

**Annex 1**  
**Quality Report**

## **Independent auditor's report to the council of governors of Royal Brompton & Harefield NHS Foundation Trust on the quality report**

We have been engaged by the council of governors of Royal Brompton & Harefield NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Brompton & Harefield NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Royal Brompton & Harefield NHS Foundation Trust as a body, to assist the council of governors in reporting Royal Brompton & Harefield NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Royal Brompton & Harefield NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

### **Scope and subject matter**

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement ("NHSI"):

- maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'. As discussed on page 39 of the Quality Report, the Trust has agreed with NHSI to early adopt the revised National Cancer Breach Allocation Guidance, dated April 2016.

### **Respective responsibilities of the directors and auditors**

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2016 to March 2017;
- papers relating to quality reported to the board over the period April 2016 to March 2017;
- feedback from commissioners, dated 17 May 2017 and 25 May 2017;
- feedback from governors, dated 16 May 2017;
- feedback from local Healthwatch organisations, dated 22 May 2017 and 25 May 2017;
- feedback from Overview and Scrutiny Committee dated 17 May 2017 and 28 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2016;
- the latest national inpatient survey 7 March 2017;
- the latest national staff survey 8 June 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23 May 2017; and
- the CQC inspection report dated 10 January 2017

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

### **Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

- making enquiries of management;
- testing key management controls;
- reviewing the process flow of the indicator with management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.



### **Basis for qualified conclusion**

The “maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway” indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in national guidance.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We found that:

- For 20% of our sample of patients' records tested, non-RTT pathways had been incorrectly created as RTT pathways at the time of migration into the new Patient Administration System (installed July 2016), affecting the calculation of the published indicator;
- For 15% of our sample of patients' records tested, the pathway was incorrectly recorded (including end of treatment not correctly recorded, and duplication of a pathway), affecting the calculation of the published indicator; and
- For 25% of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the “maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway” indicator for the year ended 31 March 2017. We are unable to quantify the effect of these errors on the reported indicator.

The maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers is calculated as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. As a tertiary provider, the Trust receives referrals from other hospitals. In 2016/17 the Trust has agreed with NHS Improvement early adoption of the draft National Cancer Breach Allocation Guidance produced by NHS England and NHS Improvement as published in April 2016. Consequently, this is the first time this new process has been assessed and changes how responsibility for cases is shared between NHS providers, placing greater onus on referring trusts to do so at an early stage in the pathway.

We have tested a sample of 27 patients on the 62 day cancer pathway during the year. Our testing included testing of a mixture of cases in breach and not in breach of the target. While the Trust uploads every referral form to the patients' electronic record (EPR) with a date-stamp, our testing identified that the Trust does not currently have in place a system to ensure retention of an audit trail for the date of receipt of referral, which is a key element of how the pathway is treated in the final metric calculation. We also noted differences in recorded referral dates on 4 cases and stop dates in 3 cases.

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting 62 day cancer wait for the year ended 31 March 2017.

The "Performance against key healthcare targets 2016-17" section on page 39 of the Trust's Quality Report details the actions that the Trust is taking to resolve the issues identified in its processes.

### **Qualified conclusion**

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement Detailed requirements for quality reports for Foundation Trusts 2016/17; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

*Deloitte LLP*

Deloitte LLP  
Chartered Accountants  
St Albans, United Kingdom  
26 May 2017



A lifetime of specialist care

Royal Brompton & Harefield **NHS**  
NHS Foundation Trust

# Quality report 2016-17

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# About the Trust's quality report

## About the Trust

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

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

## Some useful facts about the Trust:

- In 2016-17 we cared for over 200,000 patients at our outpatient clinics and over 39,000 patients of all ages on our wards<sup>1</sup>.
- We are Europe's top-ranked respiratory research centre and our cardiac, cardiovascular and critical care teams are rated in the top three most highly cited health research teams in England.
- Our Heart Attack Centre at Harefield has pioneered the use of primary angioplasty for the treatment of heart attacks and has one of the fastest arrival-to-treatment times in the UK (23 minutes compared to a national average of 56), a crucial factor in patients' survival.
- Europe's largest unit for the treatment of cystic fibrosis is based at Royal Brompton Hospital.
- Our on-site foetal cardiology service enables clinicians to begin caring for babies while still in the womb; many are scanned at just 12 weeks, when the heart measures just over a centimetre.
- The Ventricular Assist Device (artificial heart) programme at Harefield Hospital is one of the world's most established programmes with a long history of clinical and scientific excellence.
- We are the country's largest centre for the treatment of adult congenital heart disease, staffed by a specialist team including four full-time specialist consultants.
- Harefield has one of the most advanced cardiac catheterisation laboratories of its kind in Europe. The state-of-the-art equipment includes a remote-controlled robot that uses high-tech 3D mapping enabling precise catheter manipulation and the reduction of exposure to X-rays for patients and staff.
- Every year we help almost 14,000 adults who have breathing problems caused by diseases such as COPD (chronic obstructive pulmonary disease) and severe asthma.

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<sup>1</sup> In 2015-16 we cared approximately 200,000 patients at our outpatient clinics and approximately 40,000 patients of all ages on our wards.

- We provide specialised care for patients with suspected or diagnosed cancer affecting the chest (thoracic oncology). We have a specialist 'lung laser' device which uses a special wavelength laser beam to assist the surgeon in removing tumours from patients' lungs with minimal damage to neighbouring healthy lung tissue.
- We are one of only three centres diagnosing and caring for patients with Primary Ciliary Dyskinesia, a rare inherited multisystem disease, with severe lung disease.

## What is a quality report?

A quality report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. All NHS providers strive to achieve high quality care for all, and the quality report provides the Trust an opportunity to demonstrate our commitment to quality improvement and show what progress we have made in 2016-17. The quality report is a mandated document which is laid before parliament before being made available to the public on NHS Choices website.

## What is included in a quality report?

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

There are also three areas that are mandated by the Department of Health (DH) which give us a framework in which to focus our quality improvement programme, these are patient safety, patient experience and patient outcomes. To identify the Trust quality improvement priorities for 2016-17 and to reflect the priorities of our patients, the public, staff, and people we work with, there was a voting system. People were asked to choose the topics that were most important to them that fell within the three areas mandated by the DH.

The section on the Trust's quality priorities highlights:

- the areas identified for improvement for 2016-17
- what the priority was
- how we performed against the targets
- and what that means for patients

There is also a section on the quality priorities that have been identified for improvement projects in 2017-18.

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

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



## Statement of directors' responsibilities

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

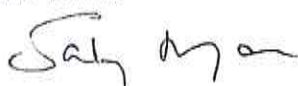
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality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

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

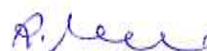
- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016-17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to March 2017
  - papers relating to quality reported to the board over the period April 2016 to March 2017
  - feedback from commissioners, dated 17/05/2017 and 25/05/2017
  - feedback from governors, 16/05/2017
  - feedback from local Healthwatch organisations, dated 22/05/2017 and 25/05/2017
  - feedback from Overview and Scrutiny Committee, dated 17/05/2017 and 24/05/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2016
  - the 2016 national staff survey, dated 07/03/2017
  - the 2015 national inpatient survey, dated 08/06/2016
  - the Head of Internal Audit's annual opinion over the Trust's control environment, dated 23/05/2017
  - CQC Inspection Report, dated 10/01/2017
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board:



**Baroness Sally Morgan**  
Chair  
26 May 2017



**Robert J Bell**  
Chief Executive  
26 May 2017



## Part 1: Chief Executive Statement

Royal Brompton & Harefield NHS Foundation Trust helps 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 pregnancy, through childhood, adolescence and into adulthood and, because this is a specialist trust, 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 mission is to be 'the UK's leading specialist centre for heart and lung disease'. The Trust will achieve this mission by a strategy of focused growth in aspects of heart and lung treatment, particularly in congenital heart disease, arrhythmia, advanced lung diseases and heart failure. We have set three strategic goals to ensure we achieve this:

- **Service excellence** across our clinical care and research work, with a focus on clinical effectiveness and quality improvement
- **Organisational excellence** throughout especially around our education and training programmes
- **Productivity and investment** ensuring that we make the best use of our capacity

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

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 research into new treatments and therapies and delivery of excellent clinical care.

The period from 1 April 2016 to 31 March 2017 has been the seventh full year in which the organisation has operated as a Foundation Trust. During the year, the Trust has achieved all of the governance targets and indicators set out in the Risk Assessment Framework and the Single Oversight Framework issued by NHS Improvement apart from the indicators relating to the 62 day cancer wait target and the 18 week referral to treatment time target for incomplete pathways. These target failures were forecast in the Forward Plan submitted to NHS Improvement and are mainly due to late referrals from referring centres for surgical treatment of lung cancer and operational pressures in respect of the 18 week pathway.

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

During the course of 2016/17, the Trust has worked closely with its commissioners at both local and national level. There is a Clinical Quality Review Group in place, where information about the quality of our services can be discussed in an open and transparent manner with our commissioners on a regular basis.

The Trust remains committed to the provision of high quality services for patients of all ages. The Trust intends to develop its services, and premises, in the future to ensure on-going delivery of this commitment.

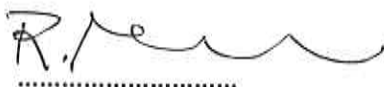
Despite an impressive record in quality and safety, we are not complacent; weaknesses are dealt with promptly and openly so that better and safer systems of care can be developed.

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

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the Trust, alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust, its Board and management team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate with the exception of the matters identified in respect of the 18 week referral to treatment incomplete pathway indicator as described on page 42 of this report and 62 day urgent GP referral to first definitive treatment as described on page 43 of this report.

Signed:



.....

**Robert J Bell**  
**Chief Executive**  
**Royal Brompton & Harefield NHS Foundation Trust**

**26 May 2017**



## Part 2: Review of quality priorities for improvement

### Part 2a: Quality priorities for improvement 2016-17

#### Quality priority one

##### Improving our Organisational Safety Culture<sup>2</sup>

What are the aims?

To continuously improve the safety culture of the organisation.

How are we measuring this?

- Training staff – Human Factors
- An increase in reporting of incidents via the DATIX system
- Progress on action from the 2015 Staff Safety Climate Survey

Whilst the objectives for this priority have been met this year, further improvements will continue to be made in 2017 and beyond, as part of a continuous cycle of improvement.

##### Training staff

Human factors – The one day course is multi-professional, and is designed for anyone who works in a team. Attendees receive practical guidance on how to change the way they work so that their team, colleagues and working environment are happier, more productive and ultimately safer for our patients. The course covers three core human factors themes - Situation Awareness, Communication and Personality and Choosing Behaviour. The Trust now holds 12 workshops on each site per year. There are 15 places available at each workshop.

The Human Factors Master class is a 2 day programme, which examines Human Factors and team working skills in more detail and it sets out a base level of knowledge for people to proceed to the Train the Trainer course

Train the Trainer - Eight staff members selected on the basis of commitment and performance during the Master class go forward to the 3 day Train the Trainer course. These staff members then form part of the Trust Human Factors teaching faculty. Faculty members are required to teach a minimum of 2 one day courses per year. There are currently 18 active multi-professional faculty members who have undergone the training course.

##### What is patient safety?

Patient safety is ensuring we treat and care for people in a safe environment and protecting them from avoidable harm (DH definition)

Number of training sessions held cross-site since April 2015 broken down by staff group

Training course attended	Administration	Nursing	Medical	Other Clinical Staff	Total No of staff Completed training
Human Factors	28	230	72	65	395
Human Factors Master Class	16	22	30	9	77
Train the trainer	1	7	7	3	18

<sup>2</sup> Quality Priority 1 maps to 'Leadership of Quality Priorities 16/17 as published 15/16 Quality Report 2016-17 / Royal Brompton & Harefield NHS Foundation Trust

### **An increase in reporting of incidents via the DATIX system**

Financial Year	14/15	15/16	16/17
Patient related incidents	2,953	3,959	4,032
Admissions to Trust	38,620	40,044	39,239
Incidents per 100 admissions	7.65	9.89	10.28
Total bed days	204,712	205,889	230,146
Incidents per 1000 bed days	14.43	19.23	17.52

#### **Raising staff awareness of incident reporting**

- Regular incident reporting feedback sessions are held with ward staff. The importance of incident reporting is discussed at these sessions
- DATIX Monthly Update which includes top 10 locations for incident reporting across the trust
- Regular reminders to staff of the importance of incident reporting

#### **Examples of changes made following incident investigation**

- A national Medical Device Alert from the MHRA was published in December highlighting a concern with a syringe pump from incidents reported at RBH.
- The new falls prevention bundle has been piloted on wards at HH and RBH to help identify patients at risk of falls and will be rolled out to other wards soon. The bundle is being introduced to help reduce falls incidents.
- Wards now have small mirrors to help clinical staff assess the back / back of head of patients for signs of pressure ulcers. These are used for patients with limited mobility or being sedated / on ECMO. These mirrors were sourced after a number of pressure ulcers were missed

### **Progress on action from the 2015 Safety Climate Survey**

The Safety Climate Survey has been undertaken 3 times across the trust in 2010, 2013 and 2015. In 2015, 865 members of front-line staff completed the survey. This was a 6% increase from 2013.

The survey covered 7 domains:

1. Teamwork climate – how teamwork and collaboration are seen within a unit.
2. Safety climate – the amount of focus given to patient safety.
3. Job satisfaction – employees' positive feelings regarding their work.
4. Stress recognition – employees' recognition of stressors and how they can impact on their work.
5. Working conditions - the quality of the working environment.
6. Perception of hospital management – how employees view support from managers
7. Perception of local management – how employees view support of local level management.

Following the results of the survey and discussions with staff each ward/department selected one area for improvement During February 2017 staff in these areas were re-surveyed on this one question.



Agreed area for improvement	What improvements have we made
Improved staff awareness and attendance at Executive patient safety walk rounds	<p><b>Baseline survey results</b> 40% of staff knew about walk-rounds and 25% had received feedback</p> <p><b>Actions taken</b></p> <ul style="list-style-type: none"> <li>Improved staff awareness of when the walk rounds will take place by displaying posters in staff areas with the date and time of the walk round – staff encouraged to attend</li> <li>Feeding back issues raised at walk rounds at team meetings and displayed on notice boards in staff areas</li> </ul> <p><b>Results of the re-survey</b> 74% said they were aware of walk rounds taking place and had seen the posters displayed in their area 42% had attended walk rounds and 46% had received feedback from walk rounds. Work is on-going to improve the awareness of walk rounds amongst front line staff: Walk rounds take place quarterly on all wards and in all clinical areas such as operating theatres and cardiac catheter laboratories and are led by an executive supported by the Quality &amp; Safety Lead for the Division.</p>
Working here makes me feel like a valuable member of my team (this scored low in some areas)	<p><b>Baseline survey results</b> Across the Trust 78% agreed with this statement; falling to 57% and 67% in theatres</p> <p><b>Actions taken</b></p> <ul style="list-style-type: none"> <li>Motivational competitions amongst the staff to boost moral</li> <li>Additional members of staff recruited</li> <li>Introduced traffic light system for staff using different colour cards to show what type of day they have had. Results fed back at department meetings and issues discussed</li> <li>Senior team ensure staff feel valued and are thanked when they go above and beyond their normal duties</li> </ul> <p><b>Results of the re-survey</b> Following implementation of the above action plan all staff re-surveyed felt that their concerns were being addressed and that they now felt valued in their role within the department</p>
Staff perception of hospital management	<p><b>Baseline survey results</b> 53% felt that support from hospital management could do more to support patient safety</p> <p><b>Actions taken</b></p> <ul style="list-style-type: none"> <li>All senior trust leads have visited the department and spent time talking to staff about on-going issues and potential solutions</li> </ul> <p><b>Results of the re-survey</b> Staff re-surveyed agreed that following the meetings with trust leads it has helped them to have a better understanding of the role of hospital management and their commitment to patient safety and supporting staff.</p>
My workplace requires additional support to improve quality	<p><b>Baseline survey results</b> 86% felt that their workplace required additional support to improve quality</p> <p><b>Actions taken</b></p> <ul style="list-style-type: none"> <li>Continue on-going recruitment and explore other methods of recruitment (agency, overseas, training staff in house)</li> </ul> <p>Staff have not yet been re-surveyed on this question due to the need for an on-going recruitment and staff training programme which has not yet been shown to significantly reduce staff shortages especially amongst nursing staff. This is an on-going action</p>



## Quality priority two

### What is patient experience?

Patient experience is ensuring people have a positive experience of care (DH definition)

### Improving the Patient Experience for surgery<sup>3</sup>

What are our aims?

To improve the patient experience through improved management of the 18 week pathway and by reducing the number of operations cancelled for non-clinical reasons.

How are we measuring this?

We will measure this by looking at the number of operations cancelled for non-clinical reasons by quarter, the reason for the cancellation and the impact for the patient.

We will also look at the number of patients who are not offered another binding date for their procedure within 28 days

#### Progress made

The Divisions are continuing to work on reducing the number of patients whose surgery is cancelled by the hospital either on the day of surgery or on the day of admission (if admitted the day before their operation). The data illustrated in the table below shows that the numbers of cancelled operations are reducing and work is continuing to further reduce the figures.

**Table 1: Number of reportable cancelled operations in Theatres 2015/16 and 2016/17**

Area	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
HH Theatres	80	105	98	57	81	46	54	61
RBH Theatres	31	31	47	27	51	11	40	28
Total	111	136	145	84	132	57	94	89

Both sites have introduced a more robust cancellation escalation procedure which ensures that the clinical and managerial teams are aware of potential cancellations before they occur so they can support any additional actions that may avoid the need for the patient to be cancelled. There are also robust processes in place to ensure that any patient cancelled is offered an alternative date for surgery within 28 days. This standard is monitored at the weekly Patient Tracking List (PTL) meeting. In September 2016 a snapshot audit was conducted to better understand the reasons for patients being cancelled by the hospital at short notice. This identified the need to better classify the reason for cancellation categories and to ensure that all staff entering a cancellation reason into the electronic system are aware of the importance in selecting the correct reason. During summer 2016 a new PAS system was also introduced and at present the Divisions are also keeping local records of patient cancellations and reasons so these can be validated each month. This work will help refine the cancellation reason categories on the new PAS system.

At Harefield, the most common reason for a patient's surgery to being cancelled at short notice is due to there not being a bed available for a patient. This can either be a lack of a ward or critical bed being available for the patient immediately post-operatively. The critical care beds at Harefield are also accessed by other specialities that may have patients requiring critical care. Both the Heart Attack Centre and Transplant activity is unpredictable and there are times when unplanned, emergency admissions to Critical Care result in there being no bed available for elective patients. The planned expansion of ITU by 6 beds (October 2017) will help address this issue.

<sup>3</sup> Quality Priority 2 maps to Projects 'Big 6' Reducing Cancellations of Quality Priorities 16/17 as published 15/16 Quality Report 2016-17 / Royal Brompton & Harefield NHS Foundation Trust

At RBH the two main reasons for hospital cancellations are insufficient theatre time (e.g. due to an overrunning case) and emergency surgery. Both sites are planning to improve theatre productivity which will also further reduce patient cancellations. As part of the transformation work planned for 17/18, both Divisions have planned work streams which aim to optimise throughput in theatres, inpatient bed flow and reduce length of stay.

#### **Pledge to offer another binding date within 28 days**

If a patient has his/her operation cancelled the Trust has a duty to offer another binding date for the operation within 28 days. Of the 849 operations which were cancelled 99% of patients were offered another date and had their operation within 28 days. The table below shows the number of patients not offered a date with 28 days. All patients have since had their procedure.

Number of breaches of the pledge to offer another binding date within 28 days								
Area/Site	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
RBH	1	4	2	0	3	0	3	0
HH	1	1	2	0	0	1	0	1
<b>Total</b>	<b>2</b>	<b>5</b>	<b>4</b>	<b>0</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>1</b>

### Quality priority three

#### **Improving the Identification and Management of Patients at Risk of Pressure Ulcers and falls in Hospital<sup>4</sup>**

What are the aims?

##### Pressure ulcers

To carry out pressure ulcer risk assessments for all adult patients on admission

To fully implement the SSKIN care bundle for patients assessed as at risk of developing pressure ulcers

To reduce the number of hospital acquired pressure ulcers

##### Patient falls

To carry out falls risk assessments for all adult patients on admission

To introduce the new falls care bundle for patients assessed as at risk of falling

To reduce the number of patient falls

How are we measuring this?

Implementation of SSKIN care bundles

Completion of falls risk assessments

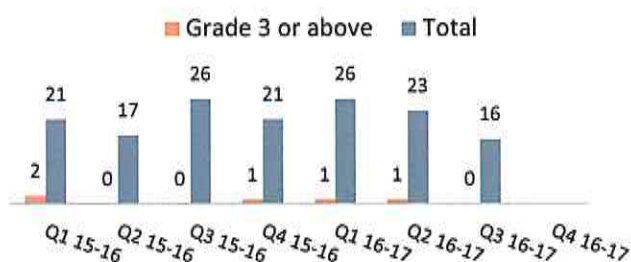
Reduction in the numbers of pressure ulcers and falls incidents

<sup>4</sup> Quality Priority 3 maps to Projects 'Big 6' No. 4 & 5 of Quality Priorities 16/17 as published 15/16  
Quality Report 2016-17 / Royal Brompton & Harefield NHS Foundation Trust



## Pressure Ulcers

### Hospital Acquired Pressure Ulcers



Trust acquired pressure ulcer incidences have decreased since Q1 16-17.

Cross site pressure ulcer recommendations, innovations and practices continue to be shared and findings discussed at the Skin Integrity Steer Group Meetings every 2 months.

### Reducing Pressure Ulcers

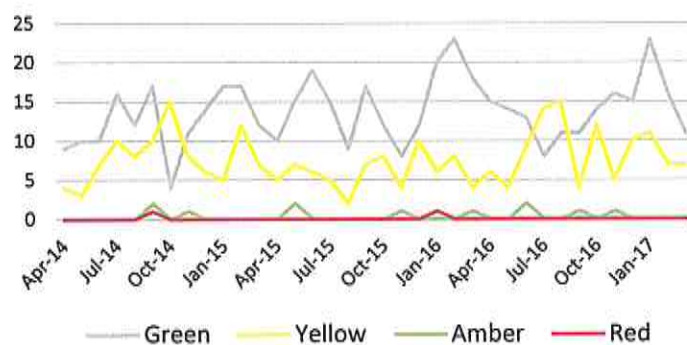
1. Implemented a 'huddle' process trust wide, whereby if a pressure ulcer of grade 2 or above is identified in a clinical area, the nurse caring for the patient, the ward sister/charge nurse, matron and tissue viability clinical nurse specialist, meet to review the case and identify an appropriate plan of action.
2. An improved focus on pressure ulcer and skin tear prevention amongst the senior teams and greater collaboration between the clinical areas.
3. Any grade 3 or above pressure ulcers are discussed within the group to identify lessons to be learnt and actions to be taken.
4. The SSKIN care bundle has been implemented in clinical areas that have electronic documentation to ensure cohesive and consistent care.
5. Evaluation of pressure relieving equipment across the trust, identifying best products and working with procurement to ensure they are available consistently across the organisation.
6. Support of the link nurse role in the clinical areas to ensure pressure ulcer and skin tear prevention is embedded in practice, undertaking audits, identifying education/equipment needs and escalating to the nurse managers and tissue viability clinical nurse specialists.

## Patient Falls

	Harm	Total	Per 1000 bed days
Q1 15-16	20	64	1.39
Q2 15-16	14	55	1.18
Q3 15-16	23	55	1.17
Q4 15-16	19	80	1.71
Q1 16-17	21	63	1.19
Q2 16-17	34	64	1.13
Q3 16-17	28	73	1.21
Q4 16-17	25	75	1.24

(Harm = any incident that is not reported as 'No Harm' or 'Near miss')

### Falls 2014 -2017



## Reducing Falls

- Falls policy and guidance for the use of bedrails in place
- Posters -Falls prevention posters in ward bathrooms and toilets/high risk areas
- Safety Thermometer- The RCP national audit of in-patient falls shows a national average of 6.63 falls per occupied bed day, and 0.19 resulting in moderate/severe harm or death. For 2015/16 we had an average of 1.37 falls per 1,000 occupied bed day and falls with harm average is 0.03 (this includes low, moderate, severe harm and death.)
- Trust intranet page - updated April 2016
- Trust advice leaflet (preventing slips, trips and falls) to any patient assessed as a falls risk
- Multi-factorial assessment- reviewed as part of the Quality Improvement project 2016 (Falls Bundles). Anti-slip socks
- Falls prevention teaching on Nursing Preceptorship course (new staff)
- General ward and other staff training regarding falls awareness and prevention
- Medchart alert for use of zopiclone as night sedation in patients over 65 years of age.

## Proposed plans

- New falls bundles being rolled out Trust-wide in 2017.
- Discharge planning post fall including community referrals (Falls Bundles)
- Update of Trust falls management policy to include new falls bundles/processes.
- Visiting other trusts to review best practice
- Continue to liaise with neighbouring Trusts re lead for older people

**Number of falls on Oak Ward**



## Quality Improvement project 2016

*Introduction of the falls care bundle on Oak Ward at HH*  
*PDSA cycle: May 2016 – Education – training of all nursing staff and HCAs on preventing falls in hospital and the new falls bundles (A&B)*  
*PDSA cycle: July 2016 - Audit*  
*PDSA cycle: August 2016 - Bundles*  
*Since the introduction of the bundle and teaching on Oak ward in May, falls have remained below the set goal for 9 of the 11 months.*



## Quality priority four

### Improving the management of patients with Cancer<sup>5</sup>

What are the aims?

Continue the focus on improving overall waiting times for the 62 day cancer pathway. In addition, we want to ensure that cancer patients receive the best possible experience whilst in our care, receiving the appropriate interventions and information at the right time.

How are we measuring this?

Contracted performance measures

Feedback on the patient and carer experience

#### Progress and Outcomes

Following the cancer service review in 2016 there was an aim to meet the challenge of treating patients once referred within 24 days of receipt of referral. Working alongside the North West London (NWL) Cancer Performance team and NHS England the Trust has actively worked in year to reduce the time of referral to admission date for all patients on the 62 day cancer pathway. This was also put in place to meet the five year forward plan that all patients would have a diagnosis by day 28 and therefore would be treated within 62 days.

In addition the key outcomes from the cancer service action plan for 2016 have been completed. There are some actions that are on-going within the action plan, such as the review of theatre and day case capacity, which is being taken forward into 17/18 at a Trust wide level. There is also some work looking at the IT systems used for tracking and a scoping exercise to see if this can be improved with the use of an in-house system.

There has also been continued collaborative work across NWL, Royal Marsden (RM) Vanguard and our referring centres. There is continued attendance at the NWL Secondary Cancer Care Board and the Trust participated in the Cancer Stocktake Engagement exercise reviewing all CT scanning capacity across NWL. The cancer team also have representation on the RM delivery board and clinical oversight groups which going into 17/18 will be important for the delivery of early diagnosis and prevention schemes that the cancer team will be involved in.

The Trust has taken part in the sixth annual National Cancer Patient Experience Survey (NCPES), with results to be published in summer 2017. Building on from last year's local patient experience events held at Harefield Hospital there will be a similar event for Royal Brompton patients in September 2017. The results from the national survey and the local events help to build a broader picture of the overall patient experience for patients being cared for on a lung cancer pathway and enables the cancer team to respond directly to areas that can be improved.

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<sup>5</sup> Quality Priority 4 maps to Projects of Quality Priorities 16/17 and has been retained as an area of continuing focus  
Quality Report 2016-17 / Royal Brompton & Harefield NHS Foundation Trust

## Quality priority five

### Safer Use of Medicines and Medical Devices<sup>6</sup>

What are the aims?

To improve the Trusts medication and devices incident reporting levels and Quality of reports  
Feedback of lessons learnt

How are we measuring this?

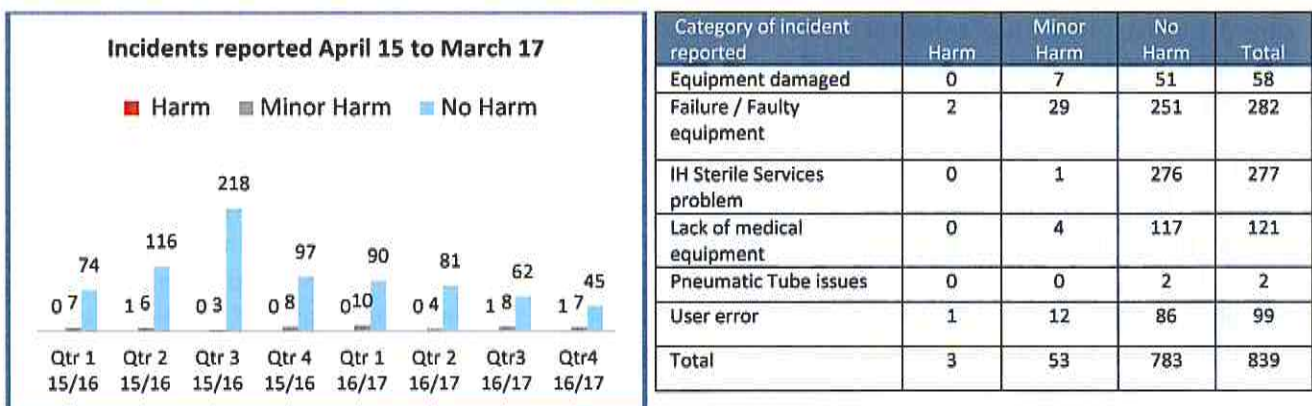
The number of medication and device incidents reported by severity per month

#### Medical Devices

Following a Patient Safety alert from the Medicines and Health Products Regulation Authority (MHRA) in November 2013 the Trust convened a multidisciplinary group which is chaired by John Pepper, Professor of Cardiac Surgery; other members include our Lead Clinicians in Clinical Risk and the Trust's Medical Devices Safety Officer. The group meets regularly to review medical device incident reports and take action to improve medical device safety. Regular reports showing the number and type of medical device incidents are submitted to this group. A Medical Device Governance and Quality Manager is being appointed and will work with the Clinical Engineering Service Manager to lead on medical device governance for the trust

Regular feedback to reporters of medical device related incident and information in DATIX bulletins has helped improve the quality of the reports received with an increased number of Incident reports containing information relating to the product type, supplier and a description of the equipment/device. This ensures a thorough investigation can be undertaken.

The charts below shows the number of incidents per quarter by harm, minor harm or no harm to the patient and the type of incident reported. The chart shows that there were 839 incidents reported during the period April 2015 to March 2017. 783 (93%) incidents resulted in no harm to the patient. 53 (6%) related to minor harm or a delay in treatment and 3 (0.3%) incidents which caused harm to the patient were related to 2 cases of faulty equipment reported to the manufacturer and one case of user error in setting up equipment in the operating theatre. In all three cases the patient made a full recovery.



#### Examples of changes made as a result of medical device incidents?

- Unable to perform a safe and timely emergency chest opening procedure due to lack of equipment on the chest opening trolley. A piece of work is being done looking at standardising what is kept on the trolley and ensuring items are replaced when used.
- No infusion pumps and syringe pumps available for expected admission on PICU. In the

<sup>6</sup> Quality Priority 5 maps to 'Big 6' No. 6 of Quality Priorities 16/17 as published 15/16  
Quality Report 2016-17 / Royal Brompton & Harefield NHS Foundation Trust



short/medium term the Trust is buying a Real Time Location System (RTLS) that enables staff to identify the location of equipment in real time. Equipment will be tagged with a device that broadcasts its location via the Trust WiFi network

- Mitral Valve was implanted into patient then valve was found to be faulty. Practice change put in place that all consultant surgeons do a visual inspection of the valve before implanting it into the patient. This minimises the risk of faulty valves being placed into patients as it could be caught upon a visual inspection.
- Incorrect set up of the perfusion set leading to patient harm- Perfusion Standard Operating Protocol (SOP) to be standardised cross site with agreed checklist setting out how circuit and direction of flow is checked and signed off

## Medicines

	Harm	Total	Per 1000 bed days
Q1 15-16	16	223	4.83
Q2 15-16	27	222	4.78
Q3 15-16	28	261	5.54
Q4 15-16	23	235	5.02
Q1 16-17	28	256	4.85
Q2 16-17	22	205	3.62
Q3 16-17	13	233	3.81
Q4 16-17	19	213	3.42

Medication incidents have decreased in 2016-17, compared to 2015-16.

- **Ward based pharmacists** undertake review of prescription charts, prescribing and administration. A ward service is available to Critical Care and transplant patients on Saturdays.
- **Strong management** established to direct medicines safety including: The Medicines Management Board, Divisional Quality and Safety Groups and the Pharmacy Clinical Governance Group established to review medication issues and respond to incidents.
- **Training** provides the relevant skills and awareness to support safe medicines usage, e.g. Medicines Management and Medical Gas Training included in corporate induction and Medicines Management training included in new doctor induction. Refresher training is completed every two years for Medicines Management Training and every year for Medical Gas Training.
- **Nurse competency handbook** re administration and IV study day.
- **IV/Infusion study days** to ensure minimum standards
- **Non-medical prescribers group** and approval of scopes via the Medicines Management Board.
- **Implementation of medicines related Patient Safety Alerts (PSA) and Central Alert System (CAS) alerts** and development of associated guidance
- **Medicines management advice** provided to staff through :  
Clinical Specialist Pharmacists  
Medicines Information Centre  
On call Pharmacy Service
- **Electronic prescribing (ICIP)**, which prevents some medication errors including those related to legibility, in place for all theatres, intensive care and high dependency across the trust. Electronic prescribing (Med Chart) in place across the remainder of the Trust except outpatients, which prevents

some medication errors including those related to legibility. There are also clear warnings to prevent patients being prescribed medicines that they are allergic to.

- A new individual was appointed to the role of **Medicines Safety Officer** role in 2016-17; focussing on providing support for local medication error reporting and learning and acting as the main contact for NHS England and the MHRA.

## Duty of Candour

The lead for Duty of Candour is Elizabeth J Haxby, Lead Clinician in Clinical Risk. The Adverse Incident policy makes specific reference to Duty of Candour (DoC).

Training in Being Open and the Duty of Candour occurs on both sites and remains advisory but is open to any member of staff. All relevant policies contain reference to the Duty of Candour requirements. A guidance document was developed and circulated and a short audit completed in early 2016 which demonstrated some difference in interpretation of the legislation on each site. Following discussion with legal advisers the Trust guidelines were updated to ensure a consistent approach to disclosure, content and dispatch of Duty of Candour letters and investigation and follow-up. A further cross-site audit was completed covering the period Oct 2016 – Dec 2016 showing the following:

- 19 incidents which appeared to meet the Duty of Candour criteria of which 6 were designated Serious Incidents and managed accordingly;
- A documented discussion with the patient / family occurred at the time of the incident in 14/19 (74%) of cases;
  - Of the 14 cases, an initial DoC letter was sent for 12 cases, which is 63% of incidents audited;
  - The average time between the incident and the initial DoC letter was 14 days (target 10 days);
  - For all 14 cases, a second DoC letter was sent as required, after the completion of investigations;
    - There were 2 cases at Harefield Hospital where an initial DoC letter was not sent after the documented discussion with patient/family but a letter was sent after the completion of the investigation, which technically qualifies as a second letter in the documented process.

### Areas for improvement and action;

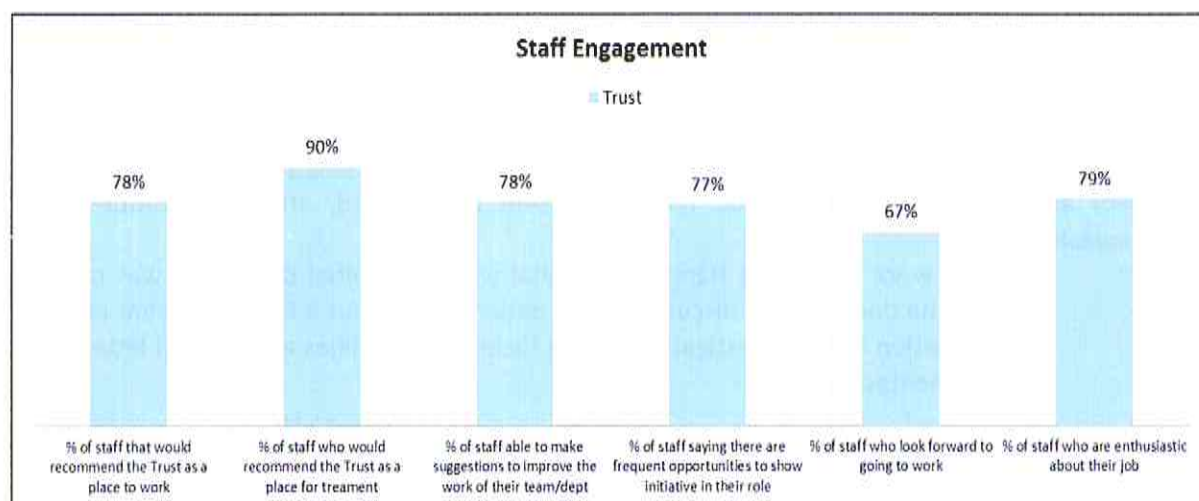
- Education and training relating recognition of incidents and moderate harm
- Documentation of discussion with patients / families
- Clarification of responsibility for signing DoC letters.
- Being open and Duty of Candour training sessions should be advertised on the Trust Learning Management System (LMS) so that numbers attending can be calculated.
- Further audit once above are in progress

## Staff Survey

The 2016 Staff Survey was conducted largely in the months of October and November 2016 and the results were published by the Care Quality Commission at the end of February 2017.

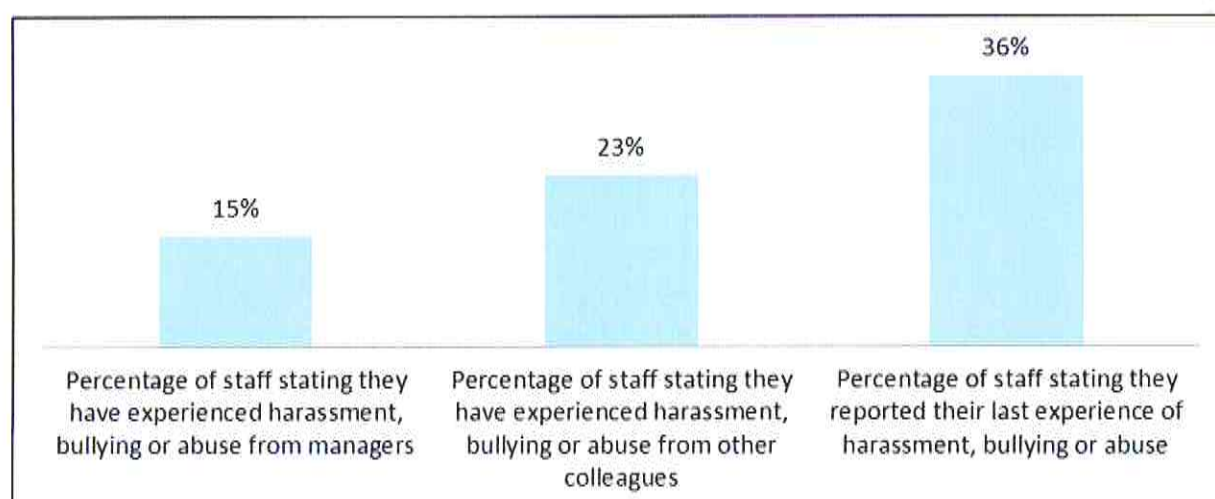
The Trust commissioned Picker Institute Europe to undertake the survey on our behalf and they surveyed all of the permanent and fixed term workforce. The response rate this year increased from 32% to 39.4%, with 1,380 members of staff completing the survey.

In general, the picture is very positive with staff engagement remaining very high across the Trust, scoring 4.02 out of 5, significantly above the National Average of 3.79.



This report will look specifically at two indicators as requested by NHS England, percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months, and percentage believing that the Trust provides equal opportunities for career progression or promotion.

When looking at harassment and bullying, 15% of staff surveyed reported harassment or bullying by a manager, and 23% by another colleague. The overall harassment and bullying score for the Trust is 30% due to the fact that some respondents will have answered yes to both questions. However, 64% of these staff stated that they did not report the issue, although five official bully & harassment grievances were raised with HR in 2016, compared to two in 2015.





The 'Working Together Better for Patients' initiative has now been running for four years, and offers departments the opportunity to take part in a team based course to try and target any areas where there has been a particular issue with conflicts between staff. Historically these courses have been run on a voluntary basis, with departments/managers putting their area forwards should they deem it necessary. However, going forwards, it could be beneficial to run mandatory sessions for departments or specific staff groups that report high levels of harassment and bullying in the staff survey.

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

A Freedom to Speak Up Guardian has now been appointed in the Trust and this project has launched Trust wide in April, encouraging staff to come forward with any issues they are experiencing, and speak to an impartial advisor in the first instance.

These projects, along with a new organisational culture and transformation project will promote a more honest and open culture across all levels of staff.

The key finding on what percentage of staff believes the Trust provides staff with equal opportunities for career progression (indicator KF21) shows 84% of staff answering positively, which is only 2% below the national average for Acute Specialist Trusts.

The Trust offers all full time permanent staff up to £2,000 per annum as a study budget for courses relevant to their post or career development. The Learning and Development department also run a variety of courses cross site, including First line leadership development, Advanced leadership development, Coaching and Coach training, Clinical Leadership Development as well as personal development courses.

The Nursing Development team also run a huge range of courses across the Trust, including professional development study days, critical care courses, clinical skills courses and many more.

## Care Quality Commission Inspection

### CQC ratings for Royal Brompton Hospital

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

### CQC ratings for Harefield Hospital

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

### CQC ratings for Royal Brompton & Harefield NHS Foundation Trust

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



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

The inspection report contained much that we are proud of. It identified five areas of outstanding service, and recognised very positive patient feedback and strong clinical outcomes, effective multidisciplinary team-working in many areas, services that are highly specialist and individualised, and staff who supported by the leadership in the Trust.

The inspectors also identified areas where we can do better. The key issues formed the basis of a Trust action plan, with others being picked up through local governance programmes.

The CQC action plan is detailed, but in summary, it includes the following things that we know we need to do:

1. Make sure that the end of list 'debrief' (one of the 'five steps to safer surgery' is part of the day-to-day routine in theatres and the catheter labs.
2. Use our recently upgraded National Early Warning Score (NEWS) charts to support our patient observation process, with particular focus on accuracy and escalation documentation.
3. Think about how some of the Trust's complicated policies and procedures can be simplified so that staff are clear about what they mean, and can articulate them.
4. Make sure that we continue to focus on good infection control behaviours as this is such an important part of the delivery of safe care.
5. Keep medical records on the wards stored securely.
6. Keep corridors in clinical areas free from clutter.
7. Improving visitor information and signage relating to antibacterial hand gel use.

The detailed changes have now all been introduced and where appropriate, a plan for monitoring and auditing is in place to make sure that the Trust knows that these changes have become embedded into every day practice.

The Trust has also identified three broader areas as its quality focus for 2017/18. These complement our quality priorities, are built on the learning from the inspection process, and designed to strengthen resilience within our most important asset – our staff. These areas of focus are;

- A. The management of the deteriorating patient. This focus is reflected in the Trusts' quality priorities for the next year, and includes embedding the updated NEWS form into all relevant clinical areas, and focusing on Acute Kidney Injury and Sepsis recognition.
- B. Moving towards excellence. This is a broad target that will be shaped by working with 'NHS Improvement' in preparation for re-inspection by the CQC.
- C. Organisational culture. Building on the highly positive impact of the CQC inspection preparation, we want to strengthen the organisation by increasing staff engagement, reviewing our approach to staff welfare, strengthening our adherence to core behaviours and values, and encouraging the team approach to working and learning.

## Part 2b: Quality Priorities for improvement in 2017-18

All Foundation Trusts are required to have a minimum of 5 quality priorities identified in their annual Quality Report, which will be a focus for the Trust over the following 12 months, and progress against them will be reported in the report the subsequent year. The current quality priorities, as listed on the previous pages, were identified in 2014-15, and the intention was for them to run for a 3 year period, ending March 2018. Quality priorities are a public declaration of where the Trust believes it could do better and where it is going to focus and prioritise effort to improve across the Board.

Two things have happened over the last 12 months, which have suggested that it may be more appropriate to look at evolving the quality priorities now, rather than waiting until the end of 2018. Firstly, a number of the current quality priorities have already shown great progress and become intrinsically embedded into our routine practices and everyday working, which negates the need to continue to run them as formal 'quality priority projects'. Secondly, both the process of preparing for and the findings of the CQC inspection have highlighted to the Trust our areas of strength and has given new perspective to where we want to evolve and improve next.

Therefore, rather than continue with the existing Quality Priorities for 12 more months, whilst also evolving the Trust in a new direction and focus following the CQC inspection; it is proposed that the quality priorities and key focus post-CQC are aligned now; leading to one clear set of objectives for everyone to work towards.

Following the CQC inspection, there is an overarching aim of 'moving towards outstanding'; underpinned by the themes of 'managing the acutely ill patient' and 'developing our culture'. These themes echo those chosen by the Imperial College Health Partnership for 2017-17 (they have chosen 'sepsis' and 'culture') and as such we will be able to share learning, ideas and experiences will colleagues from other centres through this forum.

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

### Managing the Acutely Ill Patient

1. **National Early Warning System implementation (NEWS).** This covers all inpatient care or both adults and children. A national tool to record the key observations made of patients, and an algorithm to identify quickly and simply when a patient may be deteriorating and to escalate care.

Current position: new tool has been rolled out across all clinical areas, with appropriate training and education for staff in its use.

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

2. **Implement Sepsis 6.** This covers all inpatient care for both adults and children.

Current position: elements of sepsis 6 bundle relating to identification of possible sepsis have been incorporated into new NEWS tool, rolled out across all clinical areas with appropriate training and education to staff in its use.

Aim for 2017-18: routine auditing on every ward/clinical unit, with prompt feedback of any errors found. Audit to include checking that documentation is being completed correctly, escalation is occurring appropriately, and that where care has been escalated these patients are reviewed



promptly by a more senior colleague. Aim for 90% in all areas of audit on all wards/clinical units by year-end.

### **3. Acute Kidney Injury.**

Current position: There is a new system in place to ensure that abnormal results are easily identified and can be quickly highlighted to the clinical team.

Aim for 2017-18: Start producing an monthly report to look at the incidence of: RRT, readmission rates, incidence of KDIGO AKI1, AKI2, AKI3, % CCL risk assessments completed, % risk assessment pre CT scan, % appropriately monitored and adjusted aminoglycosides, glycopeptides. Audit of laboratory alerts leading to change in patient management.

## **Developing Our Culture.**

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

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

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

### **5. Bullying and Harassment.**

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

Aim for 2017-18: The aims are still being developed and refined; a Freedom to Speak Up Guardian was appointed during 2016/17 and their role will continue to be supported and developed during 2017/18. The Trust also has trained a team of harassment advisors who provide a confidential service for staff who feel unable to discuss their situation with line managers. The Trust will also work with the Imperial College Healthcare Partnership to share ideas and initiative across the North West London patch. The aim will be for an improvement in the national staff survey results in this area from previous years.



## Part 2c: Performance against national quality indicators

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

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons				Data Source	
	2014-15	2015-16	2016-17		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally		National average
Domain 3: Helping people recover from episodes of ill health or following injury										
Percentage of emergency readmissions to our own hospitals occurring within 28 days of the last, previous discharge from hospital after admission.										
% of patients aged 0-15 readmitted within 28 days	1.54%	1.44%	0.91%	In accordance with NfS Digital definitions.	0.91%	Apr16-Jan17	0.00%	9.75%	4.61%	
% of patients aged over 15 readmitted within 28 days	1.80%	1.70%	1.47%		1.47%	Apr16-Jan17	0.10%	7.94%	5.65%	
Domain 4: Ensuring that people have a positive experience of care										
Percentage of inpatients who would recommend the provider to friends or family needing care <sup>7</sup>	98.10%	96.98%	96.89%	In accordance with NfS England guidance.	97.07%	Mar 2016-17	100.00%	75.55%	95.54%	
Percentage of staff who would recommend the provider to friends or family needing care.	97%	91%	92.57%		92.38%	Q4 2016-17	100.00%	43.75%	79.26%	
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm										
Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)	95.87%	95.59%	95.29%	In accordance with NfS England guidance.	95.36%	Q4 2016-17	100.00%	76.48%	95.64%	
Rate of <i>Clostridium difficile</i> (number of infections/100,000 bed days) <sup>8</sup>	0.5	0.73	0.68		No benchmark available					
Patient safety incidents reported to the National Reporting & Learning System										
• Number of patient safety incidents <sup>9</sup>	2,858	3,857	3,925	In accordance with National Patient Safety Agency guidelines.	1,936	Q1+Q2			<a href="http://www.nrls.npsa.nhs.uk">http://www.nrls.npsa.nhs.uk</a> <sup>9</sup>	
• Rate of patient safety incidents (number/1000 bed days)	13.4	19.9	17.52		30.69	Q1+Q2	150.63	16.34		Cluster median = 41.68
• Percentage resulting in severe harm or death	0.16%	0.054%	0.04%		0%	Q1+Q2	0%	1%		0.1%

<sup>7</sup> From 2014/15 the FFT scores have replaced the previously reported score for 'Responsiveness to inpatients' personal needs'.

<sup>8</sup> From 2014/15 measurement moved to lapses of care.

<sup>9</sup> The Benchmarking is against our 'cluster' which is other Acute Specialist Trusts, not national comparison.

<sup>10</sup> From 2014/15 the total number of patient safety incidents that were reported to the National Reporting & Learning System (NRLS), is the number of patient safety incidents which occurred in 2014-15, that was reported to NRLS. The 2016/17 figure may not include some incidents that occurred late in 2016/17, because investigations are not yet completed. Equally, some of the incidents that occurred at the end of 2015/16 had their investigations completed and reported to NRLS in 2016/17, so that the learning can be shared collectively with other centres.

## Friends and Family test

### Patient feedback comments:

*"I was delighted with the kindness and the smiles when I arrived, and throughout my 24 hour stay. The whole staff were absolutely delightful, interested, looking at me and explaining everything, introducing themselves. I thought they were the tops. Thank you very much. Please thank them."*

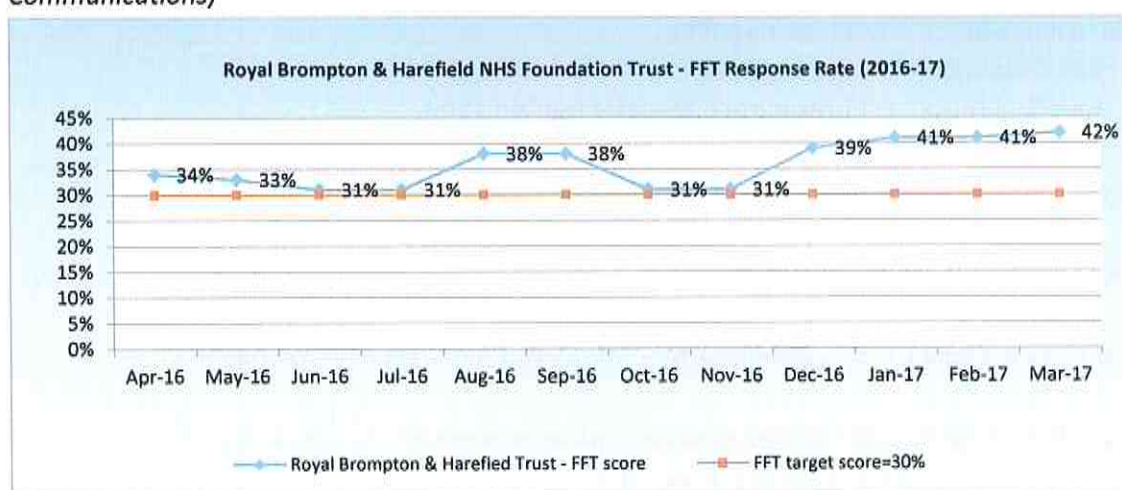
*"I wouldn't be alive without the care and skill of the wonderful staff of the Royal Brompton. I can't praise them all high enough."*

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

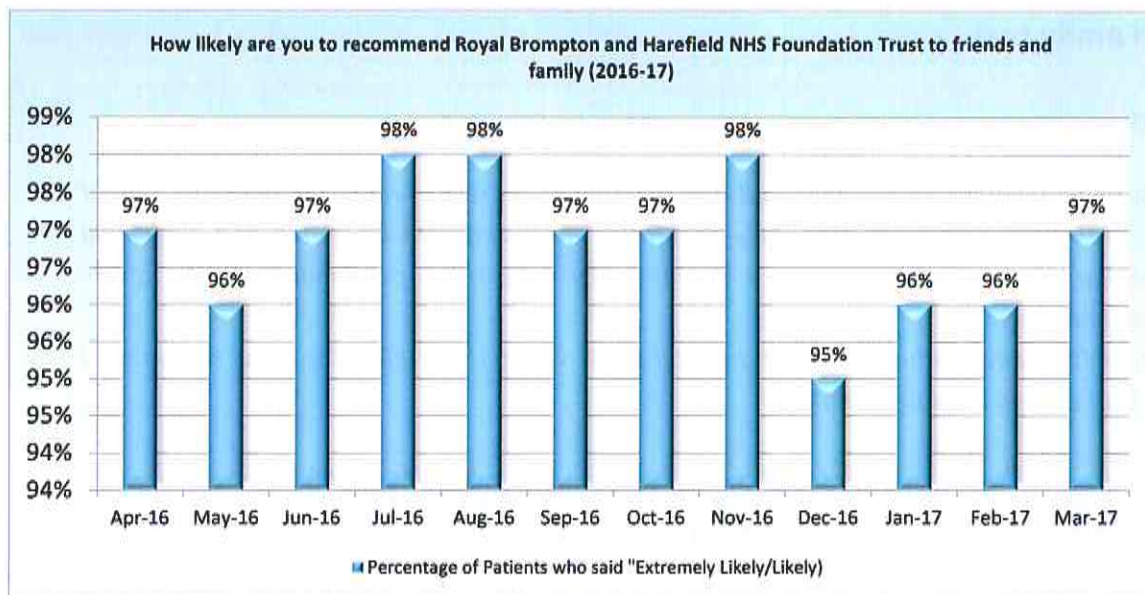
The Friends and Family Test (FFT) provides a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and make improvements where necessary to ensure that patients have a positive experience of care. Results of the test are published every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

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

Chart 1: FFT response and recommend scores for 2016-17 (Source: Picker Institute Europe/ Healthcare Communications)







The FFT recommend scores for Royal Brompton & Harefield NHS Foundation Trusts has been consistently high = >90%. However there are some comments which appear to suggest that the concept of the Friends and Family Test is not well understood by all, for example:

- "I lost my make up bag. Can you help me find it" – It is not possible to identify who left this message.
- "The rating is not given however positive feedback is received"
- "A negative rating is given however positive feedback is received"

#### Friends Family Test Benchmarking – February 2017 (Source NHS England)

- National Benchmarking – 153 trusts in England
  - Royal Brompton & Harefield Trust FFT response rate = 41% (ranked 15<sup>th</sup>).
  - 96% of patients would recommend the Trust to friends and family.
- Local Benchmarking – 57 hospitals in London
  - Royal Brompton FFT response rate = 40% (ranked 21<sup>st</sup>).
  - Harefield Hospital FFT response rate = 44% (ranked 18<sup>th</sup>).

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

*"Because the doctors and the nurses are so caring they do all they can for you."*

*"Brilliant service, friendly staff, efficient system, left feeling confident over treatment."*

*"Every single member of staff that i had contact with were fantastic !! All made me feel relaxed, secure and cared for !! Big Thank you !!!"*

*"Reputation and my personal experience of the very highest technical and practical knowledge and skills at the hospital to treat my condition. Caring well organised and disciplined ward, nurses and staff. Process and procedures seemed to be effective."*



*"All staff have made my stay comfortable and they have gone above and beyond the call of duty."*

*"Fantastic environment, friendly staff, quiet hospital, knowledgeable staff, easy for transport links. Best experience in an NHS hospital other than the birth of my daughter."*

*"There is no better NHS hospital in the country | Polite Staff that know what they are doing and genuinely care about your well-being."*

*"The treatment I had was superb, nursing staff wonderful, cleaning superb, everyone happy the atmosphere made me feel good and the clinical staff were excellent also, could not say more than that, would recommend to anyone, someone said in there it was the best hospital in the UK and I would not doubt that."*

#### Actions taken as a result of patient feedback in 2016

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

##### **1. Facilities**

A change in process during meal delivery was made to improve meal time. Patients now receive their starter separate from the main course to ensure food is served at the correct temperature.

##### **2. Compassion in Practice**

A comment received from a patient who was treated on Cherry Tree ward stated there was a large difference in the day-case service and standard ward service, with day-case being more suited to their needs. This led to a change in clinical treatment allowing for all of it to be delivered in the day-case environment..

##### **3. Information & Communication**

When patient comments are themed there are high numbers of concerns related to the issue of "waiting". In order to address these concerns a better understanding of the issue and what the Trust can do to improve the experience or improve the communication about the experience is being explored.

##### **4. Patient Experience**

Patients in AICU at Harefield are now able to contact friends and family members via Skype. This has been specifically helpful to patients who are not living in the local vicinity.

## Complaints

The following information about formal complaints received by the Trust is reviewed on a monthly basis by the operational management team: There is a 2 month time delay on reporting performance as complaints can be received on the last day of the month and not be due to be closed for at least a further 25 working days.

Period	1 <sup>st</sup> April 2016 – 31 <sup>st</sup> January 2017 <sup>11</sup>			
	Within 25 days	Over 25 Days	Total	%
Royal Brompton Hospital	30	11	41	73.2
Harefield Hospital	16	9	25	64.0
<b>Trust Total</b>	<b>46</b>	<b>20</b>	<b>66</b>	<b>69.7</b>

Amendments to the NHS complaints regulations removed the stipulation to respond to complaints within set timescales, allowing organisations to individually negotiate response dates with complainants, ensuring that they are kept informed of any delays in the investigation. During the year 2016/2017 this Trust in line with many others retained an internally set standard which aims for 25 working days from receipt of a formal complaint to a response being sent from the Chief Executive, with a target of 90% for achievement. The exception to this is where a different timescale is negotiated with the complainant in recognition of a particularly complex investigation.

26 complaints (30%) had extended agreed timescales negotiated and if these had been included in the operational management team figures the totals would be as below.

Period	1 <sup>st</sup> April 2016 – 31 <sup>st</sup> January 2017			
	Within Agreed Timescale	Not within Agreed Timescale	Total	%
Royal Brompton Hospital	36	5	41	87.8
Harefield Hospital	20	5	25	80.0
<b>Trust Total</b>	<b>56</b>	<b>10</b>	<b>66</b>	<b>84.8</b>

Setting an achievable deadline at the outset and allowing time for a comprehensive response is preferable to complainants.

We have now amended both our internal and external complaints reporting and as of April 2017 we will now report the % of complaints responded to within agreed timescales working towards a target of 95%.

The Trust received a total of 84 Complaints during the year 1<sup>st</sup> April 2016 to 31<sup>st</sup> March 2017. This included complaints from 8 Private Patients and 1 complaint led by another organisation.

Managers speak directly to complainants once a complaint letter is received to discuss the complaint in more detail and agree a timescale in which to provide a written response. Following a discussion some complainants are happy for the manager to handle their complaint informally and in the year 2016/2017 22 complaints (26%) were handled in this way. This may mean the complainant receiving a written response directly from the manager instead of the Chief Executive or attending a meeting with clinical staff. However these complaints are still included in the total number of complaints received and lessons learned and outcomes are recorded.

<sup>11</sup> The Trust reported 84 formal complaints received during the period 1<sup>st</sup> April 2016 – 31<sup>st</sup> March 2017.

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

Complaints Received	Site	Upheld	Partially Upheld	Not Upheld	Number of Complaints Re-Opened	Still Open
52	Royal Brompton Hospital	27	10	12	6	3
32	Harefield Hospital	16	8	6	4	2
84	Trust Total	43	18	18	10	5

\*Table represents the status of complaints received during the year 1st April 2016 to 31st March 2017 and the outcome if not "still open".

Of the 52 complaints received at Royal Brompton Hospital during the year 2016/2017 71% were upheld or partially upheld and 23% were not upheld. 6 complaints were reopened at the complainants request (12%) including 2 private patient complaints (25%) and they were provided with a further written response or meeting. 3 complaints received in March 2016 have not yet been responded to.

Of the 32 complaints received at Harefield Hospital during the year 2016/2017 75% were upheld or partially upheld and 19% not upheld. 4 complaints (12%) were reopened at the complainants request and they were provided with a further written response or meeting. 2 complaints received in March 2016 have not yet been responded to.

Private patient complaints at the Trust are treated under the same Trust policy as NHS complaints and are therefore included in the number of complaints received.

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

The Trust continues to improve its care and service delivery through regular review of complaints, and identification of learning via the Divisional and trust wide Governance processes. Staff undertaking investigations are supported through regular case review meetings and learning events.



## Part 3: Formal statements of assurance

### CQC registration

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

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

As a result of the inspection, the Care Quality Commission issued two Requirement Notices relating to Regulation 12 Safe Care and Treatment.

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

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

### Provision of NHS services

During 2016-17 Royal Brompton & Harefield NHS Foundation Trust provided 37 Commissioner Requested Services. Royal Brompton & Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 37 of these NHS services.

The income generated by the NHS services reviewed in 2016-17 represents 100% of the total income generated from the provision of 37 NHS services by Royal Brompton & Harefield NHS Foundation Trust for 2016-17.

## Use of the CQUIN Payment Framework

There were two CQUIN schemes in place for 2016/17, one applying to NHS England contract work and the other to Clinical Commissioning Group.

The Trust has submitted evidence to commissioners and is negotiating to a maximum 96.5% achievement of the CQUIN. The Trust will not have confirmation from commissioners as to the value of the final payment until the evidence has been reviewed by commissioners. Commissioners also have requested clarification on the evidence submitted and value during May.

### What is CQUIN measure?

CQUIN is a payment framework that enables commissioners (who pay us for providing services) to reward excellence by linking a proportion of the Trust's income to the achievement of local quality targets.

#### Commissioner: NHS England

Scheme	Weighting	£	Annual Achievement (estimated)	Total claimed
Clinical Utilisation Review	0.40	£689,400	100%	£689,400
Asthma	0.20	£344,700	100%	£344,700
ECMO	0.55	£947,925	100%	£947,925
Telemedicine (3 indicators)	0.20	£344,700	100%	£344,700
Transfer of immunosuppressant to support repatriation and home care delivery - phase 1 initiation	0.55	£947,925	100%	£947,925
TAVI - comparison of outcomes to pathways	0.10	£172,350	100%	£172,350
<b>Total</b>	<b>2.00</b>	<b>£3,447,000</b>		<b>£3,447,000</b>

#### Commissioner: Clinical Commissioning Groups

Scheme	Weighting	£	Annual Achievement (estimated)	£
Introduction of staff health & wellbeing initiatives	0.33	£189,220	100%	£189,220
Healthy food for NHS staff, visitors and patients	0.33	£189,220	100%	£189,220
Improving the uptake of flu vaccinations for frontline clinical staff	0.33	£189,220	50%	£94,610
Reduction in antibiotic consumption per 1,000 admissions	0.40	£227,291	66%	£150,012
Empiric review of antibiotic prescriptions	0.10	£56,823	100%	£56,823
Clinical Utilisation Review	0.40	£227,291	100%	£227,291
Proportion of outpatient new or follow up activity recorded as 'non face to face' activity	0.60	£340,936	100%	£340,936
<b>Total</b>	<b>2.50</b>	<b>£1,420,000</b>		<b>£1,248,111</b>



**What is clinical audit?**

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

**Participation in clinical audit**

During 2016/17 financial year 17 national clinical audits covered relevant health services that Royal Brompton & Harefield NHS Foundation Trust provides. There were no national confidential enquiries in which the Trust was eligible to take part.

During that period Royal Brompton & Harefield NHS Foundation Trust participated in 88.24%<sup>12</sup>.

The national clinical audits that Royal Brompton & Harefield NHS Foundation Trust participated in, and for which data collection was completed during 2016-17 are listed below:

Clinical Audit Topic	National clinical audit	Did the Trust participate in 2016-17	Clinical Audit Lead
Peri-and Neo-natal			
Perinatal mortality	MBRRACE-UK	✓	Val Hedley
Children			
Paediatric intensive care	PICANet / Specialised services quality dashboards	✓	Dr Sandra Gala-Peralta
Paediatric cardiac surgery/cardiology/Adult Congenital Heart Disease	NICOR Congenital Heart Disease Audit	✓	Dr Rodney Franklin and Mr O Ghez
Congenital Heart - Adult	Specialised services quality dashboards	✓	Dr Rodney Franklin and Mr O Ghez
Congenital Heart - Paediatrics		✓	
Fetal Medicine		✓	
Acute care			
Cardiac arrest	National Cardiac Arrest Audit	✓	Richard Young
Adult critical care	Intensive Care National Audit & Research Centre Case Mix Programme – Submissions to start April 2017	X	Dr TC Aw
Emergency Laparotomy	NELA	✓	Lakshmi Kaupparao Tom Pickering
Elective procedures			
Coronary angioplasty	NICOR Adult cardiac interventions audit	✓	Charles Ilsley Simon Davies
CABG and valvular surgery	Adult cardiac surgery audit	✓	Neil Moat / Rashmi Yadav Fabio de Robertis
Cardiovascular disease			
Acute Myocardial Infarction & other ACS	MINAP	✓	Rob Smith Simon Davies
Heart failure	Heart Failure Audit	✓	Rakesh Sharma
Cardiac arrhythmia	Cardiac Rhythm Management Audit	✓	Tom Wong
Vascular Procedures	National Vascular Registry - we will start to submit data 2017/18	X	Nick Cheshire
Cancer			
Lung cancer	National Lung Cancer Audit	✓	Eric Lim
Blood transfusion			
Re-audit of patient blood management in audit surgery	National Comparative Audit of Blood Transfusion	✓	Ketan Patel
End of life			
Care of dying in hospital	NCDAH – audit every 2 years, next audit 2018	X	Lauren Berry

<sup>12</sup> Note that the NCDHAH audit was not an eligible audit to participate in 2016/17 as it is a biennial audit programme, with the next audit scheduled for 2018.



### **National Confidential Enquiries**

The Trust was not issued with any new eligible NCEPOD studies in 2016/17.

The report for the Mental Health study – Treat as one was published in January 2017.

This NCEPOD report highlights the quality of mental health and physical health care for patients aged 18 years or older with a significant mental disorder who are admitted to a general hospital. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients. The report contained 21 recommendations which have been reviewed by our consultant in Psychiatry.

Progress with recommendations highlighted in NCEPOD reports are monitored through the Clinical Effectiveness & Standards Oversight Committee (CESOC).

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

Each division has in place a clinical audit programme. A report detailing the audits in progress is submitted quarterly to the Clinical Effectiveness & Standards Oversight Committee (CESOC).

## Participation in research

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

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

In 2016, the Trust was unsuccessful in securing NIHR funding for a Biomedical Research Centre and will no longer have designated NIHR Biomedical Research Units for Respiratory or Cardiovascular research from 1 April 2017. The Trust was successful in its application for a NIHR Clinical Research Facility which will enable our excellent research facilities to enable us to continue to deliver world-leading research of direct benefit to our patients. These changes give the Trust the unique opportunity to integrate research with clinical activity and we will review research governance structures and establish a new research strategy in collaboration with clinical divisions during 2017-18. In the meantime, the Trust will continue to support activity in line with its four strategic research goals to further extend and enhance the national and international research profile of the organisation:

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

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

## Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Brompton & Harefield NHS Foundation Trust during 2016-17 that were recruited to participate in research approved by a research ethics committee was 2,700. At the end of 2016-17 (31 March 2017), the Trust was participating in 200 actively recruiting studies, 120 that are continuing to follow up patients after a research intervention, with another 75 in set-up. This includes global studies sponsored by industry, trials involving new medicines or devices and international registry studies, compiling research data for better patient outcomes.

Of our active studies in 2016-17, 1,800 patients were recruited into NIHR portfolio studies (commercial and non-commercial) and 900 patients were consented to donate their tissue for retention within the Trust's ethically approved Biomedical Research Unit Biobanks. In addition 94 patients have consented to participate in the National 100k Genome project for rare diseases. We consistently perform well in the sector against our national objectives, exceeding the target set by the North West London Clinical Research Network, with 73% of our commercial studies achieving or surpassing their recruitment target.



## Data quality

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

In Royal Brompton & Harefield NHS Foundation Trust, data quality is seen as everybody's responsibility. Such an approach helps the Trust ensure that very high standards in data quality are maintained throughout the organisation.

The Trust uses the following initiatives to maintain very high quality of data and therefore a high quality service to all service users:

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

### Secondary Uses Service

Royal Brompton & Harefield NHS Foundation Trust submitted records during 2016/17 financial year to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

The percentage of records in the published data<sup>13</sup>:

which included the patient's valid NHS number was:

98.7% for admitted patient care;

99.0% for outpatient care.

which included the patient's valid General Medical Practice Code was:

98.7% for admitted patient care;

99.4 for outpatient care.

### Information governance toolkit attainment levels 2016-17

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

The Trust's information governance toolkit submission for 2016-17 achieved a '**Satisfactory**' grade (all requirements met at Level 2 or better).

Several requirements previously assessed at Level 2 were increased to Level 3, resulting in an overall score of **78%** (compared to 69% for the previous year, and where 100% represents all requirements scored at Level 3).

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

<sup>13</sup> Data Source: NHS Digital (April 2016 - January 2017)



### Clinical coding error rate

Royal Brompton & Harefield NHS Foundation Trust carried out an internal audit during November 2016 and December 2016. This was based on 200 randomly selected records from July 2016 to September 2016.

The results of the clinical coding audit are below.

#### Clinical Coding Audit Results

Primary diagnosis correct %	Secondary diagnoses correct %	Primary procedure correct %	Secondary procedures correct %	Safe to Audit %
97.5	99.3	97.7	97.1	100

The 2014/15 Reference Cost Audit Report published by PricewaterhouseCoopers on 12<sup>th</sup> of May 2016 indicated that Royal Brompton & Harefield NHS Foundation Trust demonstrated good practice in complying with Monitor's Costing Guidance. In particular enhanced data quality checks in the Trust's activity recording procedures, support assurance over the accuracy of clinical coded activity in the reference cost return.

Royal Brompton & Harefield NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17.

## Performance against key healthcare targets 2016-17

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

### Risk Assessment Framework - Performance for Quarter 1 & 2

Indicator	Target/ threshold	2016-17 Q1		2016-17 Q2	
		Score	Indicator Met	Score	Indicator Met
<i>Clostridium difficile</i> - Cases due to lapses of care	12 (de minimis)	0	Met	1	Met
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	94.0%	100%	Met	97.78%	Met
Cancer - 62 day Urgent GP referral to first definitive treatment – including breach allocations <sup>14</sup>	85.0%	69.64%	Not Met	75.0%	Not Met
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93.0%	100%	Met	100%	Met
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96.0%	98.33%	Met	97.93%	Met
Percentage of patients on an incomplete pathway waiting less than 18 weeks	92.0%	88.90%	Not Met	89.06%	Not Met

The Risk Assessment Framework was operated by NHS Improvement from 1<sup>st</sup> April 2016 to 30<sup>th</sup> September 2016, when it was replaced by the Single Oversight Framework.

During this period:

- There was one lapse of care relating to *Clostridium difficile* during Quarter 2. This related to a case where patient to patient transmission could not be definitely excluded.
- The 31 day Cancer target for subsequent treatment was met in both quarters
- The 62 day cancer target (for the time from GP consultation to first definitive treatment) did not meet the national standard set out in the Risk Assessment Framework. However, the requirements of the improvement trajectory agreed with NHS Improvement were met which enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF)

<sup>14</sup> The Trust received confirmation from NHS Improvement to implement the new cancer breach allocation methodology, which will not formally go live until October 2017, with formal reporting from April 2017, as the basis for the calculation of breaches for the Risk Assessment Framework from 1<sup>st</sup> of April 2016. Please refer to the following website for more information: <https://www.england.nhs.uk/wp-content/uploads/2016/03/cancer-brch-allocatn-guid-2016.pdf>

- The two week cancer target (for the time waiting to first out-patient appointment) was met in both quarters
- The 31 day cancer target (from diagnosis to first treatment) was met in both quarters
- The 18 week waiting time target (from GP consultation to first definitive treatment) did not meet the national standard of 92% in quarter one and quarter 2. However, the requirements of the improvement trajectory agreed with NHS Improvement were met which enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF).

**Single Oversight Framework - Performance for Quarter 3 and Quarter 4**

Indicator	Target/ threshold	Oct-16		Nov-16		Dec-16		Jan-17		Feb-17		Mar-17	
		Score	Indicator Met	Score	Indicator Met	Score	Indicator Met	Score	Indicator Met	Score	Indicator Met	Score	Indicator Met
<i>Clostridium difficile</i> - Cases due to lapses of care	23	0	Met	0	Met	0	Met	0	Met	0	Met	0	Met
MRSA Bacteraemias	0	1	Met	0	Met	0	Met	0	Met	0	Met	0	Met
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92.0%	92.40%	Met	92.85%	Met	91.98%	Not Met	93.12%	Met	93.52%	Met	92.67%	Met
Cancer - 62 day Urgent GP referral to first definitive treatment – including breach allocation	85.0%	100.0%	Met	60.87%	Not Met	92.86%	Met	20.0%	Not Met	88.89%	Met	61.54%	Not Met
Maximum 6 – week wait for diagnostic procedures	1%	0%	Met	0%	Met	0%	Met	0%	Met	0%	Met	0%	Met
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0



The Single Oversight Framework was operated by NHS Improvement from 30<sup>th</sup> September 2016 to 31<sup>st</sup> March 2017.

During this period:

- There were no lapses of care relating to *Clostridium difficile* during Quarter 3 or Quarter 4
- One sample tested positive for MRSA in October 2016. This result was reported to Public Health England. The sample was determined to be contaminated with MRSA rather than a true case of MRSA bacteraemia. The Trust is currently (5<sup>th</sup> May 2017) appealing against attribution of this case to the organisation. Please note that as the patient did not have a bacteraemia, this test result does not count against the target.
- The 18 week waiting time target (from GP consultation to first definitive treatment) did not meet the national standard of 92% in month 9 (December). However, the requirements of the improvement trajectory agreed with NHS Improvement were met which enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF).
- The 62 day cancer target (for the time from GP consultation to first definitive treatment) did not meet the national standard of 85% for 3 out of the 6 months of quarters 3 and 4. It should be noted that this national standard is designed for use in hospitals delivering a broad range of cancer services involving both long and short pathways. The 85% standard is intended to be an average set across both long and short pathways. The Trust is a specialist centre providing surgical treatment for lung cancer patients. This is an inherently long pathway, the diagnostic portion of which is carried out in secondary care. Although the national standard was not met, the requirements of the improvement trajectory agreed with NHS Improvement were met. This enabled the Trust to secure payments from the Sustainability and Transformation Fund (STF.)
- 6 week wait for diagnostic procedures. The Trust met the standard for 6 week diagnostic waits throughout the period
- Never Events, these are clinical incidents that should never occur, such as wrong site surgery and retained foreign body after surgery. There were none during the whole of 2016/17.

In accordance to NHS Improvement guidance, performance indicators that applied to both the Monitor Risk Assessment Framework and Single Oversight Framework are reported for the whole year.

Indicator	2016/17 Score
<i>Clostridium difficile</i> - Cases due to lapses of care	1
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	91.28%
Cancer - 62 day Urgent GP referral to first definitive treatment – including breach allocation	71.04%

Further details of non-financial performance, and on data quality with respect to the 18 week referral to treatment time target, are given in the Quality Report 2016/17 which can be found at Annex 1 of this document.

## 18 Week Referral to Treatment Time Data Considerations

The Referral to Treatment (RTT) performance indicator has been reported in previous financial years with data quality considerations. The data quality considerations mentioned in this section will correspond to different Patient Administration System (PAS) regimes. RTT waiting time reporting is inherently complex given the nature of the Trust specialist tertiary services. Typical data quality considerations are as follows:

- Missing clock start data, often the result of not receiving a minimum dataset from the referring provider, about the patient's RTT pathway status;
- Negative waiting time data, the result of the old "iexpress" PAS not having restrictions on the entry of clock start date values, leading to some pathways having a clock stop before a clock start;
- Incomplete pathway reported in error, as a result of a closed pathway (i.e. patient already treated) not being closed prior to the reporting snapshot being taken;
- Pathway classified in error as a RTT that should be removed from the denominator of the RTT performance calculation.

The new Patient Administration System "Lorenzo" was installed in July 2016. The installation of the new "Lorenzo" PAS was overseen by the Trust PAS Replacement Project Board. The PAS Replacement Project Board was re-constituted as the PAS Implementation Group in September 2016, with the remit to ensure the successful adoption of the new system. It is chaired by the Chief Operating Officer.

On 30 March 2017 the Trust Board received a report detailing 6,700 open pathways for the 18 Weeks Referral to Treatment Incomplete performance indicator. Whilst the Trust is confident of the accuracy of the records of long-waiting patients (and in particular those waiting over 18 weeks) as a result of monthly validation checks, the Trust does not have the same assurance over the accuracy of the reported nos. for patients with shorter waits, which may be overstated for the two principal reasons:

1. A large number of 'RTT pathways' have been opened in the new "Lorenzo" Patient Administration System following 'go live' in July 2016. The Lorenzo system, assumes all activity to be an RTT pathway, subject to the constitutional target of 18 weeks waiting time for treatment, unless actively stopped. Whereas our previous system required the users to classify whether the patient is on an RTT pathway. Alongside 3,800 open pathways necessarily migrated from the old system, we now have around another 3,000 open pathways.
2. The updates and corrections made using our administrative systems by the validating teams have observed problems, both being picked up and reflected back into Lorenzo and subsequently updating the reported clock stop position. These issues are being addressed by the PAS Implementation Group, and careful progress is being made.

The PAS Implementation Group is overseeing two related work streams aimed at improving data quality. These cover technical and system changes, both within the Trust and involving the system supplier (CSC); and development and dissemination of new training materials to improve knowledge and use of Lorenzo processes, consistent application of IT data standards and business processes.

The following points should be noted:

- NHS England and NHS Improvement are being kept informed of the progress to improve the accuracy of current RTT reports via monthly meetings and tracking reporting.



- Waiting-time reports for patients on lung cancer pathways (31-day and 62-day) are not captured in this way and are therefore unaffected.
- As previously reported, Lorenzo PAS captures referral information in a different way from the old system, greatly reducing the risk of referral information being lost or delayed.
- As planned, a post-project evaluation of Lorenzo implementation is nearing completion, and an Internal Audit review will be undertaken in early 2017/8.

## 62 day Urgent GP Referral to first definitive treatment Data Considerations

Data to support reporting against the 62 day cancer target is captured within the Infoflex system by multi-disciplinary team (MDT) co-ordinators who manage the patient's progress along the lung cancer treatment pathway. On a monthly basis, this data is uploaded to the national cancer data system known as Open Exeter.

In previous years the two key dates audited have been the pathway start date, when the patient was initially referred by their general practitioner. This referral is usually made to secondary care. The other date audited previously was the date that the patient was treated.

On 20<sup>th</sup> April 2016, NHS England and NHS Improvement wrote to trust distributing National Breach Allocation Guidance. This made provision for local data collection by 1<sup>st</sup> October 2016. Following discussion with NHS Improvement concerning the scale of the geographic area from which referrals come to the Trust, it was agreed that the Trust could report to NHS Improvement using the new Breach Allocation Guidance for the 2016/17 reporting year.

This meant that a new third date, the date that the referral is now required. Referral letters are usually received by e mail. On receipt the referral documentation is uploaded to the Trust electronic patient record (EPR). The referral e mail itself does not contain any clinical information and for 2016/17 year was not retained.

As a result of the audit a recommendation has been made that the e mails detailing the date of referral should be retained separately from the clinical information. The Trust has accepted this recommendation and a system was put place, effective from 1<sup>st</sup> April 2017, to ensure that the e mails are retained on a shared departmental drive.



## An overview of the quality of care

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

### Patient Safety

- Improving our Organisational Safety Culture (see page 8)
- Improving the identification and management of patients at risk of pressure ulcers and falls (see page 12)
- Safer use of medicines and medical devices (see page 16)

### Clinical Effectiveness

- Improving the management of patients with cancer (see page 15)
- Participation in Clinical Audit (see page 34)
- Reporting incidents on Datix (see page 8)

### Patient Experience

- Improving the patient experience on surgical pathways (see page 11)
- Percentage of in-patients who would recommend the provider to friends or family needing care (see page 26)
- Friends and Family Test; for patient feed-back comments (see page 27)

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

## Part 4: Statements from our stakeholders

### Statements from Healthwatch

#### Healthwatch Hillingdon's response to Royal Brompton & Harefield NHS Foundation Trust Quality Account 2016-2017

Healthwatch Hillingdon wish to thank the Royal Brompton and Harefield NHS Foundation Trust (the Trust) for the opportunity to comment on the Trust's Quality Accounts for the year 2016-17.

The Quality Account is again this year user friendly and easy to read. It demonstrates that the Trust is fully aware of those areas that require to be improved and show its commitment to provide high quality, patient centred care.

The Friends and Family Test results clearly illustrates this, as not only do 96% of patients recommend the Trust, but the Trust have plainly improved its service in response to patient feedback in a number of tangible ways.

We were very pleased to see that Harefield Hospital was rated as 'Good' by the CQC in the inspection report published in January 2017, with some areas of Surgery seen as 'Outstanding'. We congratulate the Trust on this achievement, which is not achieved without the continued hard work and dedication of the workforce.

The Trust has generally met its quality objectives this year. The exception being quality priority 4, which is due in the main to the 62 day cancer pathway. This the Trust has acknowledged, with a mitigating explanation. We would highlight the work carried out under priority two, around cancelled operations. It is clear from the report that the work to understand the reasoning behind cancellation at short notice has been successful, with a marked reduction in the number of operations cancelled at both Harefield and the Royal Brompton sites. It is also positive that 98% of patients were given a firm alternative date within the 28 day target.

We are in agreement with the Trusts priorities for 2017-2018 and that they align with the areas highlighted for improvement by the Care Quality Commission.

We are pleased the Trust has reacted to the results of the staff survey and will be looking to address bullying and harassment as a priority. We outlined the rising trend in last year's response, and this year not only has the number of staff feeling 'bullied or harassed' increased in the survey, but reporting is extremely low and we welcome this direct focus on the issue.

We continue to welcome the Trusts complaints processes and agree it is good for managers to speak directly to complainants once a complaint letter is received to discuss the complaint in more detail. We are encouraged by the Trust looking to continually improvement care and service delivery through regular review of complaints, and identification of learning via the Divisional and trust wide Governance processes. However, as last year, we again highlight the opportunity the Trust could take to further assure the public of the Trusts commitment to quality, through explaining in the report the themes of the complaints it receives and what in particular is being done by the Trust to address these themes.

**Conclusion**

We would acknowledge that the Quality Account not only shows the Trust's committed to the delivery of high quality care, but gives a clear indication that on the whole this is being achieved.

At a time when recruitment and retention of staff is proving difficult, it is more crucial than ever that the workforce is valued and enjoy their working environment. It is therefore important for the Trust that it nurtures a workforce culture that complements the high standard of care it delivers.

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

**Healthwatch Hillingdon**

**22nd May 2017**



## Statement from Healthwatch Central West London

### Draft Royal Brompton Hospital & Harefield NHS Foundation Trust Quality Report 2016/2017 Healthwatch Central West London Statement

Healthwatch Central West London (HW CWL) welcomes the opportunity to provide a statement on the draft Royal Brompton & Harefield NHS Foundation Trust Quality Report (QR) for 2016/2017, and to comment on the quality of the services commissioned locally to meet the health needs of residents and service users in Kensington and Chelsea, Hammersmith & Fulham and in Westminster.

We commend the Trust on the initiatives being implemented to improve the environment for both staff and patients, for instance through Human Factors Training and a £2000per annum study budget for full-time staff. Our members welcome the opportunity to be involved with this year's PLACE assessment and have highlighted a noticeable improvement on last year's assessment.

## Comments

### Safety and incidents

#### *Safety culture*

Healthwatch CWL members commend the Trust on the Human Factors training and the 'Train the Trainers' model that is being used to role the training out across teams. A table has been included listing the number of training sessions held since 2015 (page 8), it would be helpful to have a break down year by year to see how many staff members were trained in the last year. It would be also good to see details of whether the Trust is meeting the target 'faculty members are required to teach a minimum of 2 one day courses per year'.

Healthwatch CWL welcome the Trust's regular incident reporting feedback sessions however feel that it would be useful to have more information around the number of staff that attended these sessions, the nature of the incidents reported and how incidents are being addressed.

Our members are pleased that there is improved staff awareness and attendance on the Executive patient safety walk rounds however feel that the percentage of staff awareness and attendance is still fairly low. It would be useful to know whether the Trust have spoken to staff about why they are not attending the rounds, what would encourage staff to attend the rounds and how else they could promote the initiative to staff.

#### *Falls and pressure ulcers*

Our members commend the Trust on the new falls prevention bundle that has been piloted on several wards. It would be interesting to see the impact that the scheme has had on reducing falls to date and hope that the Trust will provide details of the effectiveness the initiative in next year's QR.

Healthwatch Central West London welcome the use of small mirrors to help clinical staff assess the back of patients for signs of pressure ulcers.

### Waiting times & Patient Experience

Our members await details of the progress made around waiting times for 62 day cancer pathway patients as this was an area of concern in last year's QR. The QR references an update to come based on the Cancer Service Action Plan, it would be good to see details of this plan.

Healthwatch CWL commend the Trust for collecting Family and Friends Test using various methods and would be interested to see a break down of the return rate for each method. Our members

welcome the patient experiences shared in the QR and recommend that the Trust modify the formatting so the quotes stand out to readers.

Our members were interested to see the actions taken as a result of patient feedback and would like to know how these actions have been communicated with patients and carers. Healthwatch CWL commend the Trust for providing Skype to patients in AICU at Harefield and hope that this scheme can be introduced at the Royal Brompton site as well.

### **Staff**

Healthwatch CWL welcome the Trust's decision to make the 'Working Together Better for Patients' initiative mandatory for departments reporting high levels of harassment, however with 64% of staff not reporting bullying or harassment our members suggest that these sessions become mandatory for all departments. As well as providing Bullying and Harassment Ambassadors, the Trust should consider providing Harassment and Bullying Awareness Training so staff have a better understanding of when to raise concerns. Our members would like to see examples of concerns raised by staff, details of how these have been addressed and some of the disciplinary procedures in place. Healthwatch CWL welcomes the Trust's priority around Bullying and Harassment for 2017/18.

Healthwatch CWL would like to see staff experiences included in the QR and ongoing procedures in place for collecting the staff experience and thoughts for improving the workplace.

### **Complaints**

Our members welcome the Trust's plans of responding to complaints within an agreed timescale 95% of the time and would like to have details of how the Trust plan to achieve this. It would be useful for Healthwatch CWL to see details of the nature of some of the most common complaints and the measures in place to address these.

### **2017/18 priorities**

Healthwatch CWL commend the Trust for developing new Quality Priorities to reflect the outcomes of the CQC inspection in January 2017. Since many of the 2016/17 priorities were due to run for another year, it would be good to see them referenced in the 2017/18 Quality Report to demonstrate that these are still areas of importance for the Trust. The QR references an action plan for improving outcomes ahead of the next inspection, it would be interesting to see details of the action plan or certainly the key points. Healthwatch CWL would like to see details of the engagement that took place when setting the priorities for 2017/18.

### **Report presentation**

Healthwatch CWL commend the Trust for the use of dialogue boxes to describe terms or abbreviations used in the QR and for included an extensive glossary. Our members welcome the QR introduction and details of 'What is a Quality Report?'. Our members welcome the use of graphs to show information however feel these could be made bigger (page 16). Whilst bullet points are used on occasions in the QR, we would recommend using them more to break up big chunks of text.

### **Conclusion**

Once again our members would like to commend the Trust staff on the many examples of good care and professionalism. Healthwatch CWL await the progress around the management of patients with cancer and would like to see feedback on the patient and carer experience. We would also like to understand what ongoing patient engagement the Trust has in place for 2017-18 and would welcome any opportunities for our members to be involved.

We look forward to continuing and improving our working relationship with draft Royal Brompton & Harefield NHS Foundation Trust.

**Contact:**

Healthwatch Central West London

020 8968 7049

[info@healthwatchcentralwestlondon.org](mailto:info@healthwatchcentralwestlondon.org)

25<sup>th</sup> May 2017



## Statements from Local Authority Oversight and Scrutiny Committees

### **Statement from Councillor Charles Williams (Chairman, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea) on the Royal Brompton and Harefield NHS Foundation Trust's Quality Account 2016/17**

I am pleased to provide this brief statement for the Royal Brompton and Harefield NHS Foundation Trust's Quality Account for 2016/17. The Quality Account gives a useful overview of the work and performance of trusts. The Royal Borough of Kensington and Chelsea has an excellent working relationship with the Royal Brompton and Harefield NHS Foundation Trust.

It can be more difficult for a scrutiny committee to scrutinise with a specialist trust, such as the Royal Brompton and Harefield NHS Foundation Trust, because only a small proportion of the Trust's patients are from the scrutiny committee's borough. However, having said this, we are most proud of having the Royal Brompton based in the Borough. In past years the Royal Borough's scrutiny committee, with our scrutiny colleagues from Hillingdon, have endeavoured to carry out a number of joint public meetings on the Royal Brompton and Harefield NHS Foundation Trust. These meetings have been successful in engaging the public. At these meetings the Trust's Executive have been questioned by both councillors and the public.

As at time of writing we are in the NHS England consultation period on the future of congenital heart disease (CHD) services. Royal Brompton attended the earlier Scrutiny Committee meeting back in September 2016 and is due to attend the further meeting on 11 July 2017. We are grateful for the participation of the Royal Brompton officers in this consultation process.

We have noted that the Care Quality Commission (CQC) inspection report on the Royal Brompton published on 10 January 2017 had an overall summary rating of Requires Improvement. In the coming months we look forward to hearing from the Royal Brompton its plans to address the issues identified by the CQC.

We look forward to working more closely with colleagues at the Royal Brompton and Harefield NHS Foundation Trust over the coming year to better understand the priorities and issues covered in the Quality Account 2016/17.

**Councillor Charles Williams**  
18 May 2017

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

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2016/2017 Quality Account report and acknowledges the Trust's continued commitment to attend its meetings when requested.

The number of reportable cancelled operations in theatres has decreased in 2016/2017 from 476 to 372. Having conducted an audit in September 2016, the Trust found that improvements were needed in relation to the accuracy of classifying the reasons for cancellation on the computer system. It is interesting to note that the most common reason for cancelled surgery at Harefield Hospital is due to there not being a bed available for the patient. The report states that the total number of bed days across the Trust has increased from 205,889 in 2015/2016 to 230,146 in 2016/2017 but the total number of admissions has decreased by just over 2% (from 40,044 to 39,239). Whilst the number of cancelled surgeries has decreased by approximately 12%, the number of bed days has increased by almost 12% and the number of incidents reported on DATIX has increased by just under 2% (from 3,959 in 2015/2016 to 4,032 in 2016/2017). It would appear that patients are staying in hospital for longer even though fewer operations are being cancelled. Of those 849 patients whose operations were cancelled, the Trust managed to adhere to its pledge to offer another binding date within 28 days in 98% of cases, with a reduction in the number of breaches of this pledge from 11 in 2015/2016 to 8 in 2016/2017. Although, ideally, there should be no breaches of the pledge, the Trust should be commended on this level of performance.

With regard to patient falls, the Trust has achieved an average of 1.37 falls per occupied bed days and a falls with harm average of 0.03 in 2016/2017 against the national average of 6.63 and 0.19 respectively. That said, there has been a 42% increase in the number of patient falls with harm (76 in 2015/2016 and 108 in 2016/2017). In addition, the Trust has implemented interventions which have seen a decrease in the number of medication errors from 941 in 2015/2016 to 907 in 2016/2017. Members would like an update in due course to gain reassurance that this trajectory continues.

The CQC published the results of its inspection of the Trust in January 2017 and Members were disappointed to see that, despite gaining 3 *Outstanding*, 19 *Good* and 7 *Requires Improvement* for Royal Brompton Hospital and 2 *Outstanding*, 20 *Good* and 2 *Requires Improvement* for Harefield Hospital, the Trust was rated overall as *Requires Improvement*. The Trust has put together an action plan to address the issues raised during the CQC inspection and the Committee looks forward to seeing the outcome of the re-inspection once it has been completed.

15% of respondents to the RBH staff survey reported that they had been bullied or harassed by a manager and 23% had been bullied or harassed by another colleague giving an overall score of 30%. However, 64% of these staff stated that they had not reported the issue. In fact, only two bullying and harassment claims had been made to HR during 2016/2017. Although the Committee is aware that some staff may make unfounded allegations as a result of feeling pressurised, Members are reassured that the Trust continues to run its 'Working Together Better for Patients' initiative to address conflicts between staff. Reclassifying these from voluntary to mandatory sessions for those departments that report high levels of harassment and bullying in the staff survey is a more targeted approach that would support the work of the Listening Groups. The Committee commends the Trust for the positive steps it has taken to manage and develop its staff in terms of the availability of study budgets and the range of courses provided.

Although the Trust had originally intended to keep the same quality priorities from 2014/2015 to 2017/2018, some of these priorities have already become intrinsically embedded into routine practices and everyday processes. Furthermore, the CQC inspection has highlighted areas of strength



and areas for improvement. As such, the Trust has identified five new quality priority projects to underpin the themes of 'managing the acutely ill patient' and 'developing our culture':

1. *National Early Warning System implementation (NEWS)*
2. *Implement Sepsis 6*
3. *Acute Kidney Injury*
4. *Implementation of 5 Steps to Safer Surgery and Other Procedures*
5. *Bullying and Harassment*

Members are aware that a huge amount of work has been going on with regard to addressing the issues raised in the CQC inspection report and looks forward to receiving an update on the outcome of the re-inspection in due course. Overall, the Committee is pleased with the continued progress that the Trust has made over the last year but notes that there are a number of areas where further improvements still need to be made. We look forward to receiving updates on the progress of work to support the priorities outlined in the report over the course of 2017/18.

24 May 2017



## Statement from NHS England

### NHS England Statement to support the Royal Brompton & Harefield Quality accounts 2016/17

Over the year NHS England has welcomed a closer working relationship with the Trust. A number of areas for quality improvement have been jointly monitored at the clinical quality review meetings (CQRGs). The main items for improvement have been; modernising the planned care pathway, agreeing a plan for surgical and cancer waiting times, infection control and quality in specific service areas (e.g. the ECMO service). We are pleased to note areas of good practice such as;

- service improvements in adult cystic fibrosis outpatient care,
- human factors training to improve patient safety, and
- paediatric long term ventilation care.

RBHT has continued to strengthen its role as a system leader for lung cancer although we note that performance against the constitutional standard remains below expected. The Trust was faced with a significant challenge with an infection control outbreak of *Candida auris* during 2016. The Trust has led the way across London in developing our understanding of this relatively new challenge. We are pleased to see that, now that the outbreak is over, an external review has been commissioned to examine current practice and inform the future. We are pleased to see that the Trust continues with a specialised CQUIN programme.

The Trust was inspected by the CQC in July 2016 and has been rated as "Requires Improvement". As a response the Trust has embarked on a programme along with commissioners and others to deliver long term quality improvement.

### 2016/17 Quality priorities

The trust made progress against the five quality priorities that were included in the plan for 2016/17. Highlights from our perspective on some of these are;

#### Improving organisational safety culture

The Trust has focused on learning from safety incidents and we note that progress has been made in increasing the number of incidents reported by staff. There has been notably good practice around human factors training and learning from serious incidents have been openly shared with commissioners. The improving safety culture survey involving staff demonstrated some key achievements and we look forward to working with the Trust to support this continued drive for improvement.

#### Improving patients' experience for surgery

The Trust has demonstrated a significant amount of progress throughout 2016/17 in reducing theatre cancellations. This is part of a work stream which covers the improvement of 18 week referral to treatment times. The implementation of a new PAS system in July 2016 provided some challenges to the Trust. However performance and patient tracking was scrutinised at a fortnightly meeting and changes were able to be implemented in a way that minimised any negative impact on patients. There was a reduction in the numbers of patients not offered a subsequent date for surgery within 28 days of an operation being cancelled. That is from 11 patients in 2015/16 to 8 in 2016/17. Reducing these cancellations still further remains a priority and we have welcomed the increased working across sites to offer the best possible service to patients.

## **Improving the management of patients with cancer**

The Trust cancer action plan includes the performance and improvement plans for the lung cancer pathway, individual referrals and waiting times. These are scrutinised on a monthly basis to identify key themes, learning and support planning. Referrals continue to be received by the Trust outside of agreed pathway but the Trust is working to address this issue. There has been a focus on improving theatre utilisation, reducing cancellations and increasing the capacity and capability of the clinical teams to support improvements in treatment times. Patient outcomes are reviewed and presented at regular mortality and morbidity meetings as well as being shared with commissioners for external review.

## **2017/18 Quality priorities**

NHS England is pleased to see that the quality priorities for 2017/18 have been combined with the outputs from the CQC inspection. We look forward to working with the Trust and NHS Improvement to support them achieving their aspiration to become recognised as 'Outstanding'. We have, and will continue to monitor and support in all areas of quality improvement, particularly supporting the Trust's focus on developing the culture within the organisation. We will continue to work with the Trust in maintaining improvements against statutory metrics and local priorities that lead to improvements in quality of service provision. There is a challenging CQUIN programme for 2017/18 which, if delivered will lead to significant quality improvements for patients. These include the difficult asthma services for children and pathways for the management of cardiac arrhythmias. We support the Trust's leadership in transforming services, particularly within the North West London Sustainability and Transformation Plans. We look forward to working with the Trust as it aims in fully achieving its ambitions for the year ahead.

Michael Marsh  
Medical Director Specialised Commissioning Services  
NHS England London Region

25 May 2017



## Statement from Hillingdon Clinical Commissioning Group

Dear Mr Bell

**Re: Royal Brompton and Harefield NHS Foundation Trust NWL Quality Account 2016/17**

Hillingdon CCG has welcomed the opportunity to review your quality accounts for 2016/17.

We have reviewed the content of the Quality Account and we are able to confirm that this complies with the requirements for NHS Foundation Trusts as set out by the Department of Health and NHS Improvement (formerly Monitor).

The Quality Account is a very easy to read and clear document and provides an open and transparent discussion of the Trust's CQC inspection outcome and what the Trust have done/intend to do to improve their rating. We note the following against your priorities;

**Priority 1: Improving our Organisational Safety Culture**

The Trust has made good progress against this priority and have implemented Human Factors training. There is an increase in the incidents reported by 100 admissions, but not by 1000 occupied bed days.

**Priority 2: Improving the Patient Experience for surgery**

The data illustrates that the numbers of cancelled operations are reducing and work is continuing to further reduce the figures.

**Priority 3: Improving the Identification and Management of Patients at Risk of Pressure Ulcers and falls in Hospital**

The Trust acquired pressure ulcer incidences are decreasing. The rate of patient falls fluctuates and the Trust have taken a number of actions to promote falls awareness and reduce the rate.

**Priority 4: Improving the management of patients with Cancer**

There was no data on this in the draft document that was circulated for consultation.

**Priority 5: Safer Use of Medicines and Medical Devices**

There is a downward trend of both medical device and medication incidents reported in 2016/17. The Trust have reported a number of actions following reported incidents (pages 16 and 17)

The CCG welcomes the evidence of the achievements made during the year. We note the priorities for 2017/18 have been reviewed following the findings of the staff survey and the CQC inspection and they reflect the priorities these have identified. In addition, the Trust has set appropriate clinical quality priorities. The Quality Account does not describe the consultation process with patients, the public and key stakeholders for setting these new priorities, however we acknowledge the priorities are appropriate to the Trust and its patients.

We note the difficulties the Trust has had this year with the transfer of IT systems and the affect this has had on RTT. Going forward into 2017/18, we would like the Trust to report any harm caused to patients who have breached the RTT target in a systematic way.

Hillingdon CCG have worked closely with the Trust during 2016/17 to ensure the Trust are in line with the other acute providers in North West London in terms of CQUIN schemes and regular quality



monitoring as a part of the contract. We are pleased that the Trust have agreed to the same level of contractual quality reporting and monitoring in Royal Brompton as NWL.

Hillingdon CCG looks forward to continuing to work with the Trust alongside NHS England to monitor the progress against the priorities for 2017/18 through the Clinical Quality Review Group, to gain assurance of the continuous improvement of the quality of services for the patient population.

Yours sincerely

A handwritten signature in black ink, appearing to read 'P. Street', with a stylized flourish at the end.

Signed by Pippa Street  
On behalf of Diane Jones  
Director of Quality & Safety  
Hillingdon Clinical Commissioning Group

**Chair:** Dr Ian Goodman  
**Chief Officer:** Rob Larkman  
**COO:** Caroline Morison

**Date:** 17 May 2017

## Statement from our Governors

On behalf of the Council of Governors I have been seeking re assurance since the 2016 report and then the CQC report that action is being taken to respond to the results of the Staff Safety Climate Survey in general, response rates, engagement, leadership, team environment, bullying and harassment in particular. With a new HR Director just appointed to lead the work across the Trust, Governors are hoping and expecting to be reassured of the preparedness to address these and other related issues in 2017.

"Discussion points from Governors" May 2016 CoG led to a discussion with Sally Morgan, new Chair, and Tim Mack , new Lead Governor in January 2017. As a result Governors and NEDs are now working together to:

- Build relationships and trust to enable the two groups to best carry out their roles
- Share information and views about RBHT
- Enable Governors to make a meaningful and appropriate contribution

**Date: 16 May 2017**

**Tim Mack**

**Lead Governor, Royal Brompton & Harefield NHS Foundation Trust**

## Glossary

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



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

operation/procedure	patient and staff have time to prepare.
Emergency operation/procedure	An unplanned operation or procedure that must occur quickly as the patient is deteriorating. Usually associated with higher risk, as the patient is often acutely unwell.
Expected death	An anticipated patient death caused by a known medical condition or illness.
<b>F</b>	
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 <sup>st</sup> June 2009.
(FFT) Friends & family Test	A questionnaire that service users and carers are asked to complete on discharge and within 48 hours of discharge about their experience of the care they have received and whether they would recommend the organisation to others. In addition, staff are asked to complete the questionnaire about whether they would recommend the organisation to others and be happy to receive care by the organisation.
<b>G</b>	
Governors	Royal Brompton & Harefield NHS Foundation Trust has a council of governors. Most governors are elected by the Trust's members but there are also appointed governors.  <a href="http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/">http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/</a>
<b>H</b>	
Hospital episode statistics (HES)	The national statistical data warehouse for the NHS in England.  HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations.
Healthwatch (Formally LINKs)	Healthwatch are made up of individuals and community groups working together to improve health and social care services.  <a href="http://www.healthwatch.co.uk/">http://www.healthwatch.co.uk/</a>
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.
<b>I</b>	
Indicator	A measure that determines whether the goal or an element of the goal has been achieved.

Inpatient	A patient who is admitted to a ward and staying in the hospital.
Inpatient survey	An annual, national survey of the experiences of patients who have stayed in hospital. All NHS trusts are required to participate.
Intelligent Monitoring Report	A report produced by the CQC for each NHS Trust, which provides details on a number of indicators relating to quality of care. These are published on the CQC website, and can be accessed here: <a href="http://www.cqc.org.uk/sites/default/files/media/reports/RT3_102v2_WV.pdf">http://www.cqc.org.uk/sites/default/files/media/reports/RT3_102v2_WV.pdf</a>
<b>K</b>	
KDIGO	Kidney Disease: Improving Global Outcomes. A global organization developing and implementing evidence based clinical practice guidelines in kidney disease. It is an independent volunteer-led self-managed charity incorporated in Belgium accountable to the public and the patients it serves.
<b>L</b>	
Local clinical audit	A type of quality improvement project involving individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team.
Local Authority Scrutiny Committee	These look at the question of health care delivery and act as a 'critical friend' by suggesting ways that health-related services might be improved.  They also look at the way the health service interacts with social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to meet the diverse needs of the area.
<b>M</b>	
MINAP	<b>Myocardial Ischaemia National Audit Project.</b>  A national registry of patients admitted in England and Wales who have had a heart attack or have severe angina and need urgent treatment.
Multidisciplinary team meeting (MDT)	a meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients.
Multi-resistant staphylococcus aureus (MRSA)	A type of infection that can be fatal.  There is a national indicator to measure the number of MRSA infections that occurs in hospitals.
MHRA	The <b>M</b> edicines and <b>H</b> ealthcare products <b>R</b> egulatory <b>A</b> gency regulates medicines, medical devices and blood components for transfusion in the UK.



<b>N</b>	
National clinical audit	<p>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.</p> <p>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.</p>
NCEPOD	<p>National Confidential Enquiry into Patient Outcome and Death (NCEPOD).</p> <p>NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.</p> <p><a href="http://www.ncepod.org.uk/">http://www.ncepod.org.uk/</a></p>
National Institute for Health and Clinical Excellence (NICE)	<p>NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.</p> <p><a href="http://www.nice.org.uk/">http://www.nice.org.uk/</a></p>
National Early Warning Score (NEWS)	<p>National Early Warning Score – a score that indicates deteriorating physical condition of the patient and a trigger for escalation taken from patient clinical observations such as pulse, blood pressure, oxygen levels, temperature and urine output.</p>
Never events	<p>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.</p>
NHS Improvement	<p>NHS Improvement brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. NHS Improvement is an operational name for the organisation which formally comes into being on 1 April 2016.</p>
NHS number	<p>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.</p>
NICOR - National Institute for Cardiovascular Outcomes Research	<p>NICOR is part of the Centre for Cardiovascular Preventions and Outcomes at University College London.</p>
NED	<p>Non-Executive Director.</p> <p>A member of the Trust board of directors who does not form part of the <b>executive</b> management team, who act in an advisory capacity only.</p>

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

<b>S</b>	
Safeguarding	Safeguarding is a new term which is broader than 'child protection' as it also includes prevention.  It is also applied to vulnerable adults.
Secondary uses service (SUS)	A national NHS database of activity in trusts, used for performance monitoring, reconciliation and payments.
Serious Incidents	An incident requiring investigation that results in one of the following: <ul style="list-style-type: none"> <li>• Unexpected or avoidable death</li> <li>• Serious harm</li> <li>• Prevents an organisation's ability to continue to deliver healthcare services</li> <li>• Allegations of abuse</li> <li>• Adverse media coverage or public concern</li> <li>• Never events</li> </ul>
Surgical Site Infection	An infection that develops in a wound created by having an operation.
Single sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender.
Society of Cardiothoracic Surgeons (SCTS)	<a href="http://www.scts.org/">http://www.scts.org/</a>
Standard contract	The annual contract between commissioners and the Trust.  The contract supports the NHS Operating Framework.
SSKIN	<b>SSKIN</b> is a five step model for pressure ulcer prevention: <b>Surface</b> : make sure your patients have the right support. <b>Skin inspection</b> : early inspection means early detection. Show patients & carers what to look for.
<b>T</b>	
TAVI	Transcatheter aortic valve implantation ( <b>TAVI</b> ) is a non-surgical alternative to open heart surgery. <b>TAVI</b> is carried out in a cardiac catheterisation laboratory, also known as a cath lab, and normally takes one to two hours to complete.
<b>V</b>	
Vanguard	In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View (published October 2014) and supporting improvement and integration of services.  <a href="https://www.england.nhs.uk/ourwork/new-care-models/vanguards/">https://www.england.nhs.uk/ourwork/new-care-models/vanguards/</a>



