A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Clinical Quality Report
Month 4 and Month 5 2019-20

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Latest headlines from NHSI Model Hospital

Performance	Data period	Trust value	Peer median	Benchmark value	Chart
RTT - max 18 weeks incomplete wait	May 2019	94.04%	91.66%	92.00%	
Diagnostics - max 6 weeks wait	May 2019	99.78%	89.61%	99.00%	
Cancer - 62-day wait from urgent GP referral	May 2019	62.50%	65.38%	85.00%	

Safe	Data period	Trust value	Peer median	National median	Chart
VTE Risk Assessment	Q4 2018/19	97.66%	94.64%	96.11%	
Clostridium Difficile - variance from plan	Mar 2019	-1.0	-0.5	0.0	
Clostridium Difficile - infection rate	To Mar 2019	5.50	9.33	10.84	
MRSA bacteraemias	To Apr 2019	1.57	0.80	0.55	
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Apr 2019	20	18	127	
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Apr 2019	9	15	9	
Never events	31/01/2019	1	1	2	

Caring	Data period	Trust value	Peer median	National median	Chart
Written Complaints Rate	31/03/2019	7.89	8.23	24.46	

Friends and Family Test scores	Data period	Trust value	Peer median	National median	Chart
Staff Friends and Family Test % Recommended - Care	Q1 2018/19	94.7%	87.9%	82.9%	
Inpatient Scores from Friends and Family Test - % positive	May 2019	95.9%	98.3%	96.3%	

To note: The Trust's position on the slider charts is marked by the white oval and the peer median is marked by the diamond
M3 and M4 performance against the 62 day cancer target presented in slides 10-11 of this report
No MRSA bacteraemia has been reported during M1 – M5 2019-20
Where the terms 'my peers' or 'peers' are used in this it relates to Liverpool Heart and Chest NHS Foundation Trust and Royal Papworth Hospital NHS Foundation Trust

Safe: Infection Prevention and Control

Data owner: Lucy Everett – Matron Lead - Infection Prevention and Control and Dr Anne Hall - Consultant Microbiologist & Infection Control Doctor

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

- *Clostridium difficile* infection surveillance
- MRSA (*Meticillin-resistant Staphylococcus aureus*) blood stream infection (BSI)
- MSSA (Methicillin-susceptible *Staphylococcus aureus*) BSI
- *E. coli* BSI
- *Klebsiella species* (BSI)
- *Pseudomonas aeruginosa* BSI

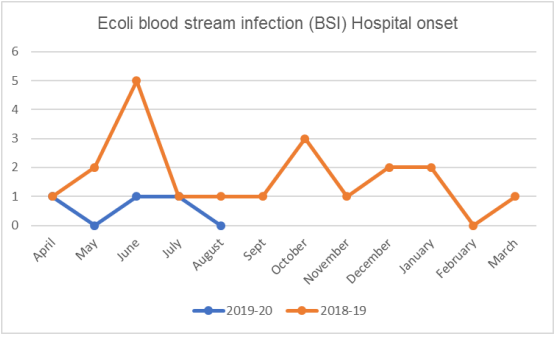
The tables to the right show the M4 – M5 and year to date position for infections within the surveillance programme. Post infection reviews are undertaken on all infections reported and learning is shared across the organisation.

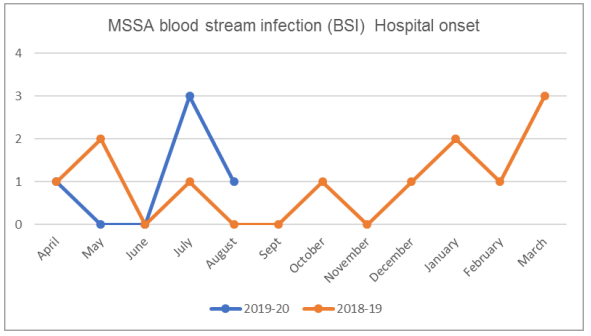
	Total reported to PHE		Hospital onset – healthcare associated		Community onset - healthcare associated		Year to date reported to PHE	Year to date total hospital-onset	Lapses in care confirmed
C.difficile	M4	M5	M4	M5	M4	M5			
	0	2	0	1	1	0	3	2	0

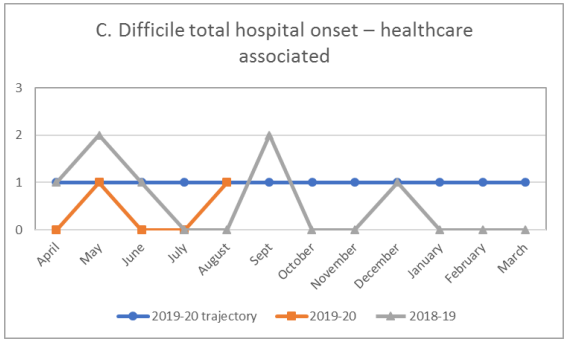
	Total reported to PHE		Hospital onset		Year to date reported to PHE	Year to date total hospital-onset
	M4	M5	M4	M5		
MRSA BSI	0	0	0	0	0	0
MSSA BSI	4	1	3	1	6	5
E. coli BSI	1	1	1	0	5	3
Klebsiella species BSI	1	4	1	3	8	6
Pseudomonas BSI	2	0	2	0	2	2

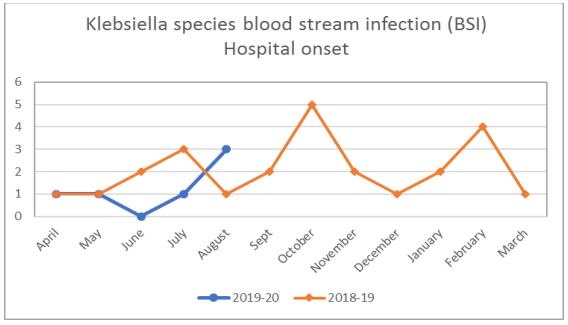
The graphs in this section of the report show the hospital onset infection rates Public Health England Mandatory surveillance programme, alongside 2018-19 hospital onset infection rates for internal benchmarking purposes.

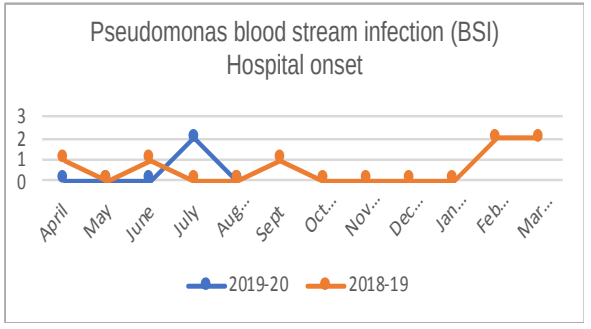
The Matron lead for Infection Prevention and Control and the Consultant Microbiologist & Infection Control Doctor confirm that there were no outbreak of infections or areas of concern to report during M4 and M5.











Safe: Incident management and reporting

Data owner: Penny Mortimer, Manjiri Dalvi and Eleanor Dunnett – Divisional Quality and Safety Leads

Serious incidents

The divisional quality leads have confirmed that no serious incidents were reported during M4 or M5.

Duty of Candour

Year to date**,** a total of 36 incidents have occurred where Duty of Candour regulations apply. As shown in the table to the right, Stage 1 of the Duty of Candour process has been completed for all 36 incidents. Stage 2 of the process is complete for all incidents where investigations have concluded. There are no exceptions to report.

	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-19	3	0	3	3	3	100%
May-19	9	1	10	9	9	90%
Jun-19	9	0	9	8	8	89%
Jul-19	6	0	6	3	3	50%
Aug-19	8	0	8	0	0	0%
Cumulative Total	**35**	**1**	**36**	**23**	**23**	64%

Safe: NHS Safety Thermometer

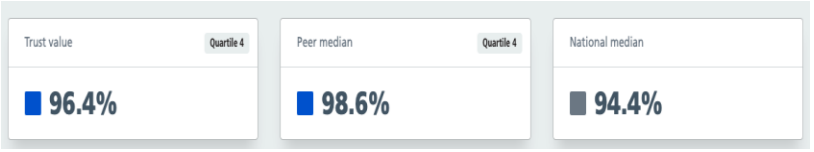
Data owner: Peter Doyle - Divisional Lead Nurse / Associate General Manager, Harefield Hospital

The NHS Safety Thermometer was designed to measure local improvement over time and was not intended to be used to compare specific levels of harm across organisations due to the complexity and variations in patient mix. 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.

NHS Safety Thermometer is presented one month in arrears. The table below shows year to date level of harm free care across the Trust and demonstrates that the level of harm free care is greater than the national average, as recorded using NHS Safety Thermometer.

Month	Number of Patients	Percentage (%)	National benchmark %
M1	295	96.38	93.8
M2	312	94	93.8
M3	251	95.2	93.5
M4	303	96.4	94

The latest national benchmarking included in NHSI Model Hospital is shown below.



Safe: Nurse staffing
Data owner: Peter Doyle - Divisional Lead Nurse / Associate General Manager, Harefield Hospital

Nurse staffing levels are presented one month in arrears to allow adequate time for the lead nurses to review month end intelligence.

M3 Nurse staffing at Royal Brompton Hospital	
% of registered nurse day hours filled as planned (Hospital)	103.7% of planned level
% of Unregistered care staff day hours filled as planned (Hospital)	52.4% of planned level
% of registered nurse night hours filled as planned (Hospital)	100.2% of planned level
% of Unregistered care staff night hours filled as planned (Hospital)	57.1% of planned level

M3 Nurse staffing at Harefield Hospital	
% of registered nurse day hours filled as planned (Hospital)	105.8% of planned level
% of Unregistered care staff day hours filled as planned (Hospital)	65.1% of planned level
% of registered nurse night hours filled as planned (Hospital)	98.1% of planned level
% of Unregistered care staff night hours filled as planned (Hospital)	89.5% of planned level

M4 Nurse staffing at Royal Brompton Hospital	
% of registered nurse day hours filled as planned (Hospital)	102.6% of planned level
% of Unregistered care staff day hours filled as planned (Hospital)	56.0% of planned level
% of registered nurse night hours filled as planned (Hospital)	95.4% of planned level
% of Unregistered care staff night hours filled as planned (Hospital)	41.3% of planned level

M4 Nurse staffing at Harefield Hospital	
% of registered nurse day hours filled as planned (Hospital)	105.9% of planned level
% of Unregistered care staff day hours filled as planned (Hospital)	65.7% of planned level
% of registered nurse night hours filled as planned (Hospital)	92.9% of planned level
% of Unregistered care staff night hours filled as planned (Hospital)	79.9% of planned level

The senior nurses confirm that no red flags, as per NICE red flag definitions, were triggered during M3 or M4.

The lead nurses report that where registered nurse fill levels are higher than planned this is due to the acuity of patient needs and due to supernumerary staff, such as new starters. Where fill rates are lower than planned this is primarily due to bed occupancy being lower than anticipated.

Fill levels for non-registered nurses are consistently lower than planned. This staff group is small in number and includes a diverse range of roles, most of which are tailored specifically for a particular clinical area, and many of which are support roles. They are difficult to recruit to, and there are limited options for finding appropriate temporary cover. Vacant roles may put increase pressure on other staff, but do not present a safety issue.

The Trust continues to review the Care Hours Per Patient Day (CHPPD) data, which includes information about patient activity, along-side nurse staffing.

Safe: Sepsis
Data owner: Peter Doyle - Divisional Lead Nurse / Associate General Manager, Harefield Hospital
Caterina Vlachou – Consultant Anaesthetist, RBH HDU

The Sepsis Commissioning for Quality and Innovation (CQUIN) was introduced in 2015-16 to help improve screening for sepsis and prompt recognition and initiation of treatments for all patients diagnosed with sepsis. In 2019, the sepsis performance metrics were integrated into the NHS Standard contact. A key sepsis, quality standard is for patients to receive antibiotics within one hour of receiving a positive screening result for sepsis. The table below shows Q1 sepsis data and confirms that 15 of the 21 patients suspected of sepsis received antibiotics within 1 hour. A review of those patients who didn't receive antibiotics within 1 hour has been undertaken, the outcome of which will help inform future practice.

Total number of patients found to have suspected sepsis in inpatient departments who are positively screened for sepsis received IV antibiotics within 1 hour of this diagnosis.	15
The total number of patients who were diagnosed with suspected sepsis in inpatient departments	21

Effective: Innovation
Data owner: Katharine Scott, Trust lead for older people

Get up, get dressed, get moving

The campaign – *Get up, get dressed, get moving* – was rolled out to all non-critical care wards at Royal Brompton and Harefield hospitals and in the weeks following both teams and patients embraced its message. Initial feedback from patients and their families in response to the campaign to get up, dressed and be more active has been very positive.

Being dressed in their own clothes makes patients feel better and encourages them stay mobile. This can result in shorter hospital stays and means patients are less likely to have falls or develop complications such as pressure sores.

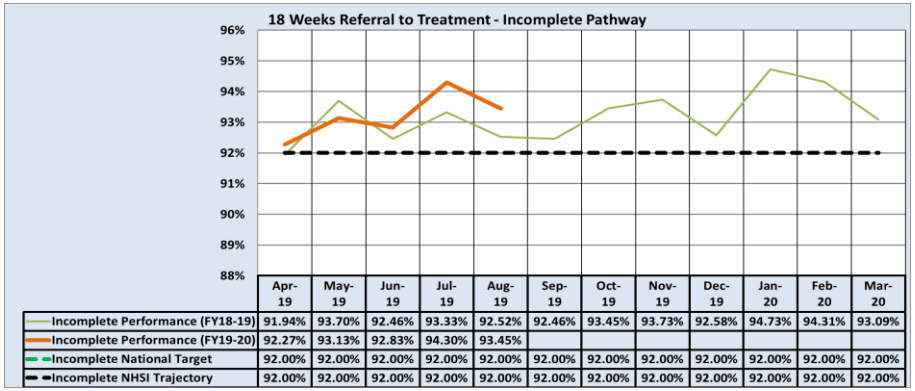
The aim is to change the culture in which patients expect to spend their time in pyjamas, in bed while they are in hospital to one where they get up, dressed and start moving around as soon as they are able to do so.

Get up, get dressed, get moving coincided with the global #EndPJParalysis campaign, which aims to reduce the number of days patients spend in a hospital bed. One member of staff on each ward has been acting as a 'champion', encouraging others to get involved and stands were set up for colleagues to sign a pledge and commit to supporting #EndPJParalysis. More than 200 pledges were signed in the first week and the champions are continuing to spread the word among their teams.

Responsive: 18-week referral to treatment time targets

Data owner: Derval Russell – Harefield Hospital Director and Ross Ellis – Royal Brompton Hospital Director

Incomplete pathway performance



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Incomplete Performance (FY18-19)	91.94%	93.70%	92.46%	93.33%	92.52%	92.46%	93.45%	93.73%	92.58%	94.73%	94.31%	93.09%
Incomplete Performance (FY19-20)	92.27%	93.13%	92.83%	94.30%	93.45%							
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	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%

M4 incomplete pathways by speciality

National Specialty	Specialty	Incomplete			
		< 18w	>= 18W	Total	% < 18w
Cardiology	Cardiology (Brompton)	283	27	310	91.29%
	Cardiology (Harefield)	1,131	103	1,234	91.65%
Cardiology		**1,414**	**130**	**1,544**	**91.58%**
Thoracic Medicine		**2,013**	**62**	**2,075**	**97.01%**
Cardiothoracic Surgery	Cardiac Surgery (Brompton)	183	36	219	83.56%
	Cardiac Surgery (Harefield)	190	40	230	82.61%
	Thoracic Surgery	222	2	224	99.11%
Cardiothoracic Surgery		**595**	**78**	**673**	**88.41%**
Other	Other	128	3	131	97.71%
	Paediatrics	717	15	732	97.95%
	Transplant	64	10	74	86.49%
Other		**909**	**28**	**937**	**97.01%**
		4,931	**298**	**5,229**	**94.30%**

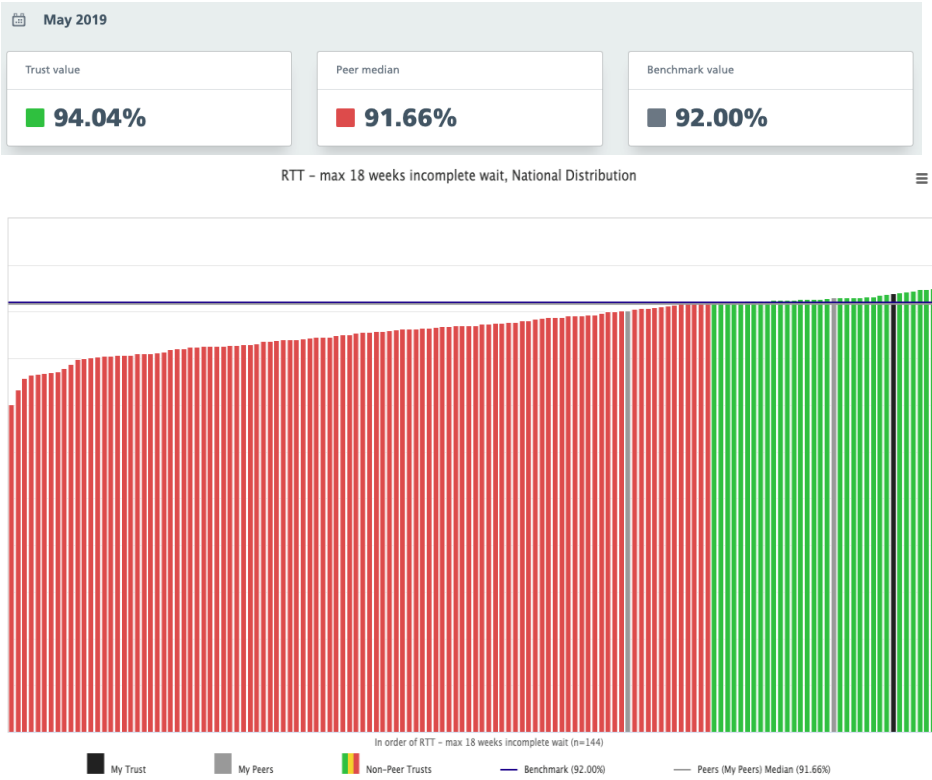
M5 incomplete pathways by speciality

National Specialty	Specialty	Incomplete			
		< 18w	>= 18W	Total	% < 18w
Cardiology	Cardiology (Brompton)	353	21	374	94.39%
	Cardiology (Harefield)	1,183	120	1,303	90.79%
Cardiology		**1,536**	**141**	**1,677**	**92%**
Thoracic Medicine		**2,237**	**89**	**2,326**	**96.17%**
Cardiothoracic Surgery	Cardiac Surgery (Brompton)	177	37	214	82.71%
	Cardiac Surgery (Harefield)	188	55	243	77.37%
	Thoracic Surgery	225	1	226	99.56%
Cardiothoracic Surgery		**590**	**93**	**683**	**86%**
Other	Other	120	9	129	93.02%
	Paediatrics	762	35	797	95.61%
	Transplant	63	5	68	92.65%
Other		**945**	**49**	**994**	**95%**
		5,308	**372**	**5,680**	**93.45%**

During M4 and M5 one patient continued to wait longer than 52 weeks for treatment. The root cause of this breach was reported in M1-M3 CQR along with mitigating actions.

M1	M2	M3	M4	M5
Apr-19	May-19	Jun-19	Jul-19	Aug-19
Patient A: 06P- NHS LUTON CCG	Patient A: 06P- NHS LUTON CCG	Patient A: 06P- NHS LUTON CCG	Patient A: 06P- NHS LUTON CCG	Patient A: 06P- NHS LUTON CCG

May 2019 NHSI Model Hospital RTT 18 week benchmarking against NHS England trusts



Responsive: Cancelled operations and procedures

Data owner: Derval Russell – Harefield Hospital Director and Ross Ellis – Royal Brompton Hospital Director

During M4 57 patients had their operation or procedure cancelled for non clinical reasons and during M5 49 patients had their operation or procedure cancelled for non-clinical reasons. All patients underwent their surgery or procedure within 28 days of cancellation.

One patient, during M5, had their urgent operation cancelled twice. This patient was transferred from a referring hospital and their case has been fully investigated by the Hospital Director. The initial cancellation occurred as there were no beds available in the Trust on the planned day of transfer. The second cancellation occurred because the theatre list over ran, due to the clinical complexity of other patients undergoing surgery on that day. The patient underwent surgery the following day and has since been discharged back to the referring trust. The lead surgeon has reported that the delay (6 days) in the patient undergoing surgery should not have a clinically adverse effect.

Year to date data for cancelled operations is shown in slide 18 of this report. The latest NHS Digital (Q4) benchmarking data was presented in M1-M3 Clinical Quality report.

Responsive: Six week diagnostic waits

Data owner: Christine Peacock – Radiology Service Manager, Royal Brompton Hospital and Juliette Tennant – Imaging Service Manager, Harefield Hospital

Following the six week diagnostic breaches reported in M1-M3, a review of patients waiting for diagnostic procedures was undertaken. This identified one additional patient who had waited longer than 6 weeks for their diagnostic procedure. The patient waited 206 days from date of referral to date of diagnostic test. The test result was reported on immediately and the patient has since been discharged without requiring further investigation.

Responsive: 62 day urgent GP referral to first treatment cancer target

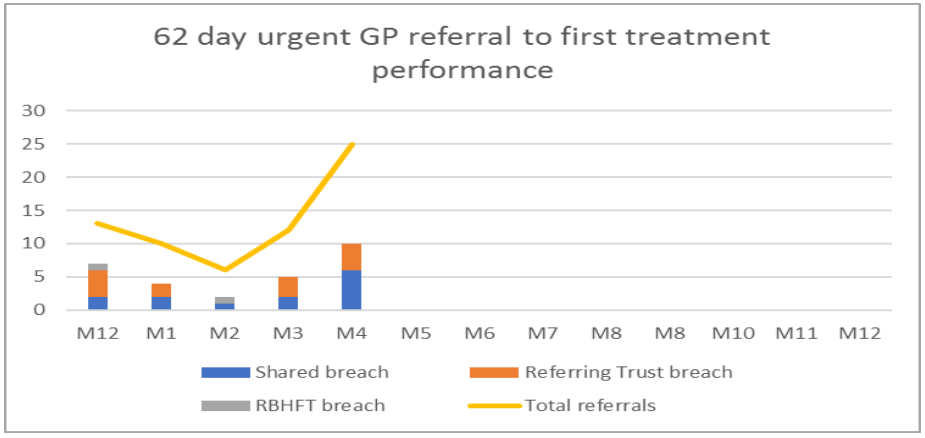
Data owner: John Pearcey – Assistant General Manager, lung division

The cancer performance data presented in slides 10-12 was accurate at the time of reporting. Referring trusts are able to edit data within NHS Digital after the publication date. Changes made by referring trusts may impact on the Trust's reporting and performance.

As the table below shows, during M3 12 patients were seen and treated on a 62 day urgent GP referral to first cancer treatment pathway. 7 of these patients were seen and treated within 62 days and 5 patients received their treatment after 62 days. During M4 25 patients were seen and treated and 10 patients received treatment after 62 days.

Month 2019-20	Total Seen/Treated	Total Accountable	Total Compliant	Total Breached	Unadjusted Performance (Target 85%)
M1	10	5.5	3.5	2	63.60%
M2	6	3	2	2	66.70%
M3	12	6	3.5	5	58.33%
M4	25	12.5	7.5	10	60.00%

The graph below shows the year to date, total number of 62 day urgent GP referrals for surgery for cancer and demonstrates the allocation of breaches.



M3 62 day cancer pathway breaches

	Referring Trust and Hospital	CCG code	Day of referral received by RBHT	Number of Days from receipt of referral at RBHT to treatment	Number of days from GP referral to treatment	Breach Allocation	NHSE Breach Code
Patient 1	Luton And Dunstable Hospital NHS Foundation Trust Luton And Dunstable Hospital - Rc971		67	3	70	Breach allocated to referring trust	
Patient 2	Great Western Hospitals NHS Foundation Trust The Great Western Hospital - Rn325		59	18	77	Breach allocated to referring trust	
Patient 3	East And North Hertfordshire NHS Trust Hertford County Hospital		46	20	66	Breach allocated to referring trust	
Patient 4	Chelsea And Westminster Hospital NHS Foundation Trust Chelsea And Westminster Hospital - Rqm01	09A	76	27	103	Shared breach	10
Patient 5	West Hertfordshire Hospitals NHS Trust Watford General Hospital - Rwg02	06N	72	32	104	Shared breach	7

Of the 5 patient pathways that breached the 62 day target during M3 the Trust has shared responsibility for 2 of these pathway breaches. These are:

Patient 4 was unfit for surgery and was therefore discharged home and admitted once fit.

Patient 5 was referred on day 72 of pathway and had to undergo further diagnostic tests to assess fitness for surgery.

Responsive: 62 day urgent GP referral to first treatment cancer target

Data owner: John Pearcey – Assistant General Manager, lung division

M4 62 day cancer pathway breaches

	CCG Code	CCG Name	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	Delay Reason Referral To Treatment (Cancer)	Breach Allocation
Patient 1:	15A	NHS BERKSHIRE WEST CCG	Frimley Park Hospital NHS Foundation Trust Frimley Park Hospital -	70	12	82	7	100% of breach allocated to referring trust
Patient 2:	06F	NHS BEDFORDSHIRE CCG	Luton And Dunstable Hospital NHS Foundation Trust Luton And Dunstable Hospital	47	21	68	7	100% of breach allocated to referring trust
Patient 3:	08G	NHS HILLINGDON CCG	The Hillingdon Hospitals NHS Foundation Trust Hillingdon Hospital	61	6	67	16	100% of breach allocated to referring trust
Patient 4:	14Y	NHS BUCKINGHAMSHIRE CCG	Buckinghamshire Healthcare NHS Trust Stoke Mandeville Hospital	60	15	75	7	100% of breach allocated to referring trust
Patient 5:	06N	NHS HERTS VALLEYS CCG	West Hertfordshire Hospitals NHS Trust Watford General Hospital	51	39	90	7	Shared breach
Patient 6:	09F	NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	Sussex Community NHS Trust Eastbourne District General Hospital	108	64	172	7	Shared breach
Patient 7:	14Y	NHS BUCKINGHAMSHIRE CCG	Buckinghamshire Healthcare NHS Trust Wycombe Hospital	50	39	89	16	Shared breach
Patient 8:	06N	NHS HERTS VALLEYS CCG	West Hertfordshire Hospitals NHS Trust Hemel Hempstead Hospital	104	33	137	3	Shared breach
Patient 9:	12D	NHS SWINDON CCG	Great Western Hospitals NHS Foundation Trust The Great Western Hospital	59	52	111	10	Shared breach
Patient 10:	06N	NHS HERTS VALLEYS CCG	West Hertfordshire Hospitals NHS Trust Hemel Hempstead Hospital	63	40	103	7	Shared breach

Of the 10 patient pathways that breached the 62 day target during M4 the Trust has shared responsibility for 6 of these pathway breaches. These are:

Patient 5: Patient was referred day 51. Patient was high risk with various co-morbidities and required further clinical review before surgery.

Patient 6: Patient was referred on day 108. Initially referred locally with suspected cancer. Multiple providers involved in the care of the patient before referral to RBH for Surgery. Required complex procedure with plastic surgery involvement.

Patient 7: Patient was referred on day 50. Two separate dates for admission for surgery due to the patient being unfit for surgery.

Patient 8: Patient was referred on day 104. Required further diagnostic referral and OPA at RBH. Unfortunately a delay of referral elongated this pathway from the referring centre.

Patient 9: Patient was referred on day 59, however required separate surgery a period of recovery, before surgery at RBH could be considered.

Patient 10: Patient was referred on day 63. However required further diagnostics which were carried out locally on day 68. Was very high risk and required Cardiology review first.

Responsive: 31 day cancer pathway targets

Data owner: John Pearcey – Assistant General Manager, lung division

31 day to first definitive treatment waiting time standard

As the table below shows, a total of 33 patients were treated on the 31 day to definitive treatment cancer pathway during M3. 32 patients were treated within the 31 day target and 1 patient was treated after 31 days.

The patient treated outside of the 31 day standard received treatment following an incidental finding of a lung cancer during an out-patient consultation. CWT Breach Reason: - *(99) Other*

During M4 a total of 56 patients were treated on the 31 day to definitive treatment cancer pathway. 55 patients were treated within the 31 day target and 1 patient was treated after 31 days.

The patient treated outside of the 31 day standard had complex clinical needs and their treatment pathway breached both the 31 day and 62 day target. CWT Breach Reason: 7 Complex Diagnostic pathway

	Published Figures				
	Total Seen/Treated	Total Accountable	Total Compliant	Total Breached	Performance (Target 96%)
Mar	40	40	40	0	100.0%
Apr	34	34	33	1	97.1%
May	28	28	28	0	100.0%
June	33	33	32	1	96.7%
July	56	56	55	1	98.2%

31 day to subsequent treatment waiting time standard

A total of 16 patients were treated on the 31 day to subsequent treatment cancer pathway during M3. 15 patients were treated within the 31 day target and 1 patient was treated after 31 days.

This patient's surgery was delayed until day 33 due to the clinical complexity of a number of referrals received. CWT Breach Reason - *(99) Other*

During M4 a total of 23 patients were treated on the 31 day to subsequent treatment cancer pathway. 21 patients were treated within the 31 day target and 2 patients were treated after 31 days.

Patient 1

Patient was not offered another surgeon but agreed to TCI date with their surgeon in clinic. Pathway breached by 1 day. CWT Breach Reason: 5

Patient 2

Patient was initially seen as a private patient. Was not offered another surgeon and agreed a TCI date with their surgeon in clinic. Pathway breached by 2 days. CWT Breach Reason: 5

	Published Figures				
	Total Seen/Treated	Total Accountable	Total Compliant	Total Breached	Performance (Target 94%)
Mar	12	12	12	0	100.0%
Apr	17	17	15	2	88.2%
May	16	16	15	1	93.8%
June	16	16	15	1	93.8%
July	23	23	21	2	91.3%

Caring: Patient experience

Data owner: Karen Taylor - Patient & Public Engagement and Sharon Gurney - Complaints Manager / PALS lead

Friends and Family Test

Inpatients & Day Care	M01	M02	M03	M04
Eligible Patients	3030	3332	3032	3442
No. of Responses from Eligible Patients	1,071	1,194	1,091	1,114
Trust FFT Response Rate	35.5%	35.8%	36.1%	32.4%
Trust Recommendation Score for FFT	96.8%	95.8%	97.2%	96.3%

Inpatients & Day Care	M01	M02	M03	M04
All Comments	802	872	792	755
Positive Comments	789 - 98.4%	849 - 97.4%	780 – 98.5%	729 – 96.6%
Negative Comments	14 - 2%	8 - 0.9%	8 – 1%	26 – 3.4%

Key areas of feedback from the Friends and Family Test were:

- Appointment cancellations
- Patient information
- Waiting times
- Administrative procedures
- Discharge process

Where possible feedback has been shared with services so as it can be used to help make improvements for the future.

Initiatives

A new family coffee morning at Royal Brompton is helping support parents of children with cardiomyopathy, giving them a chance to socialise with other parents and take a break from the ward.
Paediatric inherited cardiac conditions (ICC) nurse specialists Lucy Green and Louise Parker organised the event following requests from parents wanting to meet others in the same situation, away from the ward environment.

The coffee mornings are aimed at families of young, (under five years old), Royal Brompton patients who have cardiomyopathy (a disease of the heart muscle that makes it harder to pump blood around the body).

The first coffee morning took place in August, with the Brompton Fountain charity providing funding for a venue and refreshments.

Complaints

The Trust received 9 new complaints in June 2019, one of which has another organisation as lead investigator. All complaints were acknowledged within 3 working days. 6 of these complaints relate to the Royal Brompton Hospital site and 3 relate to Harefield Hospital site. In consultation with the complainants, 3 of these complaints were reassigned as informal concerns.

3 complaints received during Q1 were closed in June 2019 and all were closed within agreed timescales.

The Trust received 6 new complaints for July 2019. All were acknowledged within 3 working days. 1 complaint is being led by another Trust.

7 complaints were closed in July 2019, 5 within agreed timeframe and 2 had delayed responses due to complexity of case and awaiting meeting to determine the outcome. Complainants were kept fully briefed.

Complaint topics included:

- Delays and waiting times
- Clinical care
- Administrative procedures

Learning from complaints is disseminated across the Trust through the Trust wide complaints group

Well led: 2019-20 Quality Priorities

Data owner: Alex Weller – Head of Quality

Patient safety

Quality Priority	2019-20 goals	Q1 achievements to date
Implementation of NEWS2	Achieve above 90% accuracy in recording and calculating of NEWS2 scores. Undertake a successful tender process for the purchase of a new electronic patient observation system.	This project is running according to plan and is on target to achieve the goal by end of 2019-20. May 2019 compliance audit identified that 100% of wards had completed the NEWS2 scores for patients and that accuracy in recording and calculating NEWS2 scores was above 90% for 9 of the 13 wards. Action plans have been developed to address the gaps identified by the audit. The tender process for purchase of a new electronic observation system is progressing according to schedule.
Identification and management of patients with sepsis	Appointment of a Sepsis Clinical Lead for the Trust. Development of an approved plan for identifying and managing sepsis across the Trust. Successful implementation of the first steps of that plan. Achieve above 90% compliance with the sepsis 6 standards for patients suspected of sepsis.	This implementation of Sepsis 6 is running according to plan and is on target to achieve the goal by end of 2019-20. Appointment of a clinical lead and development of a plan is behind target, but will be addressed in the Autumn. It is expected that the goal will be fully met by the end of 2019-20.
Identification and management of patients with acute kidney injury (AKI)	Appointment of an AKI Clinical Lead for the Trust. Development of an approved plan for identifying and managing AKI across the Trust, successful implementation of the first steps of that plan. Reduce the number of patients requiring renal replacement therapy post-surgery.	The reduction in patients requiring renal replacement therapy is running according to plan and is on target to achieve the goal by end of 2019-20. Appointment of a clinical lead and development of a plan is behind target, but will be addressed in the Autumn. It is expected that the goal will be fully met by the end of 2019-20.

Well led: 2019-20 Quality Priorities Q1 achievements

Data owner: Alex Weller – Head of Quality

Clinical effectiveness

Quality Priority	2019-20 goals	Q1 achievements to date
Learning from deaths	Implementation of the new mortality database in Datix. By the end of 2019-20, mortality review documentation from all areas of the Trust is stored electronically on this database.	This project is running according to plan and is on target to achieve the goal by end of 2019-20. The new Datix module is currently in development; and it is expected that it will be available for trial use in early Autumn 2019.
Use of Structured Judgement Review (SJR) tool to review care of patients who have died in hospital	By the end of 2019-20, the SJR tool is used across all areas of the Trust.	Target achieved at Royal Brompton Hospital. Progress has been made at Harefield Hospital and the hospital is on target to achieve the goal by end of 2019-20.
Avoidable cancellations for surgery	A reduction in the number of avoidable cancellations for surgery in 2019-20, compared to 2018-19.	This project is part of the Darwin programme; and is in the development phase at present. However, the project is is expected to achieve it's goals by the end of 2019-20.

Well led: 2019-20 Quality Priorities Q1 achievements

Data owner: Alex Weller – Head of Quality

Patient experience

Quality Priority	2019-20 goals	Q1 achievements to date
Staff welfare – implementation of a Health & Well-being Improvement Plan	Implementation of a Health and Wellbeing Improvement Plan.	This project is on target to achieve it's goals by the end of 2019-20. The Trust is continuing with all of the initiatives set up in 2018-19; and locally there is evidence of staff feeling better supported. The NHS staff survey will be undertaken in Autumn 2019, and will provide the data for demonstrating progress with this quality priority.
Medical Examiner role	By the end of 2019-20, a Medical Examiner post is in place and monitoring of number of death certificates produced within 24 hours of death.	This project is on target to achieve it's goals by the end of 2019-20. Significant work has been undertaken to review different models for best implementing the Medical Examiner role for the Trust and plans are now well underway to incorporate this role into the next round of job planning, starting September 2019. The Trust is currently setting up a dedicated working group to lead this work.
Avoidable cancellations	The Trust will be looking specifically at how we communicate with patients and families about their surgery and cancellations.	This project is part of the Darwin programme and is in the development phase at present.

Additional Performance Data

Responsive: Cancelled operations and procedures

Data owner: Derval Russell – Harefield Hospital Director and Ross Ellis – Royal Brompton Hospital Director

Denominator	Cancelled operations and procedures																
Area/Site	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Q1	Q2	Q3	Q4	19/20 YTD
Theatres (inc Bronchoscopy)	9	14	11	8	16	0	0	0	0	0	0	0	34	24	0	0	58
Catheter Labs	6	12	6	13	8	0	0	0	0	0	0	0	24	21	0	0	45
RB Total	**15**	**26**	**17**	**21**	**24**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**58**	**45**	**0**	**0**	**103**
Theatres (inc Bronchoscopy)	9	19	13	24	19	0	0	0	0	0	0	0	41	43	0	0	84
Catheter Labs	10	8	6	12	6	0	0	0	0	0	0	0	24	18	0	0	42
HH Total	**19**	**27**	**19**	**36**	**25**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**65**	**61**	**0**	**0**	**126**
Trustwide	**34**	**53**	**36**	**57**	**49**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**123**	**106**	**0**	**0**	**229**

Numerator	Number of breaches of the pledge to offer another binding date within 28 days																
Area/Site	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Q1	Q2	Q3	Q4	19/20 YTD
Theatres (inc Bronchoscopy)	1	0	2	0	0								3	0	0	0	3
Catheter Labs	0	0	0	0	0								0	0	0	0	0
RBH Total	**1**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**3**
Theatres (inc Bronchoscopy)	0	0	0	0	0								0	0	0	0	0
Catheter Labs	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	**1**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**3**

	Performance against indicator E.B.S.2																
Site	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Q1	Q2	Q3	Q4	19/20 YTD
RB Total	6.67%	0.00%	11.76%	0.00%	0.00%								5.17%	0.00%			2.91%
HH Total	0.00%	0.00%	0.00%	0.00%	0.00%								0.00%	0.00%			0.00%
Trustwide	2.94%	0.00%	5.56%	0.00%	0.00%								2.44%	0.00%			1.31%

Urgent operations cancelled for the 2nd or more time (adjusted SITREP) 2019/20

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD Total
Brompton	0	0	0	0	0	0		0				0				0	**0**
Harefield	0	0	0	0	0	1		1				0				0	**1**
Trust Total	**0**	**0**	**0**	0	**0**	**1**	**0**	1	**0**	**0**	**0**	0	**0**	**0**	**0**	0	**1**

Total Urgent operations cancelled (Unify2 SITREP) 2019/20

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD Total
Brompton	0	0	0	0	0	0		0				0				0	**0**
Harefield	0	5	8	13	7	8		15				0				0	**28**
Trust Total	**0**	**5**	**8**	13	**7**	**8**	**0**	15	**0**	**0**	**0**	0	**0**	**0**	**0**	0	**28**

Single Oversight Framework Quality Metrics

	M12 -18/19 (Cancer Data)	M1	M2	M3	Q1	Threshold	M4	M5
		Quarter 1: 2019/20					Quarter 2: 2019	
Quality metrics								
CQC inpatient survey								
Occurrence of any Never Event		0	0	0	0	*Zero Tolerance*	0	0
Patient Safety Alerts not completed by deadline		0	0	0	0		0	0
Potential under- reporting of patient safety incidents - quarterly					TBC			
Mixed-sex accommodation breaches		0	0	0	0	**> 0**	0	0
Venous thromboembolism (VTE) risk assessment		97.6%	97.70%	98.74%	97.91%	*Quarterly 95%*	98.70%	99%
Clostridium difficile (C. difficile) plan: *C.difficile* actual variance from plan *(actual number v plan number)2*		0	1	0	1	*Performance Standard Dept. Health Trajectory = 12*	0	2
Clostridium difficile – infection rate *per 100,000 bed days - quarterly*					3.48 28772 bed days no lapse in care			
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		0	0	0	0	*Zero Tolerance*	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias		1	0	0	1	*No Standard Set*	4	1
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)		1	0	1	2	*No Standard Set*	1	1
Klebsiella species BSI		1	1	0	2	*No Standard Set*	1	4
Pseudomonas BSI		0	0	0	0	*No Standard Set*	2	0

Single Oversight Framework Operational Metrics

	M12 -18/19 (Cancer Data)	M1	M2	M3	Q1	Threshold	M4	M5
		Quarter 1: 2019/20					Quarter 2: 2019/	
Operational performance metrics								
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		92.27%	93.13%	92.83%		**92%**	94.30%	TBC
All cancers – maximum 62-day wait for first treatment from: a) urgent GP referral for suspected cancer								
Seen / treated	13	10	6	12	28		25	TBC
Compliant (Using 0.5 score)	7	5.5	3	3.5	12		7.5	TBC
Breaches (Using 0.5 score)	7	3.5	2	5	10.5		10	TBC
Cancer Target – 31-day decision to treat to first definitive treatment								
Seen / treated	40	34	28	33	95		56	TBC
Compliant	40	33	28	32	93		55	TBC
Breaches	0	1	0	1	2		1	TBC
Cancer Target – 31-day decision to treat to subsequent treatment								
Seen / treated	12	17	16	16	49		23	TBC
Compliant	11	15	15	15	45		21	TBC
Breaches	1	2	1	1	4		2	TBC
Maximum 6-week wait for diagnostic procedures		0	4	0	4	**1%**	1	0

For information: Cancer pathways overview