Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality Account 2010-11

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Statement of directors' responsibilities

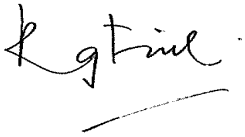
The directors of the Royal Brompton and Harefield NHS Foundation Trust have prepared this Quality Account 2011-12, as required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

The directors are satisfied that that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- that the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2010 to June 2011
    - Papers relating to quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the commissioners dated 21/05/2011
    - Feedback from governors dated 09/05/2011
    - Feedback from Hillingdon LINks dated 25/05/2011 and Kensington and Chelsea LINks dated 26/05/2011
    - The trust's draft complaints report due to published under regulation 18 of the Local Authority, Social Services and NHS Complaints Regulations 2009, dated 27/07/2011
    - The national inpatient survey 2009 and 2010
    - The national staff survey 2010
    - The head of internal audit's annual opinion over the trust's control environment dated 12/04/2011
    - CQC quality and risk profiles dated 02/03/2011
- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

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



Sir Robert Finch
Chairman
31st May 2011

Robert J Bell
Chief Executive
31st May 2011

Part 1: Chief executive statement

Royal Brompton & Harefield NHS Foundation Trust is a national and international specialist heart and lung centre based in Chelsea, London and Harefield, Middlesex.
We help patients of all ages who have heart and lung problems. From the moment they arrive, our patients become part of a community of people who have benefited from more than 160 years of expert diagnosis, treatment and long-term care.
Our care extends from the womb, through childhood, adolescence and into adulthood and as a specialist trust, our patients come from all over the UK, not just from our local areas.

We are committed to providing patients with the best possible specialist treatment for their heart and lung condition in a clean, safe place, ensuring that evidence-based care is provided at the right time, in the right way, by the right people.
Our vision is to be 'the UK's leading specialist centre for heart and lung disease' and we have set three main strategic goals to ensure we achieve this:

- Service excellence
- Organisational excellence
- Productivity and investment

These are underpinned by a set of key objectives and values of which the most important is to continuously improve the patient experience.

In order to achieve this we have established a robust system to ensure that we are accountable for continuously monitoring and improving the quality of our care and services. Our highly skilled workforce is dedicated to pursuing the best outcomes for patients through delivery of excellent clinical care and research into new treatments and therapies.

Our outcomes in both adult and paediatric care are amongst the best in the country and we have achieved some of the lowest MRSA and c*lostridium difficile* rates in England.

We were assessed by the NHS Litigation Authority in September 2010 in relation to our risk management and were awarded Level 3 status – which is the highest possible level and reflects the emphasis placed on ensuring quality and safety are at the heart of everything we do.

Despite an impressive record in quality and safety we are not complacent; weaknesses are dealt with promptly and openly so that better and safer systems of care can be developed.

Signed by the chief executive to confirm that, to the best of his knowledge, the information in this document is accurate.

Robert J Bell
Chief executive Royal Brompton & Harefield NHS Foundation Trust

Part 2a: Priorities for improvement

Review of priorities for quality improvement 2010-11

In 2010/11 the Trust identified three priority areas for improvement, which were put forward by a working group consisting of clinicians and managers and taking account of patient input and feedback. The priorities were shared with Trust stakeholders including patient groups, local LINks, Foundation Trust governors, and Overview and Scrutiny Committees via the quality account consultation process in 2010. The priorities were also in alignment with the Commissioning for Quality and Innovation (CQUIN) scheme, which was agreed with our commissioners.

The priority areas for 2010/11 fall within three categories:

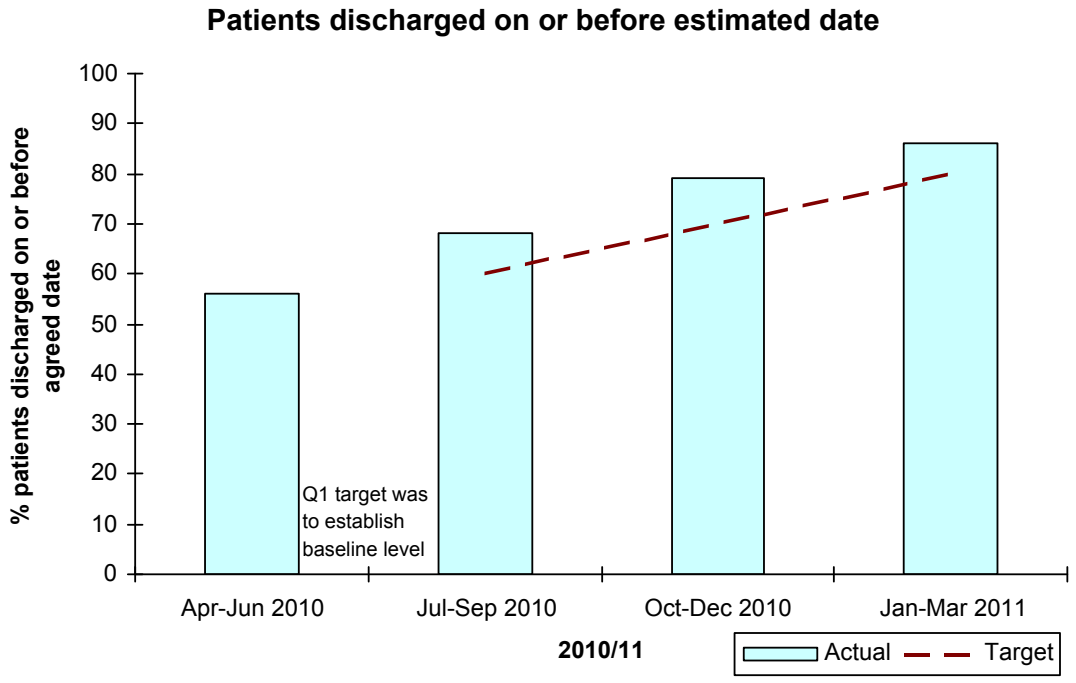
- Patient experience – making the discharge process easier for patients
- Clinical effectiveness – providing more training for staff in safeguarding children
- Patient safety – ensuring the incidence of surgical site infection is reduced

Patient experience

Discharge on agreed date

The Trust has been working on making sure we advise our patients of their estimated date of discharge and that we keep to this date whenever it remains clinically appropriate to do so. With this in mind, in 2010/11 we have been working to improve the numbers of patients who go home on or prior to their agreed discharge date when clinically appropriate.

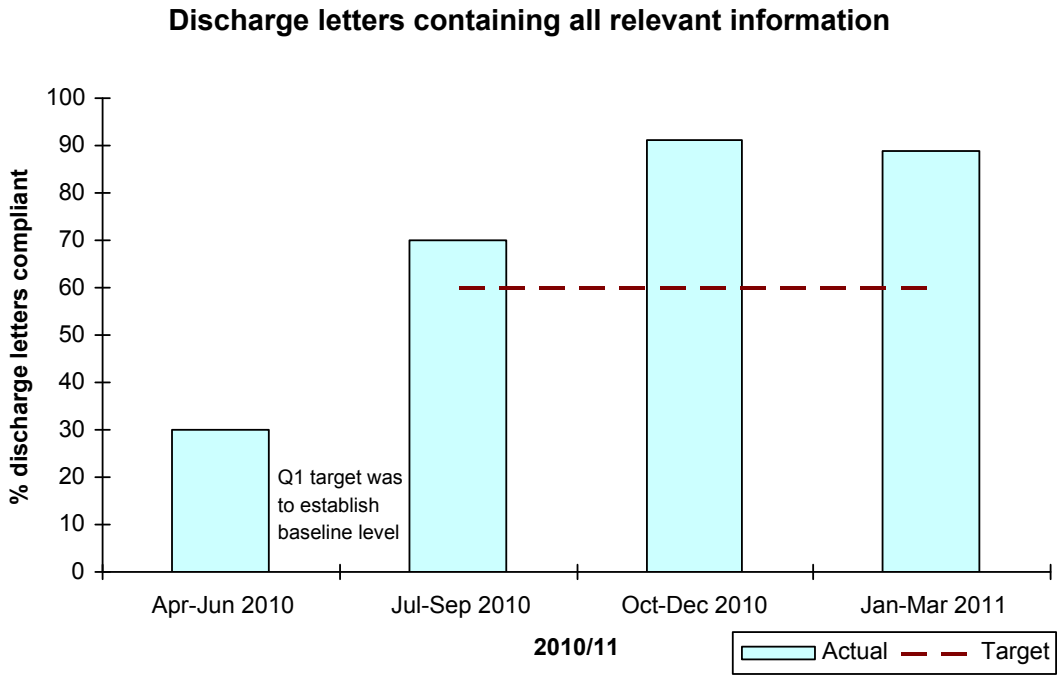
The chart below shows how the Trust has been performing against this target and demonstrates that there has been a steady increase in the number of patients being discharged on or before their agreed date. In the first quarter of the year the baseline was set, from which the targets were set for each quarter with a final target of 80% of patients being discharged on or before their agreed date. In the subsequent three quarters the chart shows the target has been exceeded with 86% of patients discharged in quarter 4 having been discharged on or before their agreed date.



Information in discharge letters

In conjunction with the discharge improvements above, in 2010/11 the Trust has also been working to improve the quality and timeliness of the discharge information that we provide to our patients and their general practitioners. The Trust is compliant with the national contract for inpatient discharge summaries which dictates what information must be included in the summary. The Trust has been working to routinely include additional information in discharge summaries in order to improve the quality and provide more information to the patient and their GP.

The chart below shows how the Trust has performed in 2010/11 on including additional information in inpatient discharge summaries. This data is based on sample audits carried out each quarter (total summaries audited by end of Q4 was 252). In the first quarter the baseline was established from which the target of 60% was set for the rest of the year. As the chart shows the target has been exceeded in the subsequent quarters of the year with 89% of the discharge summaries audited in Q4 having the additional information included. This inclusion of additional information in the discharge summary should provide a comprehensive source of information for both the patient and their GP on the admission at the Trust.



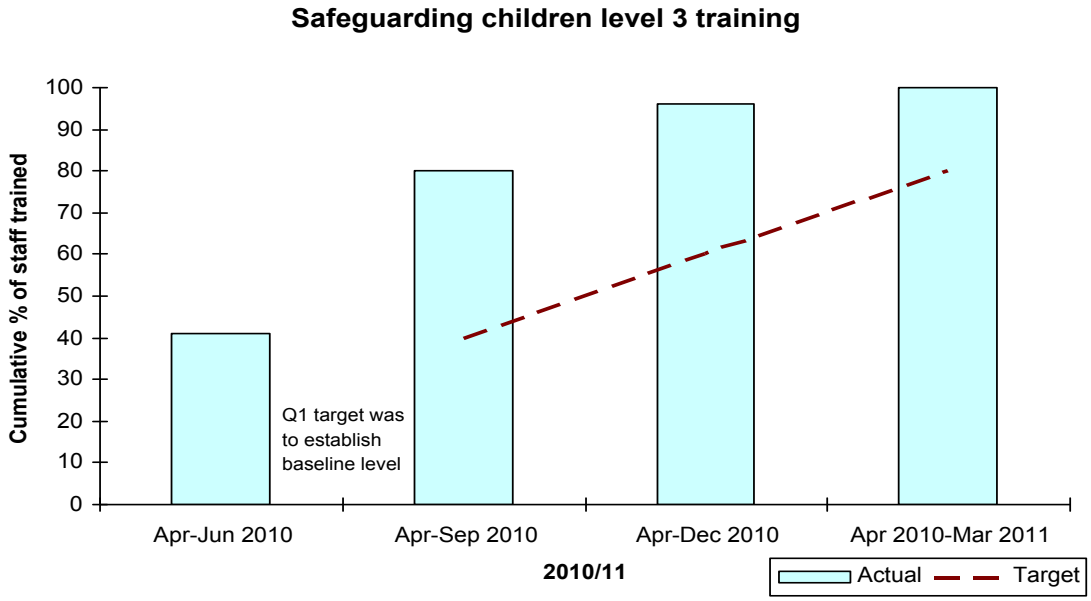
Clinical effectiveness

Safeguarding children: level 3 training for staff working in children's areas

The Trust takes the safety of its youngest patients extremely seriously. All new members of staff are assessed to determine whether a Criminal Records Bureau (CRB) check is required and those who will be working with children undergo an enhanced level of assessment. The Trust's process around safeguarding children was reviewed by the Safeguarding Children Improvement Team in September 2010 as part of a peer review of NHS safeguarding children processes within the borough of Kensington & Chelsea. In this review the Royal Brompton Hospital was commended for its processes throughout its services. In late 2010 the Trust appointed to a new post, Safeguarding Children and Young People Nurse Advisor, to support the designated nurse for safeguarding children.

The Trust has also been working to ensure all relevant staff undertake the correct level of training. In light of the nationwide review of child protection carried out by Lord Laming following the death of Baby P, the Department of Health revised the training requirements of people working with children in relation to safeguarding. In response to this, the Trust reviewed its policy on safeguarding children and the training provided and established which staff groups needed training at level 1, 2 or 3. Level 3 is the most comprehensive training and is required by all staff who work predominantly with children, young people and their parents. In response to this level 3 courses were commissioned from the start of February 2010 to ensure eligible staff received level 3 training by the end of 2010/11.

The chart below shows the progress made in 2010/11 in delivering level 3 training to relevant staff. A cumulative target was set to aim to have trained 80% of relevant staff by the end of the year but as the chart shows the target was consistently overachieved and by the end of the year 100% of staff had received training.



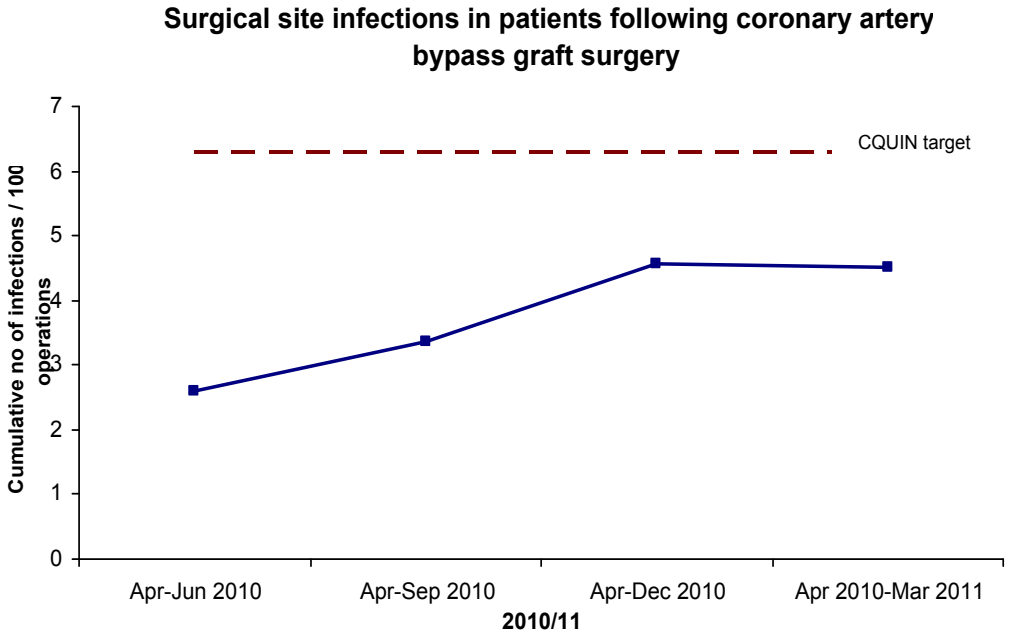
Patient safety

The Trust has continued to work to maintain its excellent record of incidences of infections which for both MRSA and *C difficile* have remained very low. Whilst these rates are very low, our surgical site infection rates (wound infections following surgery) can be improved and hence the Trust has been aiming to reduce surgical site infections with an initial focus on patients undergoing coronary artery bypass grafts and cardiac valve replacement operations. The Trust has a team of infection control nurses who carry out surveillance on all patients undergoing cardiac operations to monitor their wounds and capture and record infections at the site of surgery.

Reduce surgical site infections for coronary artery bypass grafts (CABG)

The Trust routinely collects surgical data on patients undergoing cardiac procedures. This includes data from the infection control team which has been collecting and reporting infection data on patients undergoing CABG since 2000 which is reported within the Trust and also to the Health Protection Agency (HPA).

As part of the commissioning for quality and innovation scheme (CQUIN), the Trust has agreed set targets with our commissioners for reducing the number of infections experienced by patients following CABG procedure. As part of the CQUIN scheme the targets set were linked to financial payments where the number of infections is reflected in the percentage of payment received. The chart below shows the Trust's cumulative number of infections over 2010/11. The chart demonstrates that the number of infections at the Trust at year end 2010/11 for patients undergoing CABG was 4.5 / 100 operations. This level of infection is well below the upper target set and therefore the Trust has achieved the highest level of compliance and will receive 100% of the CQUIN payment.



The table below shows the number of surgical site infections per 100 operations following a CABG procedure for the two previous years. As can be seen the target for 2010/11 was considerably lower than the rate for previous years yet has been easily achieved.

Infection rate following CABG procedures

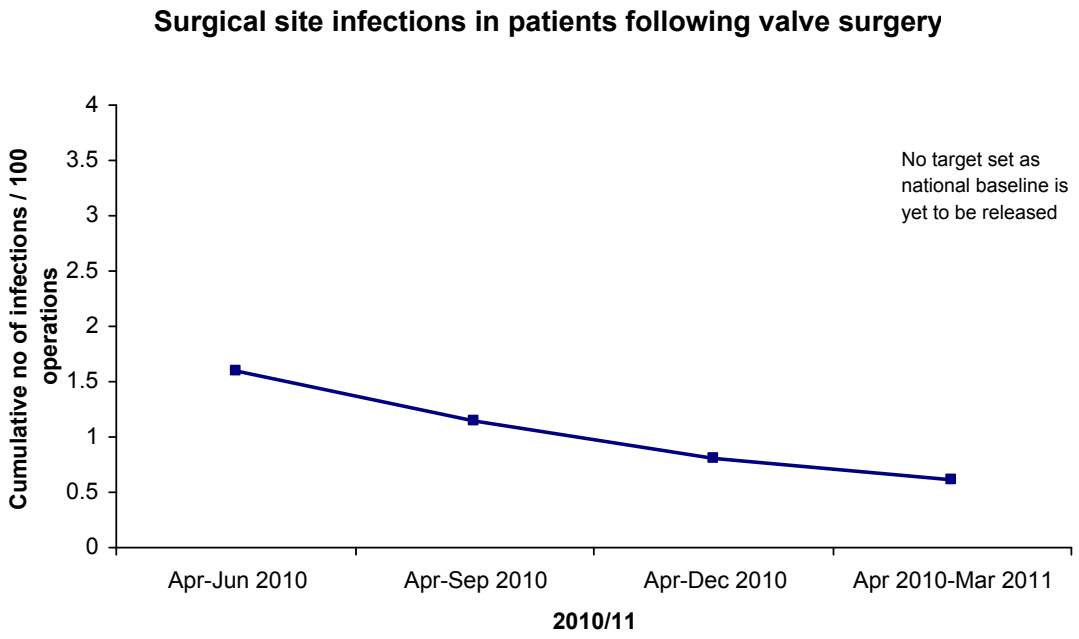
Year	Number of infections / 100 operations
2008/09	6.91
2009/10	7.16
2010/11	4.50

The Trust has been working hard to reduce surgical site infections and has introduced various new practices which have contributed to this. There is a new option for harvesting the vein required for patients undergoing CABG. The vein is harvested endoscopically therefore reducing the infection risk and also enabling the patient to mobilise more rapidly following the procedure.

The Trust is using a new wound dressing for both cardiac and thoracic surgery which allows the wound to be examined without removal thereby reducing the exposure to infection. Patients have also reported finding the new wound dressing comfortable.

Reduce surgical site infections for cardiac valve procedures

The Trust routinely collects surgical data on patients undergoing cardiac valve procedures. The infection control team has carried out surveillance of patients undergoing valve procedures since April 2009. The chart below shows there has been a reduction in the number of infections per 100 operations over the year 2010/11 with a rate of 0.62 infections / 100 operations. No target was set for this indicator as the national baseline has yet to be released. However, it was agreed to aim to reduce the rate or maintain the level if performance was good by year end. However, the overall rate of infections per 100 operations in 2009/10 was 1.96, which is considerably higher than the year end figure for 2010/11. This demonstrates a considerable reduction in the infection rate in the past 12 months.



Priorities for quality improvement 2011/12

The Trust is required to choose between three and five priorities for improvement in relation to quality each year. These priorities must encompass the key areas of patient safety, clinical effectiveness and patient experience.

This year, the Trust has taken a new approach to the choice of these priorities to better understand what really matters to patients, carers, staff, FT members and governors and other key stakeholders, such as our local LINks, and to better engage our health community in the activities of the Trust.

To this end, we have asked individuals to vote online for what is their preferred quality project in each of the three key areas for the Trust to focus on in 2011/12. Voters had the chance to choose from a shortlist of 14 topics, and this list had been carefully selected to reflect key national, local and trust areas for improvement.

The process for this and the topics selected for the shortlist was developed in consultation with both Hillingdon and Kensington and Chelsea LINks, and with our governors.

The shortlist is shown below with the topics which received the most votes emboldened. The priority topics are detailed on the following pages.

Patient safety:

- Accuracy of medication prescribing
- **Availability of patient notes for appointments and hospital stays**
- Use of national guidelines e.g. NICE
- **Discussion of treatment plans at a multi-disciplinary team (MDT) meeting**
- Accurate training records of nursing staff

Patient experience

- Minimising cancellation of planned operations
- Minimising the waiting time when coming for an outpatient appointment
- **Planning the care of patients who are terminally ill**
- Care of patients who experience a stroke whilst in hospital

Patient outcomes

- **Care of patients who have a cardiac arrest (heart attack) whilst in hospital**
- Minimising unnecessary delays for patients on day of discharge
- Planning the care of diabetic patients undergoing surgery
- Maximising nutrition for paediatric patients
- Use of patient reported outcome measures (PROMS tool)

These quality priorities will be monitored routinely throughout the year, and reported up to Trust Board on a quarterly basis.

Availability of patient notes for appointments and hospital stays

Patient safety – ensuring patient records are always available for outpatient clinics.

Rationale

It is important that the full patient record is always available when patients attend the outpatient clinic. The Trust takes this very seriously and has a good record in achieving this, but we feel we could do better, particularly in ensuring we always know where every set of paper records is, so we can easily locate them if they are needed at short notice.

Quality standards

1) 99% of paper patient records are available at the start of the outpatient clinic
2) 95% of clinics have access to the electronic patient record
3) 75% of paper patient records are tracked to the location they are in

Discussion of treatment plans at a multi-disciplinary team (MDT) meeting for elective patients undergoing surgery

Patient safety – ensuring elective patients where appropriate have their treatment plans discussed and agreed in an MDT meeting prior to surgery.

Rationale

The Trust carried out a survey on priority areas for quality improvement asking patients, staff, public, FT members and governors to vote for their priority topics. Shared decision-making for treatment plans was selected as one of the topics.

The Trust's electronic patient record (EPR) is very limited at the moment and does not contain key information on records of multidisciplinary team discussions, clinical examinations and assessment by specialist teams. For example assessment and recommendations of speech and language therapists - are key for management of many advanced respiratory patients.

Quality standards

As per the relevant MDT operational policy:
1) 90% of elective patients who need to be discussed at an MDT have their treatment plans discussed and agreed in an MDT meeting prior to cardiac surgery
2) 90% of elective patients who need to be discussed at an MDT have their treatment plans discussed and agreed in an MDT meeting prior to thoracic surgery (excluding lung cancer)
3) 100% of elective patients have their treatment plans discussed and agreed in an MDT meeting prior to lung cancer surgery

Planning the care of patients who are terminally ill

Patient experience - improving end of life (EOL) care for our patients.

Rationale

In England around half a million people die each year, nearly two thirds over the age of 75. For the majority, death is preceded by a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. In London there were 50,265 deaths in 2007, representing 0.66 per cent of the population.

This is also a regional CQUIN measure for all Trusts within NHS London.

Quality standards

1) 95% of patients identified as end of life (last 48 hours of life for expected deaths) are offered an EOL care planning discussion
2) 80% of patients offered a discussion should have an advanced care plan
3) 98% of patients who have an advanced care plan should have a record of the decision to resuscitate stated clearly in the notes
4) 50% of patients who die in hospital (expected deaths) should die on a Liverpool care pathway
5) Trusts, commissioners and community care should work together to audit achievement of death in the preferred place (within the specified RBH pilot project areas (Foulis ward/Adult Intensive Care Unit (AICU)).

In addition we will monitor the number of patients who die in their preferred choice of place and aim to improve on this.

Care of patients who have a cardiac arrest (heart attack) whilst in hospital

Patient outcomes – decrease the number of cardiac arrests occurring across the Trust. (excluding those which occur in the high risk area of intensive care).

Rationale

DH / NICE evidence shows that reducing out-of-ICU cardiac arrests is a marker of good clinical care of the acutely unwell patient. Ward-based patients should either be on an end of life care pathway or should be recognised as deteriorating via the completion of the patient at risk (PAR) scoring system and moved to a higher level of care prior to their arrest.

Quality standards

1) 95% patients should have a PAR score which is acted upon appropriately.
2) 100% patients who have a cardiac arrest outside of intensive care should be identified and their case reviewed as part of the resuscitation audit.

Part 2b: Statements of Assurance

Provision of NHS services

During 2010/11 the Royal Brompton and Harefield NHS Foundation Trust provided 16 NHS services.

The Royal Brompton and Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 16 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Royal Brompton and Harefield NHS Foundation Trust for 2010/11.

The Trust reviews the NHS services it provides to assess the quality of care via many different approaches including: patient and staff surveys; participation in national and local audits; and service improvement projects.

Since 2007 the Trust has carried out a programme of patient safety "walkrounds" where a senior member of the quality & safety team and an executive director visit a patient area (such as wards, x-ray, theatres and catheter labs) to listen to staff and patients regarding any safety issues and to address these. These are carried out on a quarterly basis where the executive director is linked to the same area for a period of 12 months.

The programme is constantly evolving and recent changes include: recording the results from all walkrounds electronically to simplify reporting; Trust Governors have begun attending the walkrounds; and the programme has been extended to include patient support areas such as laboratory medicine.

Participation in clinical audit

During 2010/11, 17 national clinical audits and three national confidential enquiries covered NHS services that the Royal Brompton and Harefield NHS Foundation Trust provides.

During 2010/11 Royal Brompton and Harefield NHS Foundation Trust participated in 94.4% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Brompton and Harefield NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2010/11, including actual participation rates, are listed below:

National clinical audit[1]	Did trust participate?	Participation rate[2]
Lung cancer (LUCADA)	✓	100%
Adult cardiac interventions	✓	100%
Adult cardiac surgery	✓	100%
Cardiac rhythm management	✓	100%
Heart failure	✓	100%
Myocardial ischaemia (MINAP)	✓	100%
Congenital heart disease (children and adults)	✓	100%
Paediatric intensive care audit (PICANet)	✓	100%
Endocarditis	✓	100%
Familial hypercholesterolaemia	✓	100%
Major complications of airway management in the UK	✓	100%
National audit of pulmonary hypertension	✓	100%
National cardiac arrest audit	x	n/a
National comparative audit of blood transfusion	✓	100%
SCTS adult thoracic surgery	✓	100%
UK cystic fibrosis registry	✓	100%
UKT cardiothoracic transplant	✓	100%
Trans-aortic valve implantation (TAVI)	✓	100%

1 *list of all national clinical audits which RBHNFT was eligible to participate in*

2 *cases submitted/number of cases required, as a percentage*

National confidential enquiry[1]	Did trust participate?	Participation rate[2]
Surgery in children	✓	100%
Peri-operative care	✓	100%
Cardiac arrest procedures	✓	100%

1 *list of all national confidential enquiries which RBHNFT was eligible to participate in*

2 *cases submitted/number of cases required, as a percentage*

The reports of 73 national and local clinical audits were reviewed by the provider in 2010/11. Details of some of the key findings and actions taken to improve the quality of healthcare are listed below.

National clinical audits

A process has been put in place to ensure we record and verify all key findings for patients undergoing procedures in the Trust. As well as submitting this data to the national clinical audit registries, we have developed an in-house monitoring system whereby trends in clinical outcomes are monitored and reported monthly. This allows us to identify and investigate at an early stage where outcomes do not meet the high standards we expect. Indeed, this often then leads to more targeted local clinical audits, some examples of which are below.

Local clinical audits

Patient identification

Audit showed that the way porters identified patients did not always follow the policy, and that they were often expected to remember verbal instructions of where to take patients. Over the last year, the porters have all attended specific training and have started to use a form to record the key information they need, which acts as a reminder and checklist. Re-audit has shown significant improvement both in understanding the procedure to correctly identify patients and in carrying this out.

PAR Score

The **P**atient-**A**t-**R**isk score allows staff on the ward to quickly identify patients who are becoming acutely unwell, and to take appropriate action to ensure they receive timely care. All wards have a sample of cases audited monthly, and wards are now consistently demonstrating that over 90% of the time patients are correctly scored, and the appropriate action is taken. The next stage is to link this information to the number of cardiac arrests occurring (outside of an intensive care environment). This is one of the quality priorities for the trust in 2011/12 (see page 5 of this report).

Bleeding following cardiac surgery

Following a trend noted in the monthly monitoring of outcomes, a trustwide project was initiated on both sites to better understand the reasons for post-operative bleeding and to identify best practice for managing it and preventing it.
This has resulted in a reduction in the rate of re-operation for bleeding to below the national average. See part 3 of this document for more information.

Continuous positive airway pressure (CPAP) therapy for patients with sleep apnoea

The introduction of CPAP machines with integrated smartcards has allowed the sleep apnoea team to access data directly from the machines used by new patients in conjunction with feedback from the patients. This approach is not only more convenient and saves time for patients but it identifies if the machine settings need to be changed to increase symptomatic relief for the patient. In 98% of cases audited the issues were dealt with by the technicians or practitioner and removed the need for the patient to wait for a consultant appointment.

Participation in research

Staying at the forefront of research and innovation is vital to the delivery of our services as a specialist medical centre for cardiothoracic disease. We have a broad portfolio of research ranging from studies aimed at identifying and validating new therapeutic targets through to pioneering research aimed at developing and evaluating new technologies and treatments. Many of our studies are led scientifically by Trust researchers although we also work in collaboration with other partners.

Our research activities are facilitated through two NIHR Biomedical Research Units; one in cardiovascular disease and one in advanced lung disease, both of which provide the organisational vehicles, state-of-the-art facilities and active patient-public involvement programmes for translational research in the Trust. In addition the Trust participates widely in large-scale evaluative clinical trials, many of which are underpinned by the Trust's clinical trials unit, to determine the effectiveness of new treatments whether developed within or outside of the Trust.

Participation in clinical research
The number of patients receiving NHS services provided or sub-contracted by Royal Brompton and Harefield NHS Foundation Trust to the end of quarter 4 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 4177.

In addition a further 1366 patients consented to donate their tissue for retention within the Trust's ethically approved research biobank. This tissue will be used in future research within the conditions governing the biobank's ethical approval.

These patients were recruited to one or more of 229 clinical research studies ongoing in respiratory and cardiovascular disease during quarters 1-4 of 2010/11, approved by a research ethics committee. These studies involved a total of 178 clinical staff.

Our involvement and leadership in clinical research has resulted in 1327 publications in the last three years (2007–2009).

This involvement and leadership in clinical research demonstrates the Royal Brompton and Harefield NHS Foundation Trust's commitment to improving the quality of care we offer and its contribution to the wider health improvement agenda. The involvement of many of our medical staff in research enables them to stay abreast of the latest treatment possibilities and facilitates the Royal Brompton and Harefield NHS Foundation Trust's commitment to testing and offering to its patients the latest and most promising treatments.

Commissioning for Quality and Innovation (CQUIN) 2010/11

1.5% of the Trust's contract income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Royal Brompton and Harefield NHS Foundation Trust and North West London Commissioning Partnership for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at:
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/2010%1011_cquin_schemes_in_london.html#1

The Trust believes it has achieved 100% of CQUIN payment for 2010/11, which equates to £2.7 million of income for the Trust. Please note: achievement of CQUIN goals for quarter 4 has not yet been ratified by the commissioners.

For more information on the Trust's CQUIN indicators please see part 3 of this document.

Care Quality Commission registration

Royal Brompton and Harefield NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The Royal Brompton and Harefield NHS Foundation Trust applied for registration with the CQC in January 2010 and has been registered, without conditions, since the registration system became effective on 1 April 2010.

At the time of registration, the Trust notified the CQC of some issues in respect of compliance with the essential standard relating to safety and suitability of premises in connection with the Fire Code. In response the CQC noted a 'moderate' concern regarding the safety and suitability of premises standard. During 2010/11, the Trust has undertaken work to ensure full compliance with the Fire Code and full compliance was achieved on 31 July 2010. The CQC have since confirmed satisfaction with the Trust declaration of full compliance with the essential standard relating to safety and suitability of premises.

The CQC has not taken enforcement action against Royal Brompton and Harefield NHS Foundation Trust during 2010/11.

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

Data quality

NHS number and general medical practice code validity

Royal Brompton and Harefield NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data. The percentage of records in the published data is as follows:

At 31st March 2011

Indicator	Patient group	Trust score	Average national score
% of patients with a valid NHS number	In-patients	96.2%	98.3%
	Out-patients	97.9%	99.0%
% of patients with a valid GP Practice code	In-patients	99.5%	99.8%
	Out-patients	99.4%	99.6%

Royal Brompton and Harefield NHS Foundation Trust is taking the following actions to improve data quality:

- Implementing the PAS data quality manual, this sets out the framework for managing data quality in that system.
- Raise the profile of data quality across the Trust. Identify areas of weakness and co-ordinate the development of local /system specific data quality manuals.

Information governance toolkit attainment levels

Royal Brompton and Harefield NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 76% and was graded satisfactory for all 45 requirements.

Clinical coding error rate

Royal Brompton and Harefield NHS Foundation Trust was not subject to the payment by results clinical coding audit during 2010/11 by the Audit Commission.

Part 3: Other information

Quality and safety indicators 2010/11

This year, the Trust has chosen to feature some changes to list of indicators from the Quality Account 2009/10. This has been for a number of reasons.

- The Trust wanted to reflect the commentary and recommendations made in the Department of Health (DH) review of last years Quality Account, which showed that many of the indicators used by trusts were difficult to interpret and not able to be benchmarked or compared against national standards.
- The Trust wanted to reflect the key quality and safety indicators which were routinely reported to Trust Board.
- Surgical site infection and pressure ulcers have been excluded from this section as they were CQUIN measures for 2010/11 - see pages 9 and 33 respectively.
- The staff experience indicators have been excluded because this information is now required to be made publicly available through the annual report.
- The World Health Organisation (WHO) surgical checklist indicator has been excluded, as the target was to implement this by the national deadline of Feb 2010. Therefore, this indicator is not relevant for 2011/12.
- Some new indicators have been added: mortality following primary percutaneous coronary intervention (PCI), readmissions, outbreaks of infection, never events, serious incidents, single sex accommodation.

Indicator	Target	Score 2010/11	Score 2009/10	Score 2008/09	Indicator met?
Patient safety					
Outbreaks of infection	**0**	1	1	1	x
Serious incidents	**-**	17	9	5	-
Never events	**0**	1	-	-	x
PAR score	**≥90%**	95.6%	90.5%	-	✓
Catheter-related bloodstream infection	**≥90%**	90.4%	83.5%	-	✓
Ventilator-acquired pneumonia	**≥90%**	96.2%	94.5%	-	✓
Indicator	**Target**	**Score 2010/11**	**Score 2009/10**	**Score 2008/09**	**Indicator met?**
Clinical effectiveness					
HSMR	Top 20% of trusts	80.0 (14th)	76.3 (16th)	63.3 (12th)	✓
In-hospital mortality rates					

• First-time, elective, isolated CABG	≤ 1.0%	1.1%	0.9%	0.9%	x
• First-time, elective, isolated AVR	≤ 2.8%	1.0%	0.4%	1.8%	✓
• Elective PCIs	≤ 2.0%	0.2%	0.4%	0.6%	✓
• Primary PCIs	≤ 6.5%	5.8%	-	-	✓
• Paediatric congenital procedures	≤ 1.4%	0.9%	1.0%	1.1%	✓
• First-time heart transplant	≤ 15.0%	See comment below	14.3%	33.3%	-
• First-time lung transplant	≤ 6.0%	5.2%	5.9%	5.9%	✓
Neurological injury	≥ 90%	95.4%	90.2%	n/a	✓
Readmissions	≤ 7%	1.5%	1.2%	1.4%	✓

Indicator	Target	Score 2010/11	Score 2009/10	Score 2008/09	Indicator met?
Patient experience					
Complaints per 1000 patient contacts	**< 4**	3.4	3.6	4.0	✓
Complaints response time	**90%**	82.8%	-	-	x
Single sex accommodation	**0 breaches**	0	-	-	✓
Patients would recommend this hospital to family/friends	**95%**	99%	99%	99%	✓
Key national patient survey indicators • Patients were offered a choice of food	**89%**	94%	91%	92%	✓
• Patients always had enough help with eating meals	**78%**	82%	79%	75%	✓
• Patients felt they were treated with dignity and respect	**90%**	95%	91%	92%	✓
• Patients felt the room or ward was clean or very clean	**90%**	93%	100%	99%	✓

National priorities

The table below shows the key national priorities from the Department of Health's Operation Framework and Monitor's Compliance Framework which were relevant for this Trust in 2010-11.

National Priority	Source	Target/ threshold	Monitor weighting	2010/11 score	Indicator met
Clostridium difficile - year on year reduction to comply with the trajectory for the year agreed with Kensington & Chelsea PCT	Compliance Framework and Operating Framework (Vital Signs)	27	1.0	18	✓
MRSA – maintaining the annual number of MRSA bloodstream infections at five or less (baseline year 2003/04) as agreed with commissioners	Compliance Framework and Operating Framework Vital Signs	2	1.0	2	✓
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	Compliance Framework and Operating Framework (Vital Signs)	94%	1.0	100%	✓
Maximum two month wait from referral to treatment for all cancers*	Compliance Framework and Operating Framework (Vital Signs)	79%	1.0	86.3%	✓
Maximum two month wait from consultant upgrade to treatment for all cancers*	Compliance Framework and Operating Framework (Vital Signs)	79%	1.0	81.48%	✓
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	Compliance Framework and Operating Framework (Existing Commitments)	93%	0.5	100%	✓
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	Compliance Framework and Operating Framework (Existing Commitments)	96%	0.5	98.9%	✓
Screening all elective in-patients for MRSA	Compliance Framework	-	0.5	1.06	✓
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance Framework	-	0.5	-	✓
Maximum two-week wait standard for Rapid Access Chest Pain Clinics	Operating Framework (Existing Commitments)	98%	-	100%	✓
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Operating Framework (Existing Commitments)	<0.8%	-	1.05%	✓^
Delayed transfers of care to be maintained at a minimal level	Operating Framework (Existing Commitments)	-	-	0.31%	✓
Percentage of patients seen within 18 weeks for admitted and non-admitted pathways	Operating Framework (Vital Signs)	Admitted: 90% Non-admitted: 95%	-	Met for all months	✓

*Threshold adjusted to account for 6% additional tolerance applied by CQC in recognition of the complexity of lung cancer pathways

^Indicator underachieved owing to ongoing difficulties balancing capacity and demand. >1.5% = Fail

Compliance Framework

In addition to the key national indicators listed on the previous page, Monitor's Compliance Framework also scores the level of concern regarding the safety of healthcare provision. In 2010-11, Monitor had no concerns with the safety of health provision in the Trust.

	Monitor weighting	Trust score in 2010-11	Indicator met
Moderate CQC Concerns regarding the safety of healthcare provision	**1.0**	0	✓
Major CQC Concerns regarding the safety of healthcare provision	**2.0**	0	✓
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) or as subsequently amended with the CQC's agreement	**4.0**	0	✓

The combination of meeting all the Compliance Framework indicators and the CQC having no concerns regarding the safety of healthcare provision has meant that the Trust has been given a green rating for Governance by Monitor in 2010-11.

Monitor Compliance Framework 2010-11

Governance rating	Score 0.0	Status – **green**

CQUIN goals 2010/11

The Trust agreed 10 goals with the commissioners for 2010/11, and these measures were a mix of nationally mandated, regionally suggested and locally developed indicators.

These goals were linked to the Trust's contractual income and in total equated to 1.5% of the income (£180 million). In 2010-11, the Trust believes it has achieved all the CQUIN goals, which equates to £2.7 million of income for the Trust. Please note: achievement of CQUIN goals for Quarter 4 has not yet been ratified by the commissioners.

1. National CQUIN indicators			
Goal	Target	Achievement 2010-11	CQUIN met?
Improve VTE prevention	National Target 90%	90%	✓
Responsiveness to patient needs	Top 20% of trusts	Top 20% of trusts	✓
2. Regional (London) CQUIN indicators			
Discharge on agreed date	Q2 – 60% Q3 – 70% Q4 – 80%	86%	✓
Information in discharge letters	60% across all divisions	89%	✓
Outpatient letters sent within five days	70% across all divisions	82%	✓
Global trigger tool	10 sets of notes audited per fortnight	10 sets of notes audited per fortnight	✓
3. Local CQUIN indicators			
CABG SSI	6.3 per 100 operations	4.5 per 100 operations	✓
Valve SSI	To be agreed – National baseline not released yet	0.62 operations	✓
Safeguarding Children Level 3 Training	80% Trained by Q4	100%	✓
Pressure ulcers	Improvement in reporting compliance	100%	✓

Five of the indicators and achievement of the goals are detailed in the quality improvement priorities for 2010/11 section (page 5) as they had been identified as priority topics: discharge on agreed date, information in discharge letters, safeguarding children training, surgical site infection following CABG and cardiac valve procedures. The other five indicators are detailed on the following pages.

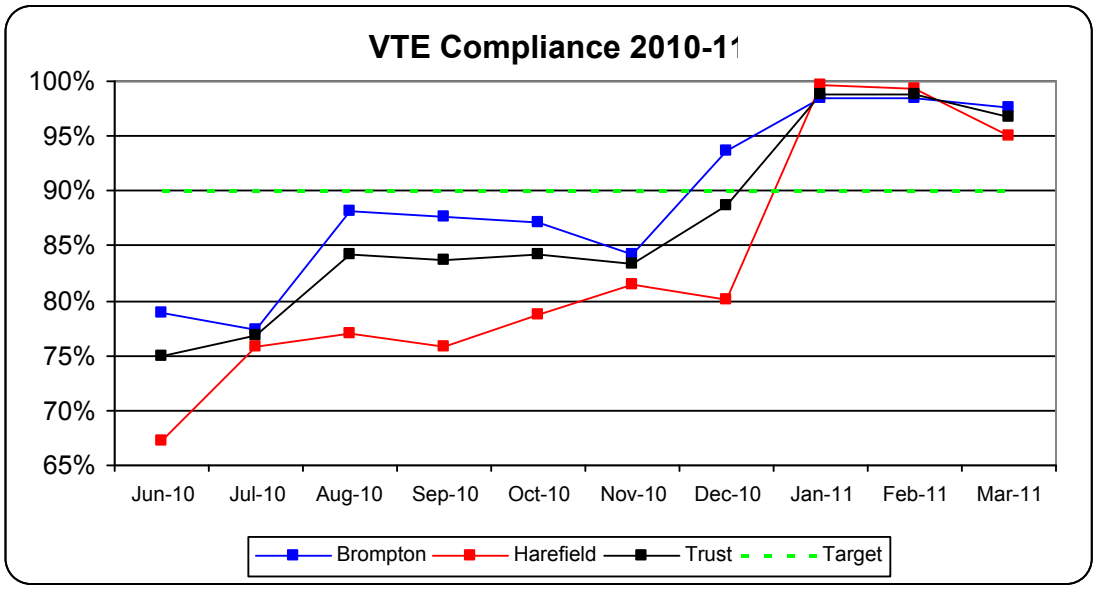
Improve venous thromboembolism (VTE) prevention

Venous thromboembolism (VTE) is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments can be used. The Department of Health (DH) has commenced data collection to quantify the number of adult admissions who are being risk assessed for VTE from June 2010.

A cohort approach to managing the indicator has been adopted since the DH recognised that the risk assessment is pointless in a large number of patients. The low risk cohorts are procedures where that risk is deemed to be small and so each patient does not need to have an individual assessment. Patients who are in a cohort are added automatically to the numerator in CQUIN.

The percentage of VTE assessments completed in Q4 is 98.1% which means achievement against the target of 90%. January and February showed the highest performance to date with over 99% compliance at Harefield and over 98% compliance at Royal Brompton. This has been achieved through regular ward rounds and logging of assessments by the Trust lead.

VTE compliance since reporting began in June 2010



Improve patient experience as per adult inpatient survey

Responsiveness to patient needs is measured through the NHS inpatient survey once a year. The survey is based on a sample of consecutively discharged inpatients who attended our Trust in June 2010 (see part 3 for more information on the inpatient and outpatient surveys and the actions taken following the 2009 surveys).

This indicator is calculated from five survey questions known to be important to patients and where past data indicates room for improvement:

- Involved in decisions about treatment/care
- Hospital staff available to talk about worries/concerns
- Privacy when discussing condition/treatment
- Informed about medication side effects
- Informed who to contact if worried about condition after leaving hospital

The target, agreed with commissioners, is to remain within the top 20% trusts nationally for each of the five questions in order to receive 100% payment.

Achievement of the CQUIN goal is based upon the Care Quality Commission report which was published in April 2011. The Care Quality Commission benchmarks our results with 100% of trusts in England.

The scores in the table below show the Trust scores for 2010 survey in comparison to the results from 2009. It demonstrates that on all five questions the Trust has scored in the top 20% of trusts as reported by the Care Quality Commission.

Trust inpatient survey scores 2009 and 2010

Improving responsiveness to personal needs of patients (CQUIN)			
	2009	**2010**	**In top 20% of trusts**
Care: wanted to be more involved in decisions	76/100	77/100	✓
Care: could not always find staff member with whom to discuss concerns	68/100	72/100	✓
Care: not always enough privacy when discussing condition or treatment	86/100	88/100	✓
Discharge: not fully told side-effects of medications	48/100	55/100	✓
Discharge: not told who to contact if worried	86/100	86/100	✓

The target, as mentioned above, is to remain within the top 20 nationally for each of the five questions in order to receive 100% payment. The Trust is in the top 20% of trusts for all five questions in the Picker report and also in the CQC report which compares the Trust to all trusts in England. Therefore, at year end 2010/11 this has been achieved and the Trust will receive 100% of the payment.

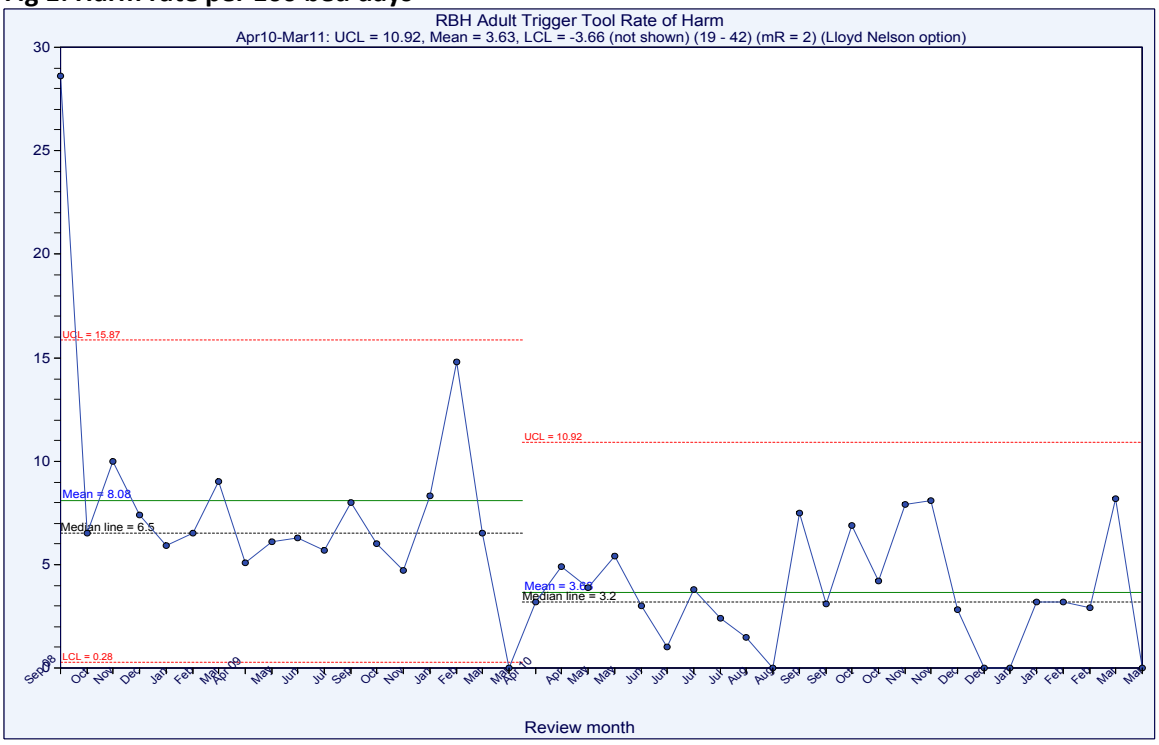
Implement the IHI global trigger tool (GTT)

The adult trigger tool (ATT) was introduced at Royal Brompton Hospital in August 2008 and at Harefield Hospital in September 2010. Regular reviews are now being carried out and, to date, 420 patients have been reviewed over a period of 42 reviews.

At each review 10 sets of patient notes (per site) are reviewed using the trigger tool to measure how many triggers are present in that episode of care and how many events have occurred as a consequence. Each event is then given a harm rating.

Figure 1 below shows the harm rate per 100 bed days. The mean, median and control limits have been calculated for 2010/11 reviews to demonstrate the reduction in harm rate since the introduction of the trigger tool.
Between the period of Sep 08 and Mar 10 the harm rate fluctuated around the median of 6.5 events/100 bed days with two peaks in Sep 08 and Feb 10.
For 2010/11 the median has reduced significantly to 3.2 events/100 bed days with the harm rate continuing to fluctuate around the median to the year end.

Fig 1: Harm rate per 100 bed days



In response to the findings a number of improvement projects have been started:

- Recommendations from the NICE guideline 'Acutely ill patients in hospital' have been implemented. This means the Trust now has a track and trigger system for identfiying deteriorating patients and monthly monitoring currently demonstrates >95% compliance across the trust.
- Both sites have multidisciplinary groups looking at peri-operative bleeding. There is evidence of a reduction in patients being returned to theatre for bleeding over the last year as a result of this work.

- A cross site group looking at wound infection prevention, has implemented a number of changes to reduce surgical site infection rates. The current rate is comparable to the national rate (as reported by the HPA) and below the CQUIN indicator rate. Wound infections in first time CABG and valve patients are monitored monthly, as is compliance with the SSI prevention care bundle. This has been extended recently to include thoracic wounds and pacemaker implant wounds.
- Work to improve the management of diabetic patients who are at high risk of wound infections is underway, including a business case for a diabetic specialist nurse.

Future plans

The UK version of paediatric trigger tool was piloted at Royal Brompton but it was found to be unsuitable, as it was not sensitive or specific enough for our specialist paediatric patient population. Therefore, we are now working to develop a bespoke tool for use at Royal Brompton.

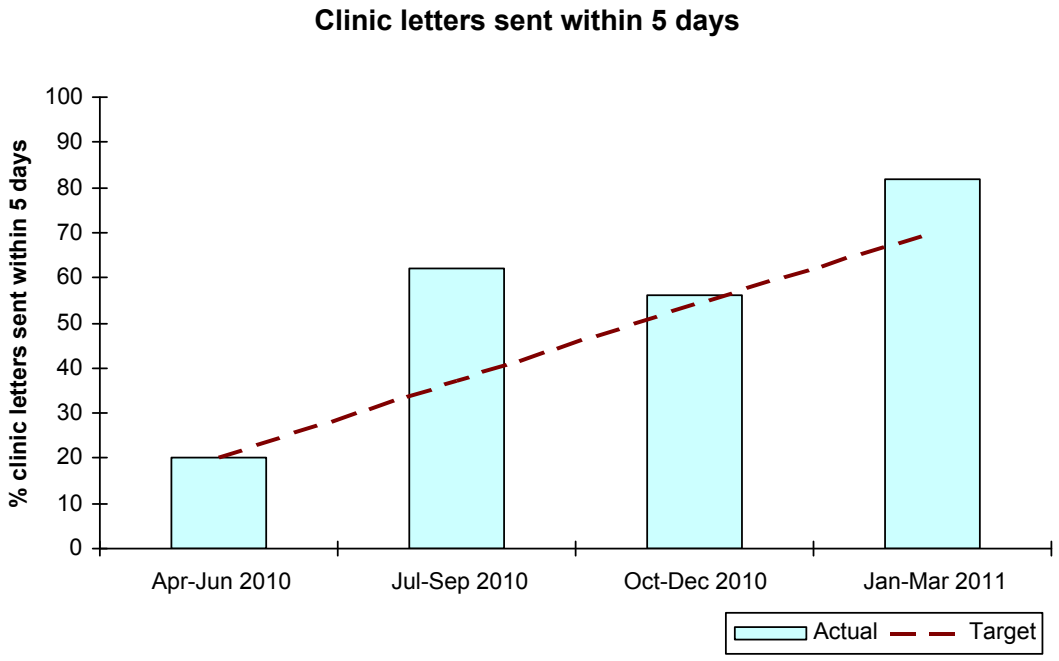
Improve planning of outpatient care

There is a significant increase in new outpatients who have a letter sent to their GP and any other relevant primary care clinician within five days of their first outpatient appointment summarising:

- the ongoing care plan
- if no follow-ups are needed at what point the GP should re-refer or explore other avenues of care (if applicable)
- estimated number of follow up appointments required (if applicable)
- medication and an explanation of why medication has been changed (if applicable)

The indicator requires a minimum of 20% of letters sent within five days with the target rising to 70% in the last quarter.

The chart below shows the percentage of clinic letters sent within five days of the outpatient appointment. This data was collected from the audits carried out on a quarterly basis which on average looked at approximately 100 sets of notes. The chart shows that by quarter 4 the Trust had exceeded the target of 70% with 82% of letters audited being sent within five days.



Preventing pressure ulcers

In 2004, it was estimated that the NHS in the UK spent between £1.4-2.1bn on treating pressure ulcers. In 2008/9 there were over 51,000 pressure ulcers identified, and, of these 6,700 were graded 3 and 5,600 graded 4. While many of these will be present on admission, many are developed in acute care.

This indicator measures the monitoring and prevention of pressure ulcers. During 2010/11 the emphasis was on setting up a robust system across all areas of the Trust which would allow the Trust to accurately monitor the number of pressure ulcers patients were admitted with, and/or occurred whilst an in-patient

The compliance is calculated weekly at ward level. Each ward sends a report including patients who have been admitted with or acquired a pressure ulcer that specific week. The compliance is calculated as the number of times each ward reported during the month divided by the number of weeks in the month. This is then aggregated for all the wards across the trust.

The table below shows that with new management emphasis being placed upon weekly pressure ulcer incidence reporting compliance by nursing management, the reporting on both sites has shown a significant improvement, and we are now confident that the number of pressure ulcers reported is accurate.

No. of patients	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011
Admitted with ulcers	43	25	32	28
Hospital acquired ulcers	57	58	81	78
Ulcer reporting compliance	83%	92%	93%	100%

Q4 has shown an increasing improvement in reporting compliance across the trust, rising from 83% in Q1, 92% in Q2, 93% in Q3 and 100% compliance in Q4.

With the increase in reporting compliance there has been a corresponding increase in reported hospital acquired pressure ulcers. Across the Trust in total the hospital acquired pressure ulcers showed an increase of approximately 33% in Q3. However, that has been followed by a small reduction in Q4. In Q4 the proportion of Grade 1 pressure ulcers to Grade 2 and above however was 62%:38%.

Actions completed or in progress:

- The implementation of eight tissue viability champions at Harefield ITU is complete.
- All grade 3 and 4 pressure ulcers have a root cause analysis investigation completed to ascertain cause of ulcer
- The trial introduction of “Anchor Fast” oral endotracheal tube fastener in ITU Harefield occurred. This device relieves the pressure of the tube from the lips, corners of the mouth and surrounding tissue and eliminates the need for re-taping. Incidence of oral pressure ulcers have reduced and the device will now be rolled out with supporting guidance.
- The P.U.M.P (Pressure Ulcer Management Process) Tool was formally launched in February 2011 in Harefield ITU and is now being uploaded onto the intensive care electronic information system. This tool incorporates the Waterlow Risk Assessment Score, NICE Pressure Ulcer Management Guidelines (2005) and RBH and Harefield NHS Foundation Trust Pressure Ulcer Prevention and Management Guidelines for Very High/High Risk Patients (2010). It also gives a measure for dependency and substantiates the use of specialist pressure relieving devices.
- “Aderma” pressure relieving gel pads continue to be the first line management of pressure ulcer prevention and management for very high/high risk patient category patients in accordance with trust guidelines.
- Quarterly Critical Care Magazine to be launched in April 2011 with a specific section for tissue viability issues.

CQUIN goals 2011/12

The following CQUIN measures have been agreed with the North West London Commissioning Partnership for 2011/12. Goals 5 and 6 were also identified as priority topics for quality improvement and have been detailed in Part 2a (page 5). Further details of the other CQUIN measures for 2011/12 can be found in the table below and on the following pages.

Goal number	Goal name	Description of goal	Goal weighting
1	**VTE prevention**	Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)	**15%**
2	**Patient experience-personal needs**	Improve responsiveness to personal needs of patients	**15%**
3	**Pressure ulcers**	Reduction of grade 2 and 3 pressure ulcers	**10%**
		Evidence in achieving grade 4 ulcer prevention and reduction trajectory	**10%**
4	**Falls**	Reduce the total number of falls according to the agreed trajectory	**10%**
		Reduce the number of falls resulting in "harm" according to the agreed trajectory	**10%**
5	**End of life care**	Improving end of life care for people and achieving the quality standards.	**15%**
6	**Availability of patient records in outpatient clinics**	Improving availability of patient records in outpatient clinics	**15%**

Quality and Risk Profile (QRP)

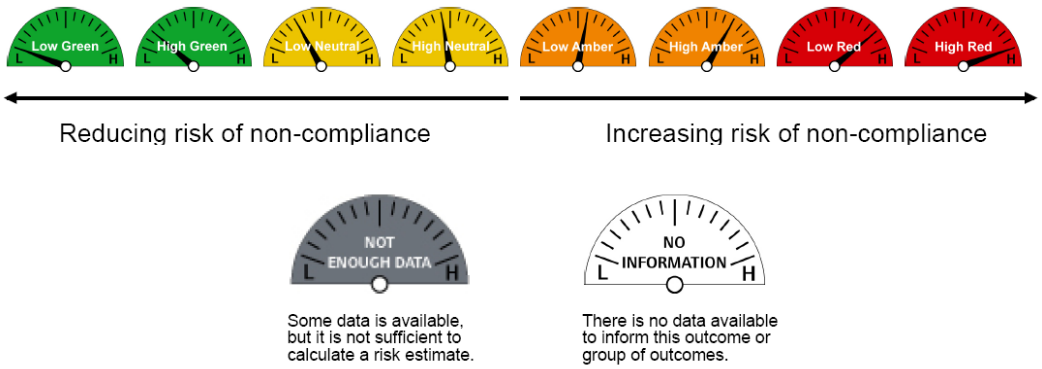
From 1 October 2010, all health and adult social care providers are legally responsible for making sure they meet essential standards of quality and safety and must be licensed with Care Quality Commission (CQC).

The essential standards are monitored by the CQC through the Quality and Risk Profile (QRP). The information presented in the profiles is organised using 16 outcomes and includes both qualitative and quantitative data from:

- Other regulatory bodies – for example the National Patient Safety Agency.
- NHS Litigation Authority.
- Routine data collections – for example, hospital episode statistics and estates return information collection.
- Other CQC regulatory activity – for example, monitoring of compliance with the regulation on cleanliness and infection control.
- National clinical audit datasets.
- Information from people using services – for example NHS Choices and feedback from Local Involvement Networks (LINks).
- National priorities and existing commitments

The CQC will inspect all healthcare providers within two years of registration. The CQC may use the Trust's Quality and Risk Profile as one of the tools to inform them on how the Trust is performing in conjunction with provider compliance assessment (PCA) tools which Trusts complete to detail their compliance against essential standards. These may be requested at any time by the CQC. Inspections by the CQC will be unannounced and will last 2-3 days.

Each standard is measured on a scale from low green to high red.
Low green is the best possible score
High red is the worst possible score



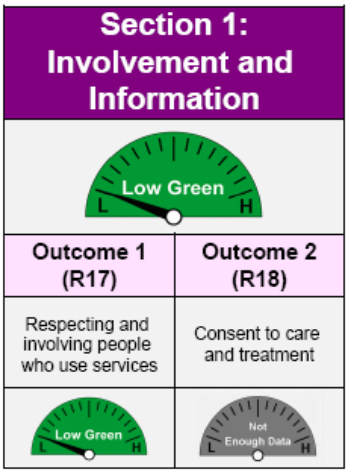
As at March 2011, the Trust scored either **green** or **yellow** for all 16 outcomes, which indicates a low risk of non-compliance with the essential standards of care.

The essential standards

The results below are extracted from the QRP for March 2011. The Trust scored between low green and high neutral for all five essential standards.

Standard 1: You can expect to be involved and told what's happening at every stage of your care

- You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
- You will be given opportunities, encouragement and support to promote your independence.
- You will be able to agree or reject any type of examination, care, treatment or support before you receive it.



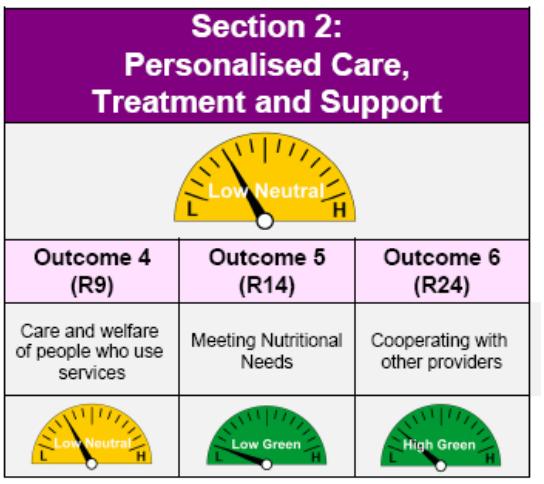
Scores range from low green to high red

Low green is the best possible score

There is only one indicator relating to consent to care and treatment, which his why Outcome 2 is scored as 'Not enough data'. The Trust scored 'much better than expected' for this indicator

Standard 2: You can expect care, treatment and support that meets your needs

- Your personal needs will be assessed to make sure you get care that is safe and supports your rights.
- You will get the food and drink you need to meet your dietary needs.
- You get the treatment that you and your health or care professional agree will make a difference to your health and wellbeing.
- You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services.



Scores range from low green to high red

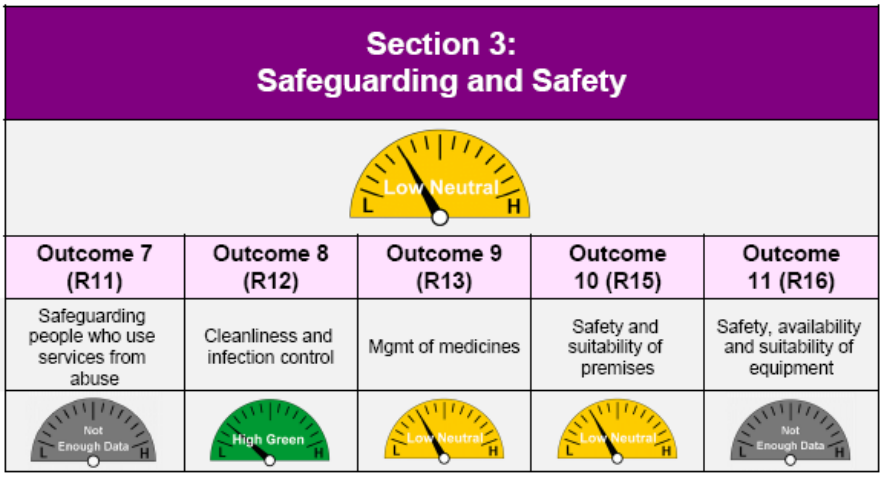
Low neutral is a better than average score

Low green is the best possible score

High green is the second best possible score

Standard 3: You can expect to be safe

- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.
- You will be cared for in a clean environment where you are protected from infection.
- You will get the medicines you need, when you need them, and in a safe way.
- You will be cared for in a safe and accessible place that will help you as you recover.
- You will not be harmed by unsafe or unsuitable equipment.



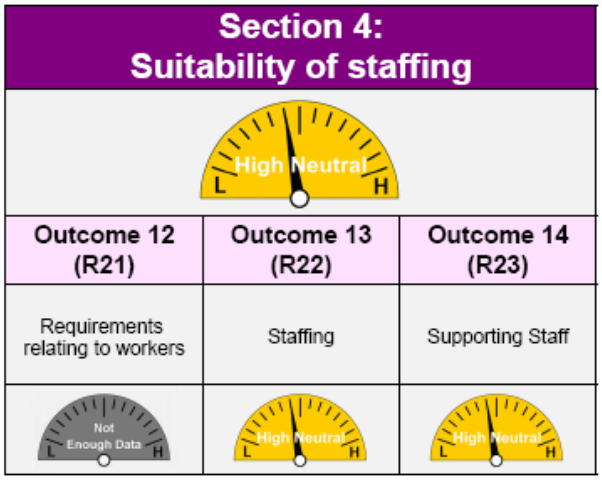
Scores range from low green to high red

Low neutral is a better than average score

High green is the second best possible score

Standard 4: You can expect to be cared for by qualified staff

- Your health and welfare needs are met by staff who are properly qualified.
- There will always be enough members of staff available to keep you safe and meet your health and welfare needs.
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.



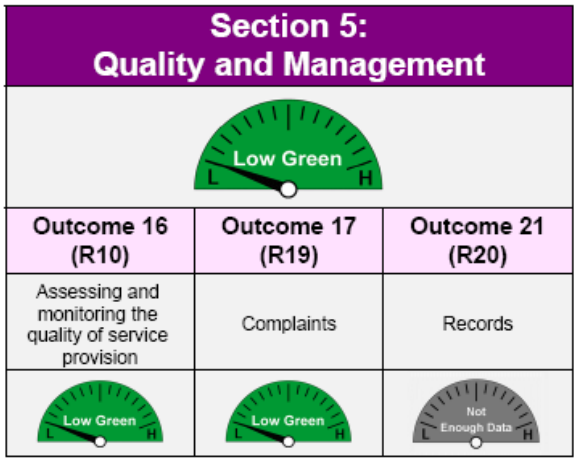
Scores range from low green to high red

High neutral is a better than average score

There are only two indicators relating to requirements relating to workers, which his why Outcome 12 is scored as 'Not enough data'.
The Trust scored 'much better than expected' for one indicator, and the other indicator is not yet updated to reflect 2010 results

Standard 5: You can expect your care provider to constantly check the quality of its services

- Your care provider will continuously monitor the quality of its services to make sure you are safe.
- If you, or someone acting on your behalf makes a complaint, you will be listened to and it will be acted upon properly.
- Your personal records, including medical records, will be accurate and kept safe and confidential.



Scores range from low green to high red

Low green is the best possible score

The majority of the indicators relating to records are not relevant to the Trust, which his why Outcome 21 is scored as 'Not enough data'.

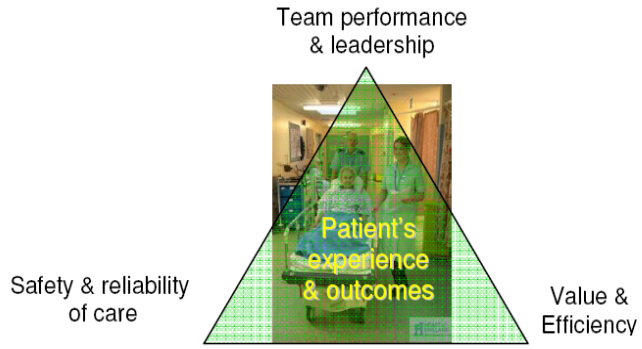
Other quality improvement projects in 2010/11

The Productive Operating Theatre and Catheter Lab Utilisation programme

The Productive Operating Theatres (T-POT) is part of the Productive Series - an improvement programme produced by the NHS Institute for Innovation and Improvement. The Trust had already successfully implemented the Productive Ward in the Trust and intended to use the programme in both theatres and catheter labs. The Trust programme was therefore named TPOT & CUP: The Productive Operating Theatre and Catheter Lab Utilisation Programme.

There are three main areas of the programme, which aim to contribute to improved clinical outcomes and experience for the patient:

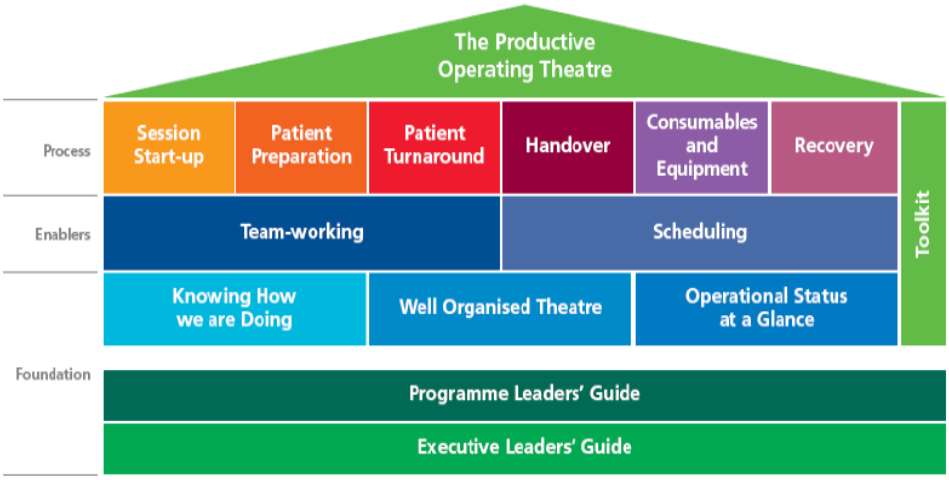
- Increase the **safety and reliability of care** through reducing errors and incidents of harm
- Improve **team-working** and performance, staff morale and leadership
- Add value and improve **efficiency**



The programme utilises lean methodology and effective team-working principles to create the 'perfect operating list' and environment. It is aligned to the principles and methodology outlined in the national quality, innovation, productivity and prevention (QIPP) agenda.

The structure of T-POT can be seen in the figure below: the model being based on the concept of a 'house' with three sets of modules; foundation, enablers and process modules:

T-POT structure



Both projects are reaching the final stages of their foundation modules and are setting plans in place for the next phase of work. The projects have begun to:

- deliver cost savings on stock and consumables, which will continue into 2011/12
- improve communication between the wards and catheter labs with electronic systems being implemented during 2011/12
- identify measures to track the improvements from this project
- Improve start times in catheter labs at Royal Brompton Hospital
- Improve team-working and communication in both theatres and catheter labs

Considerable progress on this project is expected during 2011/12.

Adaptations of the NHS Institute's Productive Series have been launched at Harefield, with work beginning on The Productive Imaging and Cardiology (TPIC) and The Productive Outpatients Department (TPOD).

Patient survey results

The Trust participates in both the national inpatient and outpatient surveys. The sample size is approximately 850 patients for each survey; the questions are nationally set and may not be amended by the Trust.

Inpatient survey 2009 - actions taken

The Trust had a 61% response rate in comparison to the national average of 52%. The feedback from patients is very encouraging and the Trust rated in the best performing 20% of Trusts for 76.6% (49/64) of the questions. These included questions on cleanliness of the hospital, having confidence in the nurses and doctors, hospital food, privacy, respect and dignity, and overall rating of the hospital.

The Trust was rated in the worst performing 20% of Trusts for only one question: ensuring that the correspondence between the hospital and their GP is written in way patients could understand.

The Trust policy is for letters written by clinicians regarding patient care to be routinely copied to patients. These letters are intended for use by another clinician, and at times it may be difficult for a patient to understand. However, this is in addition to many other ways patients receive information about their care e.g. patient information leaflets, local area support, direct line access to staff etc.

The results of the 2010 survey were published by the CQC in April 2011 and again show very positive feedback for the Trust, with the Trust being in the top 20% of Trusts for 69% of the questions. This survey has also shown that the Trust has improved significantly for provision of understandable correspondence.

Outpatient survey 2009 – actions taken

The Trust had a 58% response rate in comparison to the national average of 53%. The Trust again performed well in this survey and was rated in the best performing 20% of Trusts within the survey for 55% (22/40) of the questions. These included questions on choice of appointment times, communication with and confidence in the doctor, information provided, privacy and overall satisfaction.

The Trust was rated in the worst 20% for four areas: told how long to wait, why you had to wait, explanation of need for a test and how to find out about test results.

In response to waiting times, the Trust has recognised that good communication is key and have implemented several actions including informing patients of known delays when arriving in outpatients and of unexpected delays in clinic and regularly updating electronic waiting time boards.

In response to patients undergoing tests, the issues have been discussed at local staff meetings to raise awareness amongst staff the importance of explaining the test required and how the patient can find out about their results.

Since the survey was carried out, snapshot audits have been conducted to gain feedback from patients attending outpatient clinics. This has generally been very positive on many aspects of the service but reinforced the need to reduce waiting times in clinic. The feedback also gave an insight into what matters most to patients and has provided them with some ideas for further improvement work in 2011/12.

The outpatient survey is carried out every two years therefore the next survey will take place in 2011 with the results published in spring 2012.

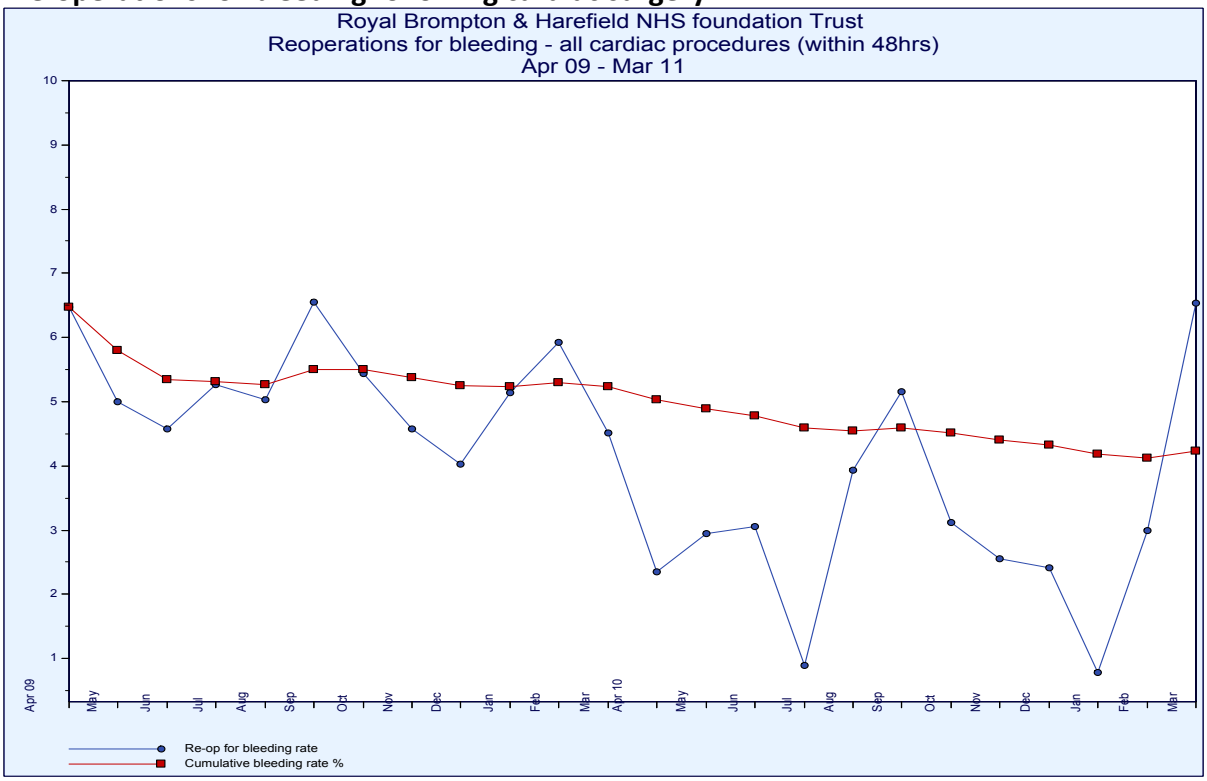
Reducing re-operations for bleeding following cardiac surgery

The Trust routinely reports on the number of patients who return to theatre for a re-operation after they have undergone cardiac surgery. Patients may return for several reasons, one being exploration for bleeding following surgery which, dependent on the cause and severity, may be managed medically or surgically. The Trust set up a group to look specifically at patients who returned to theatre for bleeding and to establish whether a reduction could be made and whether this impacted on their length of stay in the hospital.

The study found that patients who underwent a re-operation experienced an increased average length of stay in intensive care from 2.7 days to 9.8 days and on the ward from 13.4 days to 21 days. Several strategies were put in place to help reduce peri-operative bleeding such as updating guidelines in light of new national guidance, publishing guidance on how to manage peri-operative bleeding and how to respond to thromboelastography data (a form of monitoring coagulopathy), and clarification of lines of accountability.

The chart below shows the Trust-wide re-operation rate by month and cumulatively since April 2009. As the chart shows, on a monthly basis there is still fluctuation in the re-operation rate however, when comparing the overall cumulative figure for 2010/11 against 2009/10 there is a consistent decrease with a 39.6% reduction in the number of patients returning to theatre which equates to 40 fewer patients over the year.
When breaking this down by site the rate of patients returning to theatre for a re-operation at RBH has reduced by 54.6% and at HH by 27.2% over the year 2010/11 when compared to 2009/10.

Re-operations for bleeding following cardiac surgery



Annex: Statements from commissioners, local involvement networks and Overview and Scrutiny Committees

The local involvement networks, Oversight and Scrutiny Committees and our local commissioners have been offered the opportunity to comment on the draft copy of this document, and hence offer some valuable feedback regarding its content, and in particular its accessibility for members of the public, which can be incorporated into the final version.

The same groups have also been invited to make a formal review and comment on the final report for 2010/11 – and these statements are represented on the following pages.

Statements from local involvement networks

Kensington and Chelsea LINks

Kensington and Chelsea Local Involvement Network (K&C LINk) welcome the opportunity to comment on the Royal Brompton & Harefield NHS Foundation Trust Quality Account. The LINk would like to thank Trust staff for their support over the consultation period.
To summarise, the main issues of concern to K&C LINk in the Royal Brompton & Harefield NHS Foundation Trust Quality Account are:
1. The performance report contained within the QA is very slight. The QA should we think, give a clear idea of the FT's performance in absolute and comparative terms so that the public can form a view about whether they want to use the RB&H or go elsewhere.
2. Although there is an improved level of detail compared to last year on the level of patient/public involvement, we would appreciate further information on how exactly the Quality Account reflects the year-long stakeholder engagement process and locally identified priorities.

The K&C LINk wishes to strengthen the relationship it has with the Trust and suggests establishing a formal liaison arrangement. We are happy to share the information and intelligence we collect and to offer our support to the Trust with patient and public involvement.

We strongly recommend the Trust considers their approach to the Quality Account process for 2011/12 now. Engagement with the public and patients, should be continuous throughout the year. Then, the public, the target audience for the QA, will have the opportunity to feedback in a timely and effective way throughout the year. The Quality Account should also be more reflective of local priorities as a result.

Hillingdon LINks

We are grateful for the opportunity to comment on the QA for Royal Brompton and Harefield Hospitals. This was carried out by a sub committee of the Hillingdon LINk dedicated to Quality Accounts following the guidance issued to Links for this task.

However, despite having some very interesting content regarding the hospitals activity such as improvements following audit and involvement of staff patients and other stakeholders in choosing priorities for development there are points in the report that need addressing.

The most obvious comment from the group is that it is very long and as such becomes inaccessible to the public who simply would not struggle through it. The QA is aimed at a local, public readership and this seems to have been forgotten in some areas. The document contains many areas of jargon and use of abbreviations which are not always explained.

- Part 2 starts with inconsistency of naming the topics selected as priorities i.e. "treatment options discussed by a group of relevant specialists" becomes "Discussion of treatment plans at a multidisciplinary team (MDT) meeting for elective patients undergoing surgery"
- ""care of patients who have cardiac arrest (heart attack) whilst in hospital" becomes "Out of Intensive care cardiac arrests…"
- Throughout the document there is overuse of three letter abbreviations (TLAs) without explanation (see page 6 for an example).
- The section on Improvement plans is very confusing and inconsistent. Perhaps page10 should come before page 5 so that references to payments and standards are clearer.
- There is no explanation of CQIN until page 23
- And what is a "goal weighting"?
- Quality of Life and Risk Profile is a good section which is easy to understand with good explanations.
- CQUIN info on page 23
- The table contains too many TLAs to be understood by the general public.
- The section on" Improve venous thromboembolism "second paragraph is full of jargon and is not reader friendly.
- Page 27. IHI used as abbreviation before being used in full and the "harm rate" graph is too small and the text is full of jargon which continues into page 28 "..as is compliance with the SSI bundle"etc.

Using the links guidance notes for assessing QAs the following applies

Provider priorities reflective of population?	Yes
Important issues missed from Account ?	Not obviously
Demonstration of public and patient involvement	Yes
Clear presentation to public	Not fully met as yet

Statement from Overview and Scrutiny Committees

Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee

Introduction

As Chairman of this Council's Health, Environmental Health and Adult Social Care Scrutiny Committee, I welcome the opportunity to comment on the Royal Brompton and Harefield NHS Foundation Trust's Quality Account 2010/2011.

The Royal Borough of Kensington and Chelsea's Health, Environmental Health and Adult Social Care Scrutiny Committee (HEHASC SC) and Council both have good working relationships with the Royal Brompton and Harefield NHS Foundation Trust.

Comments

I am concerned about the financial outlook for Royal Brompton and Harefield NHS Foundation Trust and particularly about any impact on the Trust of changes to children's congenital heart services in England. Cash pressures could lead to cuts to patient care. The Trust's efforts to make efficiency savings without loss of service are to be supported.

There is also concern about the effects of removing Royal Brompton's children's heart surgery on other services at the Trust, most notably those for children with cystic fibrosis. The knock-on effects at Chelsea and Westminster Hospital Foundation Trust also need to be borne in mind when considering changes to paediatric services at Royal Brompton & Harefield, and the Scrutiny Committee will be responding to the relevant public consultation accordingly.

It remains unclear as to how the Royal Brompton and Harefield NHS Foundation Trust's long-term plans fit with the long-term plans of Imperial College Healthcare NHS Trust, but I am aware that the first shared service to be launched as part of the two trusts' Academic Health Science System, the aortic dissection service, was launched successfully in February.

The HEHASC SC has found it a challenge to make a meaningful response to the Trust's draft Quality Account. The Trust needs to pay due attention to how readable and accessible its Quality Account is. For example, it is difficult to analyse these Quality Accounts, as much information is not included (e.g. data comparisons over a long timeframe to show the ups and downs of performance).

Overall, the progress that the Trust has made over the last year is to be welcomed, particularly with respect to patient safety issues such as surgical site infections, and I look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2011/12.

Councillor Mary Weale

Chairman for the Health, Environmental Health and Adult Social Care Scrutiny Committee

External Services Scrutiny Committee at the London Borough of Hillingdon

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2010/2011 Quality Account and acknowledges the Trust's commitment to attend its meetings when requested. It is noted that the Trust has formulated its 14 priority topics for the forthcoming year in consultation with Hillingdon and Kensington & Chelsea councils. Individuals were then invited to vote on line for their preferred quality project in each of the three key areas. The views of the Committee have been broadly categorised under these three key areas:

1. Patient safety;
2. Patient experience; and
3. Patient outcomes.

1. Patient safety

We are pleased to note that the Trust has been awarded Level 3 status (the highest level) by the NHS Litigation Authority in September 2010 in relation to its risk management. This is undoubtedly a reflection on the Trust's emphasis on ensuring that quality and safety are at the heart of everything it does.

With regard to the availability of patients' records, we are concerned that the availability of paper records has been given a higher target (99%) than electronic records (95%). Given that electronic records are more easily accessible across an indefinite area, we would have liked to have seen that electronic records were awarded the same target.

It is reassuring to note that, where there are areas for improvement, the Trust has put measures in place to address the issues. For example, the work that is currently underway to increase the percentage of Venous thromboembolism (VTE) assessments undertaken at Harefield will go a long way to ensure that the Trust reaches its target by the end of Q4.

2. Patient experience

As the Trust's primary angioplasty workload has increased by 40% over the last four years, bed capacity is tight, particularly at Harefield with regard to acute cardiac interventions. This does cause the Committee some concern.

We congratulate the Trust for the various consultation exercises that it has carried out with patients, staff, FT members and governors to establish where improvements can be made.

3. Patient outcomes

Consideration should be given by the Trust to ensuring that there is information about current performance available within the report so that the targets that are being set can be put in context. For example, on page 7, a quality standard has been set for the next year to ensure that "95% of patients should have a PAR [patient at risk] score which is acted upon appropriately". It would be useful for the report to include the current figures for such targets, where possible. Furthermore, the use of subjective words such as "appropriately" should be discouraged.

Overall, the committee is pleased with the continued progress that the Trust has made over the last year and looks forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2011/12.

Statement from Commissioner

North West London Commissioning Partnership

The Royal Brompton and Harefield BNHS Foundation Trusts Quality Account for 2010/11 is a statutory requirement under the Health Act 2009 and Monitor's regulations for Foundation Trusts. The Trust has combined the two reports into one document for the purposes of filling the dual requirements.

The presentation of the account details largely follows the format laid out in the Quality Account Toolkit published by the Department of Health and also details the consultation process that lead to the identification of the three priority areas - which is an improvement from last year. It would be beneficial to have a longer consultation period on the choice of priority topics for next year.

It is noted that Royal Brompton & Harefield NHS Foundation Trust has achieved the targets for quality improvement through the CQUIN scheme and has participated in a wide range of national audit programmes and research.

Glossary

A

Adult Intensive Care Unit (AICU)	A special ward for people who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.

B

Biobank	A cryogenic 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
Care Quality Commission (CQC)	The independent regulator of health and social care in England www.cqc.org.uk
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.
Coagulopathy	Defects in the body's mechanism for clotting blood
Commissioning for Quality Innovation (CQUIN)	A payment framework that enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals
Compliance Framework	The *Compliance Framework* sets out the approach Monitor uses to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.

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 patients body

D

Delayed transfers of care	A national indicator. Assesses the number of patients who are delayed when being transferred from one health organisation to another e.g. from one hospital to another, or from hospital to community care.
Department of Heath (DH)	The government department that provides strategic leadership to the NHS and social care organisations in England www.dh.gov.uk/
Dr Foster Intelligence	Dr Foster Intelligence is a joint venture with the Department of Health. It offers a range of information tools to help the NHS and other organisations improve the quality and efficiency of services. http://www.drfosterintelligence.co.uk/

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.
Elective operation/procedure	An operation or procedure that is planned. It is usually a lower risk procedure, as the patient and staff have time to prepare.
Emergency operation/procedure	An operation or procedure that is unplanned, and must occur quickly as the patient is deteriorating. Usually associated with higher risk, as the patient is often acutely unwell.
End of life care (EOL)	Care in last 48 hours of life for expected deaths
Endoscopic vein harvest (EVH)	A new technique using keyhole surgery to remove a section of vein for use in a CABG procedure. This technique minimises the size of the wound required, reducing the risk of infection and the recovery time for patients.
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 1 June 2009.

G

Global trigger tool (GTT)	A tool to measure adverse events via a system of specific triggers. The triggers identify possible adverse events and actual events are rated by harm level to the patients. Over time the results are used to identify areas for improvement.
Governors	Foundation trusts have a board of governors, who are elected by the members. http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/

H

Health Protection Agency (HPA)	The Health Protection Agency is an independent organisation set up to protect the public from threats to their health from infectious diseases and environmental hazards. It provides advice and information to the government, general public and health professionals http://www.hpa.org.uk/
HH	Harefield Hospital
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
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 staying in hospital
Inpatient survey	An annual, national survey of the experiences of

	patients who have stayed in hospital. All NHS Trusts are required to participate.

L

Local clinical audit	A type of quality improvement project that involves individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team
Local involvement networks (LINkS)	Local involvement networks (LINks) are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. http://www.nhs.uk/NHSEngland/links/Pages/links-make-it-happen.aspx
Liverpool care pathway	A care pathway specifically for patients who are dying

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
Monitor	The independent regulator of NHS Foundation Trusts http://www.monitor-nhsft.gov.uk/
Multi-disciplinary team meeting (MDT)	A meeting involving health-care professionals with different areas of expertise to discuss and plan the care and treatment of specific patients
Multi-**R**esistant **S**taphylococcus **A**ureus (MRSA)	A type of infection that can be fatal. There is a national indicator to measure the number of MRSA infections which occur in hospital.

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

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 Patient Safety Agency (NPSA)	An arm's length body of the Department of Health which leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. http://www.npsa.nhs.uk/
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. Never relevant to the Trust is 2010-11 were: • wrong site surgery • retained instrument post-operation • misplaced naso-gastric or orogastric tube not detected prior to use • inpatient suicide using non-collapsible rails • intravenous administration of mis-selected concentrated potassium chloride
NHS Innovation and Improvement NHSIII)	Assists the NHS in transforming healthcare for patients by developing and spreading new work practices, technology and improved leadership
NHS London	NHS London is the Strategic Health Authority (SHA) for the Greater London area. They provide strategic leadership for the capital's healthcare. http://www.london.nhs.uk/
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.
Northwest London Commissioning Partnership	The group responsible for commissioning the services provided by the Trust.

O

Operating Framework	An NHS-wide document which outlines the business and planning arrangements for the NHS. It describes the national priorities, system levers …
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but does not stay overnight

Outpatient survey	An annual, national survey of the experiences of patients who have been an outpatient. All NHS Trusts are required to participate.
Overview and Scrutiny Committee (OSC)	OSC looks at the work of the primary care trusts and NHS trusts and London Strategic Health Authority. It acts as a 'critical friend' by suggesting ways that health related services might be improved. It also looks at the way the health service interacts with our 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.

P

PAR Score – **P**atient **A**t **R**isk score	This is a national tool to help staff recognise and act appropriately when a patient's condition is deteriorating. Patients are scored depending on key observations such as blood pressure, pulse rate, respiratory, temperature etc. A patient with a high score may be deteriorating and should be referred for further review
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
Pressure ulcer	A sore that develops 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 clinical effectiveness.
Productive Ward	'The Productive Ward' focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency

Q

Quality and Risk Profile (QRP)	A tool for used by the CQC to monitor compliance with the essential standards of quality and safety. They help in assessing where risks lie and play a key role in providers' own internal monitoring as well as informing the commissioning of services. The QRPs include data from a number of sources which is analysed to identify areas of potential non compliance.

R

Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge.
RBH	Royal Brompton Hospital

S

Safeguarding	Safeguarding is a new term that 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, which is 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 that monitors whether ward accommodation has been segregated by gender
Sleep apnoea	A sleep disorder characterised by abnormal pauses in breathing or instances of abnormally low breathing, during sleep
Society of Cardiothoracic Surgeons (SCTS)	http://www.scts.org/

Standard sontract	The annual contract between commissioners and the Trust The contract supports the NHS Operating Framework
Surgical Site Infection Surveillance Service (SSISS)	A national scheme whereby Trusts must collect and analyse data on surgical site infections (SSI) using standardised methods. It provides national data that can be used as a benchmark allowing individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the service.

T

Trans-**a**ortic **v**alve **i**mplantation (TAVI)	A new technique for valve replacement, using keyhole surgery This prevents the need for open heart surgery, reduces the risk of infection and reduces the length of recovery for patients
The Productive Operating Theatre (TPOT)	A national programme to improve performance across four dimensions of quality: • safely and reliability of care; • team performance and staff well-being; • value and efficiency; and • patient outcomes and experience.
Thromboelastography (TEG)	A diagnostic test used to assess the efficiency of clotting in the blood

V

Venous thrombo-embolism (VTE)	An umbrella term to describe venous thrombus and pulmonary embolism. Venous thrombus is a blood clot in a vein (often leg or pelvis) and a pulmonary embolism is a blood clot in the lung. There is a national indicator to monitor number of patients admitted to hospital who have had an assessment made of the risk of their developing a VTE.