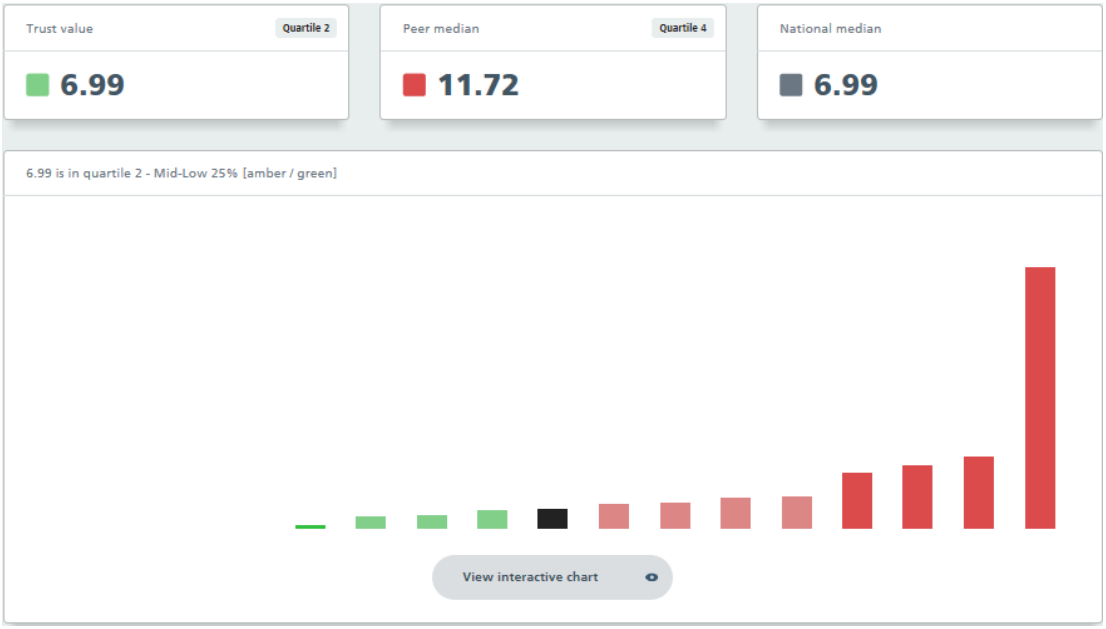
The table below shows M12 infection occurrence reported within the surveillance programme.

| | Total reported to PHE | Hospital onset | Year to date reported to PHE | Year to date total hospital-onset | Lapses in care confirmed |
|---|---|---|---|---|---|
| C. difficile | 0 | 0 | 12 | 7 | **0** |
| MRSA Blood Stream Infection (BSI) | 0 | 0 | 2 | 2 | |
| MSSA BSI | 3 | 3 | 15 | 12 | |
| E. coli BSI | 1 | 1 | 25 | 20 | |
| Klebsiella species BSI | 1 | 1 | 27 | 25 | |
| Pseudomonas BSI | 2 | 2 | 9 | 7 | |

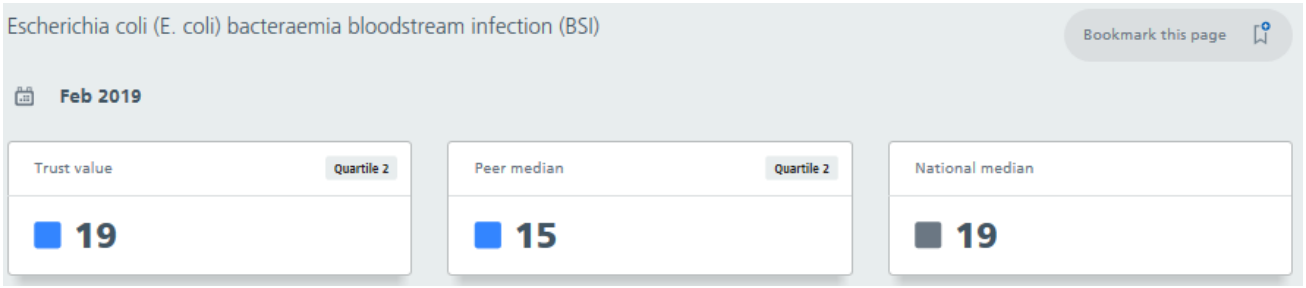
Benchmarking the Trust's infection rates is often challenging due to availability of appropriate and timely national data. The NHS Improvement Model Hospital does incorporate a rolling 12 month count of trust-apportioned (now known as hospital acquired) C. difficile infections in patients aged 2 years and over per 100,000 bed days.

However, given the complexity of each case, this data does not provide a basis for decisions on the clinical effectiveness of infection control interventions in individual Trusts.

The graph below shows a rolling 12 month count of Trust apportioned (hospital acquired) C. difficile infections in patients aged 2 years and over per 100,000 bed days up to January 2019 and indicates that the Trust's value is level with the national median value. The peer group included in this data set consists of Royal Papworth Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust.




Similar information is available for Trust apportioned (hospital acquired) MSSA infections and E. coli blood stream infections, shown below. The peer group remains the same.


**Influenza**

Cases of influenza are now decreasing, in line with the national picture as reported by the UK Severe Influenza Surveillance System (USISS).

**MRSA Post Infection Review (PIR)**

As reported in the M11 clinical quality report, one incidence of MRSA bacteraemia was confirmed during this period. The post infection review identified several possible sources of infection, all of which related to clinical device insertion through the skin. It was however not possible to trace the particular puncture site that was responsible for the infection, or whether this occurred at this Trust or the referring hospital. The clinical teams have been reminded about the importance of adequate skin preparation and accurately record skin preparation procedures in the clinical records.

## 1.2 Incident management and reporting

**Serious incidents and Never Events**

The divisional quality leads have confirmed that no serious incidents were reported during M12.

The Risk and Safety Committee continues to have oversight of serious incidents and receives updates on learning and subsequent actions resulting from the investigation of serious incidents. This includes the following actions from recently concluded investigations:

- NEWS2 observation chart has been implemented across the Trust which now captures any confusion experienced by patients
- The nursing transfer letter template is being reviewed with a plan to include observations recorded and medications given prior to transfer. Copies of the NEWS chart and drug charts will also be included with the transfer letter
- A review of scheduling and anaesthetist allocation for CT based procedures is underway in order to aligned with theatre / cardiac catheterization laboratory (CCL) based procedures to ensure appropriate clinical prioritisation
- The falls policy has been updated to include details on the use of care bundles and the escalation of care post-fall

**Duty of Candour**

The divisional quality teams have full oversight of local compliance with statutory Duty of Candour requirements and each stage of the Duty of Candour requirements is closely monitored, ensuring that each requirement is met.

There is no national benchmarking data available for Duty of Candour however, as the table below shows, the Trust is compliant with statutory requirements. It is important to note that Stage 2 of the Duty of Candour process cannot be completed until the incident investigation has concluded. Due to the nature of incidents, some investigations do take longer than others.

The figures in the table below were correct at the time of writing.

| | Red and amber incidents declared | | | | | |
|---|---|---|---|---|---|---|
| | Moderate harm (amber) | Severe harm (Red) | Total with stage 1 complete | *Total with stage 2 complete | *Total with both stages complete | *Percentage fully compliant |
| Apr-18 | 5 | 0 | 5 | 5 | 5 | 100% |
| May-18 | 9 | 0 | 9 | 9 | 9 | 100% |
| Jun-18 | 4 | 0 | 4 | 4 | 4 | 100% |
| Jul-18 | 6 | 1 | 7 | 7 | 7 | 100% |
| Aug-18 | 7 | 0 | 7 | 7 | 7 | 100% |
| Sep-18 | 6 | 0 | 6 | 6 | 6 | 100% |
| Oct-18 | 5 | 0 | 5 | 5 | 5 | 100% |
| Nov-18 | 4 | 1 | 5 | 4 | 4 | 80% |
| Dec-18 | 1 | 0 | 1 | 1 | 1 | 100% |
| Jan-19 | 5 | 0 | 5 | 5 | 5 | 100% |
| Feb-19 | 1 | 0 | 1 | 1 | 1 | 100% |
| Mar-19 | 3 | 0 | 3 | 0 | 0 | 0% |
| Cumulative Total | **56** | **2** | **58** | **54** | **54** | 93% |

### 1.3 Nurse safe staffing

**The lead nurses and senior matrons have confirmed that**

**safe staffing levels were maintained throughout M12.**

The lead nurses have confirmed that where staffing levels were lower than planned this was primarily due to reduced clinical activity or reduced acuity of patients. The senior nurses confirm that no red flags, as per NICE red flag definitions, were triggered.

Where staffing levels were higher than planned this was due to higher clinical activity, higher acuity of patients or supernumerary staff such as new starters receiving orientation/training.

The Trust continues to review the Care Hours Per Patient Day (CHPPD) data, which includes information about patient activity along-side nurse staffing. The matrons are considering how to provide an 'acceptable range' for each area to help identify red flags generated by the CHPPD data.

### 1.4 NHS Safety Thermometer

The Trust continues to submit data to the national NHS Safety Thermometer programme. This is just one tool used by the Trust to measure harm free care and is used alongside other measures to help understand themes, analyse findings and plan improvements in care delivery. Safety Thermometer is a snapshot of care across the Trust at a given time, on a given day.

Using Safety Thermometer, the care of 323 patients was audited during M12. A summary of the results of this snapshot audit is shown below:

| Harms | Number of patients | % | National % |
|---|---|---|---|
| All Pressure Ulcers | 4 | 1.2% | 4.6% |
| Falls with Harm | 0 | 0% | 1.5% |
| Catheter & UTI | 1 | 0.3% | 0.6% |
| New VTE | 4 | 1.2% | 0.6% |
| Harm Free | 315 | 97.5% | 93.9% |

As the table above shows, the percentage of harm free care in M12 was above the national rate with 315 (97.5%) of the 323 patients recorded as experiencing harm free care. This compared with a national rate of 94.3% of harm free care.

The incidence of a new Venous Thrombo-Embolism (VTE) in this snapshot audit does exceed the national average. However, as reported in the previous VTE annual report, the clinical complexity of the patients treated at the Trust is associated with major risk factors for both thrombosis and bleeding. Each new incidence of VTE is reviewed and the number of VTE events considered preventable remains small.

NB: The NHS Safety Thermometer asks whether or not a patient is being clinically treated for VTE of any type. A patient may be defined as having a new VTE if they are being treated for a deep vein thrombosis (DVT), pulmonary embolism (PE) or any other recognised type of VTE with appropriate therapy such as anticoagulants.

### 1.5 Ionising Radiation (Medical Exposure)

The radiology service managers confirm that no incidents of exposure to ionising radiation were reported to the CQC during M12.

## Section 2: Effective

### 2.1 National Clinical Audits

Three national clinical audit reports, published in 2018-19, were relevant to the services provided by the Trust. These are:

**The National Audit of Lung Cancer Clinical Outcomes Publication (LCCOP)**

This is a joint study by the Royal college of Physicians (RCP) and The Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS). LCCOP is an NHS England initiative, commissioned by the Healthcare Quality Improvement Partnership (HQIP), to publish quality measures at unit level and at the level of individual consultant doctors, using national clinical audit and administrative data. The aims of publishing these results are to:

- reassure patients that the quality of clinical care is high
- assist patients in having an informed conversation with their consultant, GP or healthcare professional about the procedure or operation that they may have
- provide information to individuals, teams and organisations to allow them to monitor and improve the quality of the clinical care that they provide locally and nationally
- inform the commissioning of NHS lung cancer services.

The latest LCCOP report disseminates results on the outcomes of lung cancer surgery for patients who had operations between 1 January and 31 December 2016.

In addition to publishing the number of operations performed by hospitals and by individual consultant surgeons, the following outcomes are reported:

- the proportion of patients who survive at 30 days, 90 days and 1 year after their operation for each unit
- the median length of stay in hospital following an operation
- the proportion of patients who were readmitted within 90 days of hospital discharge
- the pooled resection rates for the lung cancer team meetings (MDTs) which a surgical unit serves.

The survival results have been adjusted to take into account the patient case-mix, which may affect the outcome of the operation. For example, the age and fitness of a patient before surgery affects the risk that they will face from undergoing surgery.

The report details that the Trust had the third highest volume of procedures at 402 in 2016 and survival rate at 30 days, 90 days and 1 year were well within the confidence limits. All of which indicates positive outcomes for patients undergoing surgery at the Trust.

The Trust's resection rate was 18.6% which was slightly above the average for all Trusts of 17.5%. This indicates that we have a higher percentage of curative lung cancer surgery, as would be expected of a specialist centre.

The area of focus for the Trust was the median Length of Stay (LoS) of 7 days, which was joint second longest length of stay within the study. It is anticipated that the work being undertaken on introducing Day of Surgery Admissions (DOSA) will to help to address this.

**Acute Heart Failure – failure to function**

This national study looks at care for patients admitted to hospital with acute heart failure.

The Head of Quality has confirmed a full dataset was submitted to this study in 2017. The quality team is currently working with clinical teams to consider improvements required as a result of these national recommendations. The key recommendations made in the report are shown below:

- Patients need better access to heart failure specialists. Our patients already have access to a highly skilled heart failure specialist team on both sites. However, we are looking at how we can further improve our working relationship with referring hospitals to better support a wider group of patients.
- There should be improvement in the investigation of these patients; especially in the use of a diagnostic test called serum natriuretic peptide measurement and in the use echocardiogram. We already routinely use both these investigations for patients under our care.
- Patients with advanced heart failure should have access to a specialist, multi-disciplinary palliative care team. We already provide this routinely; but are looking at whether we can do more to support patients and their families at an earlier stage of their disease pathway.

**Perioperative Diabetes – High and Lows**

This study looks at the management of with patients with diabetes from referral to surgery (elective) or admission to hospital (emergency) to discharge from hospital.

The Head of Quality has confirmed a full dataset was submitted to this study in 2017. The quality team is currently working with clinical teams to consider improvements required as a result of these national recommendations. The key recommendations made in the report are shown below:

- Organisations need to provide better continuity of care for patients with diabetes who undergo surgery. We are looking at whether we can improve our planning and management for patients with diabetes who require surgery by developing a care plan for them as part of their surgery pre-assessment.
- The management plan for a patient with diabetes undergoing surgery should include their prioritisation on the operating list. A review of this will be built into a Darwin project for 2019-20 looking at optimising the surgical pathways. Timescales for this project and achievements will be reported through Darwin project reports.
- Patients with diabetes undergoing surgery should have more regular monitoring of their blood glucose. We believe we already provide a high level of monitoring of blood glucose for patients with diabetes requiring surgery – in the pre, peri and post-operative phases. However, as a result of this study, we will look again at this area, to see if further improvement can be made.

## Section 3: Caring

### 3.1 Patient Experience monthly update

| M12 | |
|---|---|
| 1161 responses of 2995 eligible patients | All comments 831 |
| Trust FFT Response Rate – 38.8% | Positive Comments – 773 (93%) |
| Trust Recommendation score for FFT – 96% | Negative Comments – 18 (2.2%) |
| Negative Response: 1% | |

Staff continue to encourage patients to respond to Friends and Family Test (FFT): as a result of this work, we are achieving above the mandated 30% response rate. The outpatient response rate continues to increase across both hospitals with 1460 responses in March, of which 96% (1,408) were rated positively.

### 3.2 Complaints

The Trust received 11 new complaints in M12. 5 of these complaints relate to Harefield Hospital and 6 relate to Royal Brompton Hospital. 10 of these complaints were acknowledged within 3 working days.

Eight complaints were closed in M12 which included 2 re-opened complaint from previous quarters.

### 3.3 Trust Initiatives

The rb&hArts team have completed a pilot of a new virtual reality programme designed to help patients with mobility issues experience the arts.

The pilot, which saw patients 'step' into virtual reality worlds to produce virtual artwork, was found to support patient wellbeing and increase confidence. Feedback included: "It made me happier," "it would make a huge difference to people in hospital" and that they were "no longer anxious about using technology or virtual reality."

The idea came after conversations with SDNA, a cutting-edge digital art agency. They had previously collaborated with the arts team in 2016 to create a moving 'botanical mandala' – a spiritual and ritual symbol in Hinduism and Buddhism, representing the universe – for Harefield's theatres reception.

Initial sessions were held with patients during the arts team's 'Silver Sunday' event as part of the national day to celebrate and support older people, and with respiratory patients in Singing for Breathing sessions both at Harefield's local library and Victoria ward at Royal Brompton Hospital.

Wearing a headset, participants were able to use ergonomic controllers to 'paint' around a selection of virtual environments, such as outer space, or under the sea. Once the group members were accustomed to the software, they collaborated on a group artwork within the same environment.

The team then partnered with Open Age, a local charity that focuses on enabling the over-50s to sustain active lifestyles and develop new interests. Additional sessions were held in North Kensington for the local community, and in Harefield's Rowan ward for transplant patients.

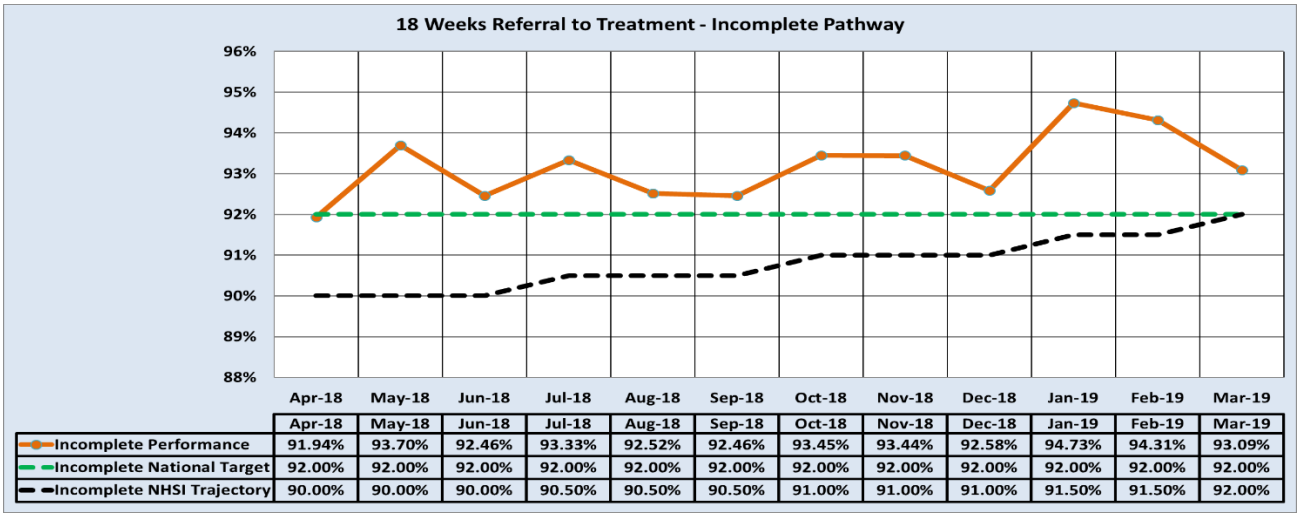
The project was brought to life thanks to funding from the Royal Borough of Kensington and Chelsea's 'Arts Grant Scheme' and Hillingdon Arts.

## Section 4: Responsive

## 4.1 18-week Referral to Treatment Time Targets

### Performance against the NHS Improvement Trajectory

The graph below presents that Trust's year to date position against the 18-week Referral to Treatment (RTT) performance measure. The M12 performance is 93.09%, exceeding the national threshold of 92% for RTT and the Trust threshold of 92.00% agreed with NHSI during the annual activity planning exercise.




| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incomplete Performance | 91.94% | 93.70% | 92.46% | 93.33% | 92.52% | 92.46% | 93.45% | 93.44% | 92.58% | 94.73% | 94.31% | 93.09% |
| Incomplete National Target | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% |
| Incomplete NHSI Trajectory | 90.00% | 90.00% | 90.00% | 90.50% | 90.50% | 90.50% | 91.00% | 91.00% | 91.00% | 91.50% | 91.50% | 92.00% |

### 18 weeks RTT by National Specialty – Incomplete Pathways March 2019

| National Specialty | Specialty | Incomplete | | | |
|---|---|---|---|---|---|
| | | < 18w | >= 18W | Total | % < 18w |
| Cardiology | Cardiology (Brompton) | 700 | 28 | 728 | 96.15% |
| | Cardiology (Harefield) | 1,058 | 147 | 1,205 | 87.80% |
| **Cardiology** | | **1,758** | **175** | **1,933** | **90.95%** |
| **Thoracic Medicine** | | **1,900** | **38** | **1,938** | **98.04%** |
| Cardiothoracic Surgery | Cardiac Surgery (Brompton) | 205 | 56 | 261 | 78.54% |
| | Cardiac Surgery (Harefield) | 189 | 42 | 231 | 81.82% |
| | Thoracic Surgery | 225 | 2 | 227 | 99.12% |
| **Cardiothoracic Surgery** | | **619** | **100** | **719** | **86.09%** |
| Other | Other | 103 | 5 | 108 | 95.37% |
| | Paediatrics | 623 | 45 | 668 | 93.26% |
| | Transplant | 35 | 11 | 46 | 76.09% |
| **Other** | | **761** | **61** | **822** | **92.57%** |
| | | **5,038** | **374** | **5,412** | **93.09%** |

As shown in the table below, during M12 one patient pathway continued to breach the 52-week target. This breach occurred in the Inherited Cardiac Conditions service at Harefield Hospital and has been investigated by the Hospital Director. After several cancelled clinic appointments by the patient, this patient attended an outpatient on March 1st, 2019 (week 58). The patient requires further diagnostic tests and a follow-up clinic appointment and, therefore, the 52-week pathway breach will continue to be recorded in coming months.

| M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Apr-18** | **May-18** | **Jun-18** | **Jul-18** | **Aug-18** | **Sep-18** | **Oct-18** | **Nov-18** | **Dec-18** | **Jan-19** | **Feb-19** | **Mar-19** |
| No breach reported | No breach reported | Patient A -X24-NHS England | Patient C - X24-NHS England | Patient C - X24-NHS England | Patient C - X24-NHS England | Patient C - X24-NHS England | No Breach | No Breach | Patient D - 8G - NHS Hillingdon CCG | Patient D - 8G - NHS Hillingdon CCG | Patient D - 8G - NHS Hillingdon CCG |
| | | Patient B -8G - NHS Hillingdon CCG | Patient B -8G - NHS Hillingdon CCG | Patient B -8G - NHS Hillingdon CCG | | | | | | | |

## 4.2 Cancer Targets

### 62 Day Urgent GP referral breaches

Three patient pathways breached the 62-day target during M11. As the table below shows, one of these patients was treated by the Trust within the Trust's 24-day referral to treatment window and is therefore not included in this exception report.

The remaining two pathway breaches are shown below:

Patient 1: Complex diagnostic pathway. Patient had to undergo ENT test before undergoing surgery at point of referral - this caused a delay in the pathway as was over Christmas period. Patient had surgery and was discharged home.

Patient 2: Complex diagnostic pathway. Patient had to undergo several diagnostic tests before being considered for surgery and was found to have a new pathology which required further review before surgery could go ahead. Patient had surgery and was discharged home.

| Referring Trust & Hospital | Day Referral Received by RBHFT | No. of days from receipt of referral at RBHFT to treatment | No. of days from GP referral to treatment |
|---|---|---|---|
| West Hertfordshire Hospitals NHS Trust Watford General Hospital - Rwg02 | 67 | 30 | 97 |
| West Hertfordshire Hospitals NHS Trust Watford General Hospital - Rwg02 | 70 | 37 | 107 |
| Milton Keynes Hospital NHS Foundation Trust Milton Keynes Hospital - Rd816 | 50 | **19** | 69 |

### Cancer Target – 31-day decision to treat to first definitive treatment:

No breaches

### Cancer Target – 31-day decision to treat to subsequent treatment

One patient pathway breached the 31-day decision to treat to subsequent treatment target during M11 and this was due to patient choice. The patient was offered a date within time however failed to attend. A new date was then agreed with the patient however, there are no options to add in a pause to this pathway. Patient had surgery and was discharged home.

### 4.3 Cancelled operations

**Urgent operations cancelled for a second time (E.B.S.6)**

No patients had an urgent operation cancelled for a 2nd time or more during M12.

**Cancelled Operations - E.B.S.2**

**Detail of Numerator – Cancelled Operations (28-day rescheduled bookings)**

**Numerator:** Number of operations and procedures not rescheduled and carried out within 28 days.

During M12 one patient had their operation cancelled and did not have their operation rescheduled within 28-days.

Due to AICU bed pressures the Lung Volume Reduction Surgery (LVRS) was temporarily suspended which resulted in the cancellation of this patient's surgery and prevented the operation from being rescheduled within 28-days

**Cancelled Operations**

**Detail of Denominator – Cancelled Operations and procedures**

**Denominator:** The number of patients whose operation was cancelled at the last minute by the hospital, for non-clinical reasons.

There were 58 patients whose operation or procedure was cancelled in M12.

## Section 5: Well led

### 5.1 National lung cancer optimal pathway

In the summer of 2017 Professor Chris Harrison, NHS England's National Clinical Director for Cancer, issued guidance on a new diagnostic and treatment pathway. All NHS trusts are required to work towards fully implementing the new pathway 2020.

The aim of the new pathway is to ensure that all patients undergo the necessary diagnostic tests and have a definitive diagnosis within 28 days of referral from their GP. Following this, the organisation providing treatment has 24 days with which to then offer an outpatient appointment and a curative treatment.

We have been working towards achieving the treatment target of 24 days since 2016/17 because we believe that our patients should not wait longer than necessary for their surgery. We have also been shadow reporting against this performance metric in anticipation of the full implementation of the National Lung Cancer Optimal Pathway.

We are pleased to confirm that in 2018/19, from April to December, the average time from referral to RBH to surgery was 24 days.

The national lung cancer optimal pathway team are working with GPs and acute trusts to improve referral times, in order to reduce the overall waiting time for lung cancer treatment. In order to help improve earlier referral times to us, we will continue to work those hospitals who refer patients to us.

### 5.2 Staff learning management system

The new learning management system, Learn Now, has been launched across the Trust. It has a modern look and feel, with direct links to training held on Health Education England's website and a

layout that makes navigation quick and easy. Teams can also track and record their learning activity in real time – with no need to rely on locally held records – and upload learning evidence simply and quickly.

The first phase of *Learn Now* launches with mandatory and statutory training but is part of a much larger project to transform the way staff record learning and skills development. All mandatory learning, leadership and skills development programmes will eventually be accessible in one place, on a system that can be tailored to each person's learning needs.

### 5.3 ELSO Award for Excellence in Life Support

The Trust's ECMO (Extracorporeal Membrane Oxygenation) services have been praised at the international Extracorporeal Life Support Organisation (ELSO) awards for Excellence in Life Support. Harefield Hospital ECMO service received the silver award and Royal Brompton Hospital ECMO service has achieved the prestigious platinum award. Both awards recognise excellence and the platinum certification is the highest distinction given by ELSO, with Royal Brompton the only commissioned centre in England to achieve it.

To achieve this award, centres must be experienced in patient care with established policies and procedures, as well as demonstrating that they go above and beyond expectations.

A comprehensive, in-depth training and education process, as well as a defined family education program is required. In addition, to gain this award centers must incorporate highly developed quality initiatives and continuously review processes within their program. Outcome reviews must be demonstrated as an integral component of their organisation.

The application for the ward was divided into seven sections:

1. **Systems Focus** – the ECLS Centre provides generalised information about your institution
2. **Environmental Focus** – the Centre provides information about the facility and equipment available for ECLS
3. **Workforce Focus** – the Centre describes the personnel caring for the patient
4. **Knowledge Management** – the Centre provides information on the ECLS Team training and competencies
5. **Quality Focus** – the Centre provides evidence regarding continuous quality improvement activities
6. **Process Optimization** – the Centre provides information concerning outcome reviews and developmentally focused care
7. **Patient & Family Focus** – the Centre describes the family education and participation in care

The Award Ceremony will be held on Thursday April 11th, 2019 in Barcelona.

## Section 6: Operational Performance Metrics and Quality Indicators

### Month 12 2018/19 – period ending 28th February 2019

| NHS Improvement - Single Oversight Framework | | | | | | |
|---|---|---|---|---|---|---|
| Indicator | Total Reported to PHE M12 | Hospital onset confirmed M12 | Total Reported to PHE M12 YTD | Hospital onset confirmed M12 YTD | Target / Trajectory | Variance from Target / Trajectory M12 Position |
| **Clostridium difficile** | 0 | 0 | 12 | 7 | Lapses in care = 0 M10 YTD; Performance Standard Dept. Health Trajectory = 23 | -11 Met |
| **MRSA Bacteraemia** | 0 | 0 | 2 | 2 | Zero tolerance | Not met for M12 |
| **E coli** | 1 | 1 | 25 | 20 | *No Standard Set* | |
| **MSSA** | 3 | 3 | 15 | 2 | *No Standard Set* | |

| Indicator | M12 | M12 Target | Variance from Target / Trajectory M12 Position |
|---|---|---|---|
| **18 weeks RTT Incomplete** | 93.09% | 92% | Target met for M12 |
| **Number of diagnostic tests waiting 6 weeks+ (%)** | 0 | 1% | Target met for M12 |
| ***Cancer - 62-day Urgent GP referral to first definitive treatment – with breach allocations** | 57% treated in time See page 9 of report | M11 Trajectory = 72.00% | Trajectory not met for M11 |
| **VTE Risk assessments** | Q4 = 97.66% | 95% | Target met for Q4 18/19 |
| **Never Events** | M12 0 / YTD M12 1 | Zero tolerance | Zero breaches for M12 |

| NHS England - NHS Standard Contract | | | |
|---|---|---|---|
| **Urgent operations cancelled for the 2nd time** | 0 | Zero tolerance | 0 breaches for M12 |
| **Cancelled Operations; not carried out within 28 days (Theatres & Bronchoscopy)** | 1 | Zero tolerance of no readmission within 28 days | 1 breach for M12 |
| **Cancelled Procedures; (Catheter Labs); not carried out within 28 days** | 0 | Zero tolerance of no readmission within 28 days | Zero breaches for M12 |
| **52 week breaches** | 1 | Zero tolerance | 1 breach for M12 |
| ***Cancer – 14 day Urgent GP Referral** | 100% | 93% | Target met for M11 |
| ***Cancer – 31 day 1st treatment** | 100% | 96% | Target met for M11 |
| ***Cancer – 31 day subsequent treatment** | 14 patients - 1 breach 93% | 94% | Target not met for M11 |

| Incidents | | |
|---|---|---|
| | 18/19 M12 | 18/19 YTD Incidents at M12 |
| **Outbreaks of Infection** | 0 | 0 |
| **Serious Incidents** | 0 | 12 |

** Cancer Performance is based on published NHS Digital data and is reported a month in arrears on this report*

## Cancelled operation performance metrics

| Numerator | Number of breaches of the pledge to offer another binding date within 28 days | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area/Site | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Q1 | Q2 | Q3 | Q4 | 18/19 YTD |
| Theatres (inc Bronchoscopy) | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 1 | 1 | 2 | 0 | 6 | 9 |
| Catheter Labs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **RBH Total** | **0** | **0** | **1** | **2** | **0** | **0** | **0** | **0** | **0** | **0** | **5** | **1** | **1** | **2** | **0** | **6** | **9** |
| Theatres (inc Bronchoscopy) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Catheter Labs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **HH Total** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Trustwide** | **0** | **0** | **1** | **2** | **0** | **0** | **0** | **0** | **0** | **0** | **5** | **1** | **1** | **2** | **0** | **6** | **9** |

| Denominator | Cancelled operations and procedures | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area/Site | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Q1 | Q2 | Q3 | Q4 | 18/19 YTD |
| Theatres (inc Bronchoscopy) | 4 | 11 | 19 | 16 | 10 | 14 | 15 | 8 | 9 | 16 | 20 | 15 | 34 | 40 | 32 | 51 | 157 |
| Catheter Labs | 10 | 10 | 12 | 7 | 9 | 8 | 10 | 6 | 6 | 8 | 4 | 8 | 32 | 24 | 22 | 20 | 98 |
| **RB Total** | **14** | **21** | **31** | **23** | **19** | **22** | **25** | **14** | **15** | **24** | **24** | **23** | **66** | **64** | **54** | **71** | **255** |
| Theatres (inc Bronchoscopy) | 18 | 22 | 26 | 24 | 12 | 35 | 34 | 34 | 12 | 19 | 19 | 20 | 66 | 71 | 80 | 58 | 275 |
| Catheter Labs | 7 | 10 | 4 | 6 | 9 | 5 | 14 | 15 | 2 | 5 | 6 | 15 | 21 | 20 | 31 | 26 | 98 |
| **HH Total** | **25** | **32** | **30** | **30** | **21** | **40** | **48** | **49** | **14** | **24** | **25** | **35** | **87** | **91** | **111** | **84** | **373** |
| **Trustwide** | **39** | **53** | **61** | **53** | **40** | **62** | **73** | **63** | **29** | **48** | **49** | **58** | **153** | **155** | **165** | **155** | **628** |

| Performance against indicator E.B.S.2 | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Site | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Q1 | Q2 | Q3 | Q4 | 18/19 YTD |
| RB Total | 0.00% | 0.00% | 3.23% | 8.70% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 20.83% | 4.35% | 1.52% | 3.13% | 0.00% | 8.45% | 3.53% |
| HH Total | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Trustwide | 0.00% | 0.00% | 1.64% | 3.77% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 10.20% | 1.72% | 0.65% | 1.29% | 0 | 3.87% | 1.43% |

## Section 7: Nurse staffing and CHPPD

Below is the national, nurse staffing reporting template, including care hours per patient day (CHPPD) that the Trust is required to report. The Board is advised that this is a snapshot of midnight ward occupancy combined with overall staffing levels.

| Ward name | Day | | | | Night | | | | Care Hours Per Patient Day (CHPPD) | | | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Registered midwives/nurses | | Care Staff | | Registered midwives/nurses | | Care Staff | | Cumulative count over the month of patients at 23:59 each day | Registered midwives/ nurses | Care Staff | Overall | Average fill rate - registered nurses/ midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/ midwives (%) | Average fill rate - care staff (%) |
| | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | | | | | | | | |
| PICU | 6417 | 6382 | 1501 | 587 | 6417 | 5648 | 357 | 190 | 425 | 28.3 | 1.8 | 30.1 | 99.5% | 39.1% | 88.0% | 53.2% |
| Rose | 5348 | 4737 | 1501 | 587 | 5348 | 4041 | 357 | 190 | 869 | 10.1 | 0.9 | 11.0 | 88.6% | 39.1% | 75.6% | 53.2% |
| AICU | 7487 | 7946 | 1302 | 720 | 7487 | 8187 | 341 | 112 | 505 | 31.9 | 1.6 | 33.6 | 106.1% | 55.3% | 109.3% | 32.8% |
| Princess Alexandra | 2604 | 3269 | 1302 | 788 | 1705 | 2530 | 341 | 750 | 936 | 6.2 | 1.6 | 7.8 | 125.5% | 60.5% | 148.4% | 219.9% |
| Elizabeth | 4464 | 4456 | 1302 | 740 | 4092 | 4631 | 341 | 222 | 352 | 25.8 | 2.7 | 28.5 | 99.8% | 56.8% | 113.2% | 65.1% |
| Paul Wood | 2364 | 2895 | 1302 | 747 | 1364 | 1903 | 341 | 255 | 614 | 7.8 | 1.6 | 9.4 | 122.5% | 57.4% | 139.5% | 74.8% |
| Sir Reginald Wilson | 3720 | 2988 | 1302 | 725 | 1705 | 2079 | 341 | 167 | 558 | 9.1 | 1.6 | 10.7 | 80.3% | 55.7% | 121.9% | 49.0% |
| York | 2244 | 1995 | 1302 | 743 | 1705 | 1254 | 341 | 200 | 386 | 8.4 | 2.4 | 10.9 | 88.9% | 57.1% | 73.5% | 58.7% |
| Foulis | 2112 | 2693 | 930 | 443 | 1705 | 1980 | 0 | 0 | 803 | 5.8 | 0.6 | 6.4 | 127.5% | 47.6% | 116.1% | - |
| Victoria | 2232 | 2744 | 473 | 255 | 1364 | 1463 | 308 | 440 | 596 | 7.1 | 1.2 | 8.2 | 122.9% | 53.9% | 107.3% | 142.9% |
| Cedar Ward | 2496 | 2532 | 713 | 725 | 1783 | 1748 | 713 | 644 | 732 | 5.8 | 1.9 | 7.7 | 101.4% | 101.7% | 98.0% | 90.3% |
| Rowan/Fir Tree | 3922 | 4236 | 1178 | 787 | 3069 | 2831 | 714 | 587 | 992 | 7.1 | 1.4 | 8.5 | 108.0% | 66.8% | 92.2% | 82.2% |
| HDU Harefield | 2139 | 2058 | 0 | 0 | 2139 | 1990 | 0 | 0 | 205 | 19.7 | 0.0 | 19.7 | 96.2% | - | 93.0% | - |
| ITU | 8913 | 11357 | 1220.5 | 746 | 8913 | 10091 | 357 | 357 | 731 | 29.3 | 1.5 | 30.8 | 127.4% | 61.1% | 113.2% | 100.0% |
| Maple | 1783 | 1752 | 713 | 615 | 1023 | 1068 | 713 | 621 | 441 | 6.4 | 2.8 | 9.2 | 98.3% | 86.3% | 104.4% | 87.1% |
| Oak/Acom | 5580 | 5055 | 2418 | 1084 | 3751 | 2915 | 682 | 457 | 953 | 8.4 | 1.6 | 10.0 | 90.6% | 44.8% | 77.7% | 67.0% |
| Juniper | 2381 | 2425 | 955 | 749 | 2496 | 2048 | 713 | 356 | 333 | 13.4 | 3.3 | 16.8 | 101.8% | 78.4% | 82.1% | 49.9% |

## Section 9: Patient comments

The Patient and Public Engagement (PPE) team are currently reviewing all Friends and Family Test (FFT) intelligence received during 2018-19 to help inform plan of improvements during 2019-20.

The following comments are submitted by patients who completed the Friends and Family Test during M12.

### Positive comments

Paul Wood Ward: Very polite, helpful informative and explained everything in detail. All day, timings for all my test were spot on. The whole day was very pleasant and easy going {very relaxed} 10/10 outstanding!!! A credit to the hospital.

Radial Lounge: Well, the care and service given to me from the beginning till the end was professional and, I feel better and relieved. Best Hospital and Best staff ever in the country I admire always. God Bless everyone at Royal Brompton & Harefield Hospital.

Princess Alexandra Ward: After having a biopsy air got in and was preventing me from breathing but I cannot fault the care and attention I received so fast from the doctors and nurses. I had a drain put in and had to stay for a couple of days but all the nurses were so friendly and caring. I would recommend The Royal Brompton to everyone.

York Ward: We were just in awe of the hard work, dedication and professionalism from all the staff. Our son who has Downs syndrome had open heart surgery- his care was superb. We were humbled and impressed with everyone. We felt he was in the very best place and are so grateful for his care.

Oak Ward: I've been to many different hospitals and this one has been the best. The nurses were great. The Doctors were brilliant. The guys in surgery were absolutely fantastic that put me at ease as soon as I walked in. The food was excellent always fresh and hot, so big shout-out to the catering staff Personal I think you did a great job and I will recommend you to all my friends NHS GREAT JOB KEEP IT UP Ps thank you Amy (my nurse) xxx

Cherry Tree Ward: Harefield hospital is the best! If I could only use Harefield I would. Everyone is so helpful and caring. Would recommend to anyone | I thought I had! All the hospital staff are so helpful, caring and professional. I don't like going to any other hospital.

Lind Day Case Unit: All the nurses, doctors and consultants that I was involved with were extremely professional, courteous and friendly. They all went out of their way to ensure that I was comfortable, at ease and informed. Cannot fault the excellent treatment.

Victoria Ward: I thought all the staff were excellent. Everyone greeted me with a smile and couldn't do enough for me. The care was like no other hospital. I can't recommend enough. Thank you very much and for looking after me so well. I am sure I will recover more as time goes on; I can't thank you enough.

Foulis Ward: Foulis ward is like a family. You build relationships with every level of staff - consultant, nurse, HCA, cleaner, caterers, physios and psychologists. They care for you as a whole person not just your symptoms.

Acorn Ward: My answer is definitely no 1 my experience at Ivy (?) and Acorn was exceptional. Nurses on both wards wonderful and Helen on Acorn was outstanding. Harefield is a brilliant hospital ...

Maple Ward: The care I have been given by all the staff on Maple Ward was second to none. Nothing too much trouble for any of them, from the cleaners to the doctors. I cannot praise them highly enough.

**Negative comments**

We have received 8 negative comments from patients attending Royal Brompton Hospital as a day case. These comments were about waiting times, the environment and dignity/privacy. These comments have been reviewed and we will be using this feedback to help us improve services for people attending the hospital for day case procedures.