A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality report 2014-15

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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 2014-15 we cared for 178,495 patients at our outpatient clinics and more than 38,619 patients of all ages on our wards.
- 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 Europe.
- Our Heart Attack Centre at Harefield Hospital 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, 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 millimetre.
- 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.
- 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 over 8,000 adults who have breathing problems caused by diseases such as COPD (chronic obstructive pulmonary disease) and severe asthma.

- We provide specialised care for patients with suspected or diagnosed cancer affecting the chest (thoracic oncology). 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.

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 2014-15. 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 2014-15 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 highlight:

- the areas identified for improvement for 2014-15
- 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 2015-16.

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

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

Statement of directors' responsibilities

The directors of Royal Brompton & Harefield NHS Foundation Trust have prepared this Quality Report 2014-15, as required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

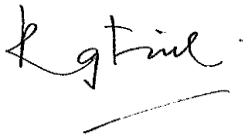
The directors are satisfied that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014-15;
- the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2014 to May 2015
    - papers relating to quality to the Board for the period April 2014 - May 2015
    - feedback from NHS England dated 14/05/2015
    - feedback from governors dated 13/05/2015
    - feedback from local Healthwatch organisations dated 11/05/2015
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13/05/15
    - the national inpatient survey 2014
    - the national staff survey 2014
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 20/03/15
    - the CQC Intelligent Report Monitoring dated December 2014

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

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

By order of the Board:



Sir Robert Finch
Chairman
26th May 2015

Robert J Bell
Chief Executive
26th May 2015

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
- Organisational excellence
- Productivity and investment

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 2014 to 31 March 2015 has been the fifth 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 issued by Monitor apart from the indicator relating to the 62 day cancer wait target. This target failure was forecast in the Forward Plan submitted to Monitor and is mainly due to late referrals from referring centres. The Trust continues to be registered by the Care Quality Commission without conditions.

Significant events for 2014-15:

- In the Intelligent Monitoring report, published by the CQC in December 2014, the Trust was placed in band 4 which indicated a low risk (band 1 being highest risk and band 6 being lowest risk).
- The Trust has been working closely with its commissioners at both local and national level. Excellent links have been built up and 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. A particular focus for improvement has been in relation to waiting times for surgical treatment for lung cancer. This has been a quality priority during 2014/15 and will continue to be so during 2015/16.

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.

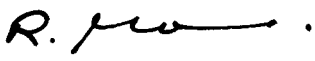
- Data is collected by a large number of teams across the trust, alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably 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 29 of this report.

Signed:



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Robert J Bell
Chief Executive
Royal Brompton & Harefield NHS Foundation Trust **26th May 2015**

Part 2: Review of quality priorities for improvement

Part 2a: Quality priorities for improvement 2014-15

In this part of the report, we tell you about the quality of our services and how we have performed in the areas identified for improvement in 2014-15. These areas for improvement are called our quality priorities and were identified in 2014. The priorities fall into three areas of quality as mandated by the Department of Health: patient safety, patient experience and patient outcomes, and we are required to have a minimum of one priority in each area.

We chose six quality priorities in 2014-15 which represent the views of our key stakeholders, but are also in line with the Trust's overarching strategy and priorities for 2014-15. An account of progress against each of the quality priorities is given below. Some of these were achieved during 2014/15 and others will require continued focus during 2015/16.

The Quality Priorities are only ever a small sample of the quality improvement work undertaken across the Trust in any one year. The projects selected in previous years will almost always continue into subsequent years, although the focus may change, according to need.

The Quality Priorities chosen for 2014-15 were:

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)

What is patient experience?

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

Quality priority one

Quality & Productivity Programmes

What was the aim?

This programme started at Harefield Hospital in autumn 2012 to look holistically at the cardiac surgery service, identify where there are challenges, to agree the changes to be made and to oversee their implementation. The programme focus was broad, incorporating clinical leadership and staffing, conduct, waiting list management, equipment and building improvements, quality of care and outcomes in theatres, intensive care and on the wards. It included all the surgeons and other relevant multidisciplinary clinical leads, clinical and non-clinical directors, managers and other support staff. Notable achievements to date: outcomes improved for 3rd year in a row, two new consultant posts created, new clinical leadership for and improved staffing of intensive care, agreement on the equipment and building developments which would be of most benefit and pooling of surgical waiting lists which will assist with waiting list management.

In autumn 2013, the programme was extended to the cardiac surgery service at Royal Brompton Hospital. This programme has identified a different set of challenges, but the principles of the programme and membership are similar. For Royal Brompton the focus is spread over eight sub-groups – caseload composition, referrals, plant, efficiency in theatres and catheter laboratories, patient pathway, team working, research, education and training, information technology and communications.

The stated ambition for both these programmes is to merge; in order to further strengthen the links between the two sites.

How did we measure this?

Both site-specific Quality & Productivity programmes to deliver on their stated objectives; and a cross-site Quality & Productivity programme is developed, which leads to the development of a cross-site strategy for the cardiac surgery service.

Progress and Outcome

During this financial year the focus has been on improving patient experience with work streams addressing:

- Referral relationship management (identifying core referral sites and addressing communication and patient access)
- Reviewing inpatient pathways with an emphasis on level 1 & 2 patient management (identifying workforce required to ensure consultant delivered/led care to meet the 7-day services standards)
- Team work and team composition in theatres and catheter laboratories (to improve communication, patient flows, increasing patient throughput and eliminating waste)
- Capacity – development of hybrid theatre
- Information technology
- Training, education and research (ensuring appropriate training and support for junior doctors)

Over the upcoming year, work will continue in these areas to ensure the environment in which care is delivered is safe, effective, performed with compassion and care and is well-led and responsive.

Quality priority two

Lung cancer review

What was the aim?

The aim was to review the whole lung cancer pathway at Harefield Hospital, looking at the whole service, and including surgical and non-surgical support; as well as input from key partners outside the Trust, and the relationship with referrers and primary care /community services. We wanted to look at improving the waiting times for patients to start receiving specialist care and treatment for lung cancer.

The baseline assessment of the current service was conducted between March and May 2014, and reported to the Trust Board in July 2014.

How did we measure this?

This was measured as the timely implementation of the recommendations identified by the review; with the aim of reducing the waiting times for patients to receive treatment for lung cancer.

Progress and Outcomes

The lung cancer service review and subsequent action plan is already making improvements for lung cancer patients. It was presented to the Governance and Quality Committee on 1st July 2014 and to a Committee of the Trust Board, the Risk and Safety Committee on 15th July 2014.The Governance and Quality Committee has monitored the results of the review throughout 14/15 and will continue to do so in 15/16. The Trust Board is informed of progress against the action plan through the Clinical Quality Report which is an item of business at every meeting of the Trust Board. The action plan has received support from our commissioners as well as Mr Sean Duffy, National Clinical Director for Cancer at NHS England.

There were several key recommendations from the review; initially there were a series of clinical visits to key referring Lung Cancer Multi-Disciplinary Teams which have taken place this year with further follow up meetings due in 15/16. This has been important in identifying areas of the diagnostic and treatment pathway that can be improved locally at referring centres, and where appropriate, these can be supported by the Trust. For example it was identified that access to cardio pulmonary exercise testing at Luton and Dunstable was limited. The respiratory physiology team at Harefield Hospital quickly set up and now provide a service for Luton and Dunstable patients.

A monthly meeting has been held since October 2014 with the Clinical Advisor from the Transforming Cancer Services Team for London and the Specialist Commissioning Lead for Blood and Cancer from NHS England. The focus of the meetings has been to review patient pathways where the target has been breached, to review progress against the Trust's action plan, and to enable support via the commissioning route in improving the lung cancer pathway across the several different regions we accept referrals from.

The London Cancer Alliance (LCA) Clinical Lung Forum Group, which is made up of consultants and other multidisciplinary clinical staff who provide lung cancer services to patients, have produced a 'timed pathway' which we are now expecting our referring Trusts to adopt and implement. The key message here is to ensure patients are referred on or before day 42 to the treating centre. It can be seen from recent analysis of the lung cancer pathway at the Trust that day 42 is an important point of referral for surgery. Patients who are referred at this point are less likely to breach, unless there are further complex clinical reasons.

The Trust is also participating in the North West London Commissioner and Provider Action Plan for the 62 day pathway and is represented there by Mr Niall McGonigle, consultant thoracic surgeon and John Pearcey, assistant general manager Lung Division. Workshops for planning and improving cancer waiting times were held in February 2015.

There is still a lot of work to be done as the target was not met during 2014/15. Therefore; the lung cancer pathway will continue to be a quality priority throughout 2015/16.

Quality priority three

Theatre cancellations

What was the aim?

This project looked at reducing the number of patients who have their surgery cancelled for non-medical reasons. This is an acknowledged challenge for all hospitals. The Trust already has a programme running to review and manage theatre cancellations on a day to day, case by case basis.

The programme this year will therefore look at longer term trends, to identify and implement multiple small changes which should make the process more efficient and effective and reduce the number of cancellations occurring. This programme was started in 2014-15, but implementing all the improvements and then giving time for these to take effect is likely to take longer than 12 months.

How did we measure this?

This quality priority was measured by comparing the total number of patients who had their operations cancelled for non-clinical reasons during 2013/14 with the number for 2014/15.

Progress and Outcomes

The outcome was disappointing. During 2013/14, 401 patients had their operation cancelled for a non-clinical reason. For 2014/15 the number was 422.

The reasons for this increase were related to operational pressures during 2014/15. These included pressures caused by increased numbers of patients being transferred from other hospitals, pressures on critical care due to patients requiring assistance with breathing through Extra Corporeal Membrane Oxygenation, and pressures related to priority work associated with the transplant service.

Theatre cancellations will remain an area of focus during 2015/16 and there will be further review of this indicator alongside the proposed 2015/16 quality priority relating to patients experience of admission.

Quality priority four

Family Satisfaction Survey in Intensive Care

What was the aim?

This programme asked patients, and particularly the families of patients who have stayed in intensive care, to complete a bespoke questionnaire about their experiences at such a difficult time. It was started in Royal Brompton adult intensive care, but then rolled out to the adult intensive care unit at Harefield; and a modified version to the paediatric intensive care unit.

The feedback gained assists staff to understand the perspective of the family, and identify where and how we can improve and take that more into account. For example, making sure more regular updates are given to families in the waiting room, when the patient is acutely unwell. The palliative care team, who have usually already developed a relationship with the family, have started to take on that role.

This year, the aim is to embed the programme fully across all areas, and to look at sharing the learning across the different units involved, as well as just within each unit.

How did we measure this?

We will measure the number of families who are asked to participate.
We will actively improve our service based on the recommendations made

Progress and Outcomes

To date since August 2013 there have been 230 completed questionnaires. The survey is handed out to the relatives when the patient has been on the unit for 48 hours. The return rate of the survey varies between 31-70% per month. Our aim is to have at least a 60% return rate. The data is regularly analysed providing quantitate and qualitative data and feedback from the relatives on the Adult Intensive Care. The data is being used to improve the experience of the relatives on the intensive care unit. Using thematic analysis we can target specific areas of improvement for example installation of the drinks machine for relatives.

Quality priority five

7 Day Working

What was the aim?

NHS England requires all trusts to have defined what 7-day working means for their particular organisation, and to have put in place the necessary changes to deliver it by April 2017. This is important, as it will allow us to provide more routine services at weekends for patients.

The High-intensity Specialist Led Acute Care (HiSLAC)[1] project is a national research programme which the Trust has volunteered to be involved in. Funded by the NIHR-HSDR programme, the project is designed to evaluate the efficacy and cost-effectiveness of that component of seven day services which focuses on increasing specialist (consultant) input to the care of acutely ill medical admissions at weekends.

How did we measure this?

The measures are in line with those chosen by the national project and include time to first consultant review and ongoing review.

Progress and Outcomes

Prioritisation of the standards: the sequencing of the 7 day clinical standards has been agreed by the Shaping a Healthier Future (SaHF) Clinical Board and the CCG Collaboration Board (Chairs of all 8 CCGs). Our focus throughout 2014/15 was to ensure that the Trust met the priority standards. These were:

- Acute Wards:
  - *Time to First Consultant Review*: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
  - *On-going Review*: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.
- Diagnostics:
  - *Diagnostics*: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: within 1 hour for critical patients; within 12 hours for urgent patients; within 24 hours for non-urgent

[1] For more information about HiSLAC, please see http://www.hislac.org/

Actions:

Acute Ward: Time to First Consultant Review

As a Trust we assessed ourselves as meeting this standard across both sites. This means that our patients are reviewed by a consultant within 14 hours of admission.

Acute Ward: On-going Review of patients on our Critical Care Units

As a Trust we assessed ourselves as meeting this standard across both sites. We will begin a chart audit to evidence compliance. Our critical care services for adults and paediatrics are consultant delivered 7 day services

Diagnostics:

1. Laboratory Testing: 7 days per week Audits of compliance are conducted for each of the Turnaround targets. Consultants are not on-site at weekends. An on-call out of hours service is provided and if required they come to the hospital if needed.

2. *Future 7 day services – Pharmacy:* Our expectation is that we should provide a clinical service for all in-patients, both during their admission and in preparation for discharge. In addition we need to deliver a medicine supply service 7 days a week. Further investment is required in order to extend current services to cover 7 day working.

3. *Future 7 day services - Consultant Ward Rounds Level 1 inpatients* A draft proposal is in the process of being finalised to provide consultant ward rounds twice a day, 7 days a week for all patients on level 1 wards. This proposal would require significant investment by the Trust to recruit the necessary additional consultants.

4. *Future 7 day services for Allied Health Professionals* Plans and models of working are currently being reviewed and evaluated. All weekday services will need to consider a shift pattern system to provide therapy services from 0800-1800 hrs each day. Physiotherapy will continue to provide an out of hours emergency on-call service overnight.

Quality priority six

Medication errors for Children's Services

What was the aim?

Medication errors are one of the main categories of incidents reported nationally and within the trust. Most are 'near-miss' events, and result in minor or no harm to the patient.

There is already a strong improvement programme in this area overseen by the Medicines Management Board, and the Trust has a good record of medicine safety.

The focus for 2014-15 was for additional focus specifically with Children's Services, to look at all aspects of medication errors from prescribing, to calculation, to administration, to drug interactions; and to identify and implement multiple small changes across all these areas, which should lead to more efficient and effective processes in place.

How did we measure this?

We measured the number and rate of medication errors occurring; and monitored how this changed in response to the raised awareness, training programmes and other improvement measures that were put in place.

Please note: An increased focus on a particular type of incident, can lead to an increase in reporting. This is a positive outcome, as research has shown that organisations focussed on patient safety, will tend to report more incidents.

Progress and Outcomes

- A mechanism has been put in place to consolidate the multiple quality improvement work streams being carried out to prospectively manage medication safety and a system put in place to continually identify new risks and necessary work to be carried out to mitigate these.
- Medicines Management Champion (MMC) successfully put in place on Rose Ward to promote adherence to medicine-related policies and procedures, be the eyes and ears of the team to help inform training needs, ensure safe, appropriate and secure storage of medicines, and encourage medicine-related incidents reporting via Datix.
- A quality improvement project on omitted doses undertaken by the MMC, resulted in a reduction of the total number of omitted doses by 54%. The number of incidences where no reason for an omission was documented also fell by 71% during the 4 month project period.
- A self-administration of medicines scheme was successfully launched and evaluated for paediatric cystic fibrosis patients, with the intention of rolling out to the remaining specialties on Rose ward.
- Numerous quality improvement projects successfully underway including a review and re-design of the medicines administration double checking process; use of standard concentrations for heparin and morphine infusions in pre-filled syringes; rapid feedback for prescribing errors on PICU.

Part 2b: Quality Priorities for improvement in 2015 - 16

This section of the report outlines areas identified for improvement in 2015-16. These areas for improvement are called our quality priorities and were identified in 2015. The priorities cover all three areas of quality as mandated by the Department of Health: patient safety, patient experience and effectiveness / patient outcomes. It incorporates the Trusts commitment to Sign Up To Safety and the Safety Improvement Plan.

Quality priority one

Improving our Organisational Safety Culture

What are the aims?

We aim to continuously improve the safety culture of the organisation. Through the implementation of the "Sign Up To Safety" Safety Improvement Plan we will demonstrate clear leadership and further embed a safety culture across all levels of the organisation that places safety, effectiveness and continuous quality improvement at the heart of all that we do across the Trust for staff, patients and carers. We will build capacity and capability across the workforce and implement evidence-based safety and quality improvement projects. We will implement a formal communications strategy across the whole organisation to enable an inclusive approach for all.

How will we measure this?

We will measure through a number of different methods, through the outcomes of the Staff Safety Climate Survey, an increase in reporting of incidents via the Datix system, executive patient safety walkarounds, training staff in Quality Improvement Methodology, Root Cause Analysis and Being Open, human factors and simulation training. In addition, through the implementation of quality and safety projects, staff pledges and the outcomes of the Safety Improvement Plan.

Quality priority two

Improving the Patient Experience for the cardiac surgery pathway

What are our aims?

We aim 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 will we measure this?

We will measure this by comparing the number of operations cancelled for non-clinical reasons in 2014/15 with the number cancelled in 2015/16 and, subject to the volume of activity commissioned by NHS England, by comparing the percentage of patients on the waiting for cardiac surgery on the incomplete referral to treatment pathway at 31st March 2015, with those waiting at 31st March 2016.

Quality priority three

Improving the Identification and Management of Patients at Risk of Pressure Ulcers and Falls in Hospital

What are the aims?

Both falls and pressure ulcers are significant patient safety issues that can significantly affect the quality of life and the experience of patients from both a physical and psychological perspective. We aim to improve the care of patients at risk of falls and pressure ulcers and to fully implement the care bundles for these patient safety issues. We will ensure that risk assessment is carried out, utilising evidence-based prevention techniques, care planning and treatment and management plans.

How will we measure this?

We will utilise a number of metrics to establish our success against these areas including the implementation of care bundles, completion of falls risk assessments and reducing the numbers of pressure ulcers.

Quality priority four

Improving the management of patients with Cancer

What are the aims?

We intend to 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 will we measure this?

We will utilise a number of indicators to establish our effectiveness against this priority including the contracted performance measures and feedback on the patient and carer experience.

Quality priority five

Improving the Management of the Deteriorating Patient – Reducing Acute Kidney Injury, Effective Sepsis Identification and Management, Appropriate Escalation of NEWS and PEWS Scores

What are the aims?

We will improve compliance with NEWS and PEWS , SEPSIS 6 System to 95% and reduce the incidence of new onset AKI by 50% by 2018.

How will we measure this?

For AKI – 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.

For NEWS / PEWS - % level 1 patients with accurate score, % incidents of failure to detect and escalate, % appropriate care plans, number of cardiac arrests

For sepsis – staff training levels, care bundle compliance, documented review, number of sepsis cases, % cases tool correctly used within one hour

Quality priority six

Safer Use of Medicines and Medical Devices

What are the aims?

To improve the Trusts medication and devices incident reporting levels, quality and feedback.

How will we measure this?

We will monitor the number of medication and device incidents and severity by division and clinical area, benchmark reporting rates, review the quality of information in reports (device name, category), number of staff champions, number of safety bulletins / alerts, levels of reporting and submission to NRLS within 30 days.

Part 2c: Performance against national quality indicators

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

Indicator	From local Trust data		Benchmark Comparisons					Benchmark Data Source
	2013-14	2014-15	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.			No benchmark available					
• % of patients aged 0-15 readmitted within 28 days	0.15%	0.20%						
• % of patients aged over 15 readmitted within 28 days	4.10%	3.06%						
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[2]	86[3]	98.10%	98%	Mar 2014-15	100%	78%	95%	http://www.england.nhs.uk/statistics/
Percentage of staff who would recommend the provider to friends or family needing care *Source: national NHS staff survey*	92%	97%	97%	Q2 2014-15	98%	41%	75%	Unify2 Data Collection
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)	95.53%	95.87%	96%	Feb 2014-15	100%	81%	96%	http://www.england.nhs.uk/statistics/
Rate of *clostridium difficile* (number of infections/100,000 bed days)	8.6	0.5[4]	13.5	2013-14	0	37.1	14.7	https://www.gov.uk
Patient safety incidents reported to the National Reporting & Learning System								
• Number of patient safety incidents	2838[i5]	2469	-	-	-	-	-	
• Rate of patient safety incidents (number/100 admissions)	5.8	1.13	5.2	Q1+2	1.4	24.9	------	http://www.nrls.npsa.nhs.uk
• Percentage resulting in severe harm or death	0.18% (=5/2838)	0.16% (=4/2469)	0.10%	2013-14	0.00%	0.30%	0.10%	

[2] For 204/15 the FFT scores have replaced the previously reported score for 'Responsiveness to inpatients' personal needs' as FFT scores have become the patient experience metric for CQUIN

[3] For 2013-14 the FFT inpatients measurement was the Net Promoter Score (NPS). For 2014-15 the measurement moved to percentage of inpatients recommended the provider.

[4] For 2013-14 rate is calculated based on number of attributable cases to Trust. For 2014-15 measurement moved to lapses of care of which only 1 case occurred.

[5] This is the total number of patient safety incidents that were reported to the National Reporting & Learning System in 2013-14, not the number of patient safety incidents which occurred in 2013-14. This also includes some incidents which occurred late in 2012-13, where the investigations could not be completed by year-end. Equally, some of the incidents that occurred at the end of 2013-14 were still under investigation, and were be submitted in 2014-15, so that the learning can be shared collectively with other centres.

Friends and Family test

Patient feedback comments:

"The kindness and professionalism of all the staff was wonderful. I felt very safe here and that I mattered"

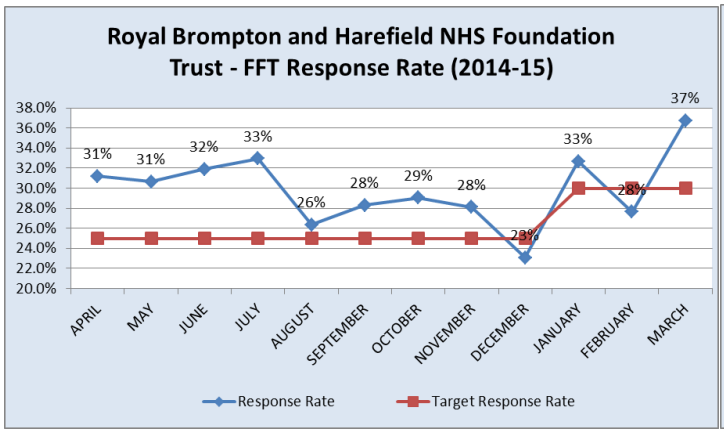
"From the moment of arriving I felt comfortable, relaxed, and very much at ease. No one likes coming in to hospital but my warm welcome made it so much easier. Thank you to all the staff"

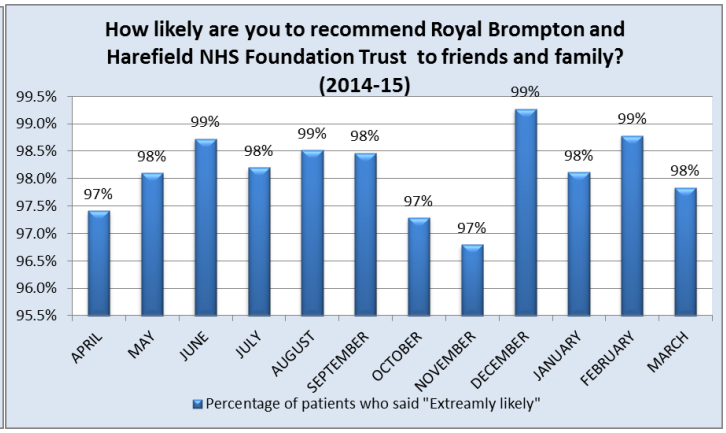
The Friends and Family Test was introduced by the Government in May 2012. All hospital trusts are mandated to ask all inpatients: *"How likely are you to recommend our ward/clinic to friends and family if they needed similar care or treatment*?"

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 paper questionnaires given to all patients on the day of 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 for the final quarter of the year.

Chart 1: FFT response and recommend scores for 2014-5 (Source: Picker Institute Europe)





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:

- "Would not recommend anyone to attend hospital by the very nature you are ill"
- "Because they would have to be referred through GP or Dr from anther hospital"
- Because my friends would not be interested"

Friends Family Test Benchmarking – March 2015 (*Source NHS England*)

a) National Benchmarking – 151 trusts in England

- Royal Brompton & Harefield Trust FFT response rate = 37% (ranked 127th)
- 98% of patients would recommend the Trust to friends and family.

b) Local Benchmarking – 49 hospitals in London

- Royal Brompton FFT response rate = 38.5% (ranked 30th)
- Harefield Hospital FFT response rate = 33.4% (ranked 38th)

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

"I was treated very professionally and the nurses were helpful and friendly. If I had a question to ask it was explained clearly"

"Very good staff, treated like adults and given chance to be involved in day to day management of meds etc."

"Everything was top quality! But what else would you expect at the Royal Brompton!"

"Because I was looked after very well"

"The staff are friendly and keep you informed about what is happening and answer your questions if they can't they get someone who can"

"Excellent care has been given on this ward both clinical and holistic. All members of staff both clinical and support care very friendly and helpful and wanting to put you at your ease"

"Loveliest staff I've ever met at a hospital, efficiently run and good food. All contributed to making me enjoy what should have been a horrible experience"

"Everyone on the ward has been exceptionally kind, friendly and reassuring. You feel it is an incredibly safe environment and this makes a frightening situation so much easier"

Actions taken as a result of patient feedback in 2014

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

Across the Trust "You Said == We Did" posters are displayed in individual wards to demonstrate to patients that we listen and act on their feedback.

An example of where this approach has been used can be seen in our children's cardio-respiratory ward where as a result of comments/feedback made by parents of patients the following plans were instigated:

1. Facilities
    - The waiting room was refurbished and seating extended.

2. Information & Communication
    - New name badges have been provided.
    - A drive to remind all staff asked to see a child to introduce themselves to the parents.
    - Information packs have been introduced

3. Compassion in Practice
    - A theatre group has provided teaching on cross-cultural expression of compassion.

Complaints

The following information about formal complaints received by the Trust is reviewed on a monthly basis by the operational management team:

Period	1st April 2014 – 31st March 2015			
	Within 25 days	**Over 25 Days**	**Total**	**%**
Royal Brompton Hospital	53	8	61	86.9
Harefield Hospital	31	5	36	86.1
Trust Total	84	13	97	86.6

During the year 2014/15, the Trust has operated to an internally set standard which allows 25 working days from the time from when a formal complaint is received until the time a formal response is sent by the chief executive, with a target of 90% for achievement.

This standard was selected by governors as their local indicator for audit by the Trust's external auditor. The results of this audit can be found in the External Assurance Review of the Quality Report which will be presented to the governors at their Annual General Meeting.

Whilst the standard is challenging, and has not been met during 2014/15, it does help to provide a focus on ensuring a timely response. During 2015/16 a new national process for complaints data collection will be put in place. This follows on from the Francis and Clwyd Hart reviews. It will enable complaints information to be seen in context and comparisons to be made between similar organisations. Over time this data will produce a clearer picture of complaints made and the way they are handled to the benefit of the service and its users.[6]

[6] Revisions to the NHS Written Complaints Data Collection, Department of Health, November 2014

Part 3: Formal statements of assurance

CQC registration

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

The CQC has not taken enforcement action against Royal Brompton & Harefield NHS Foundation Trust during 2014-15. Royal Brompton & Harefield NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC inspected both Royal Brompton Hospital (inspected in August 2013) and Harefield Hospital (inspected in February 2014) during the course of 2013-14. As in previous years, the CQC declared both hospitals compliant with all of the standards that were inspected:

Treating people with respect and involving them in their care
Providing care, treatment and support that meets people's needs
Caring for people safely and protecting them from harm
Staffing
Quality and suitability of management

The full reports can be found on the CQC website: http://www.cqc.org.uk/directory/rt3

Provision of NHS services

During 2014-15 Royal Brompton & Harefield NHS Foundation Trust provided 16 NHS services. Royal Brompton & Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 16 of these NHS services.

The income generated by the NHS services reviewed in 2014-15 represents 100% of the total income generated from the provision of NHS services by Royal Brompton & Harefield NHS Foundation Trust for 2014-15.

Use of the CQUIN Payment Framework

2.5% of Royal Brompton & Harefield NHS Foundation Trust income in 2014-15 was conditional on achieving quality improvement and innovation goals agreed between Royal Brompton & Harefield NHS Foundation Trust and our Commissioners for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The following topics were covered by the scheme in 2014/15:

Topic	Specific details of indicator	2014/15 achievement
Friends and Family Test	• To introduce the staff friends and family test • To achieve a response rate of more than 30% for January to March 2015	Met
Safety Thermometer	• To establish a baseline and demonstrate a 10% reduction in the number of pressure ulcers	Met
Dementia	• To screen patients on admission • To undertake a risk assessment • To appoint a clinical lead for dementia • To provide support for those who care for people with dementia	Met
Specialised Services dashboards	• To submit data as required	Met
Highly specialist Clinical Outcomes Collaborative	• To engage with national programmes	Met
Patient Held Records	• To introduce patient held records	Met
Cardiac Surgery for inter hospital transfer patients	• 70% of patients to be transferred and have their operation, within 7 days	Met
Consultant Review following emergency admission	• Review to take place within 14 hours of admission	Met
Coronary Surgery Pathway	• To review and improve the pathway	Met
Intensive Care	• To review and improve the pathway	Met

What is a 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.

For 2014/15, the financial value associated with the CQUIN payment is £5.504m. The outcome for 2014/15 is subject to confirmation by NHS England.

For 2013/14, £4.582m was achieved which was 97.8% of the CQUIN value.

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 2014/15, the Trust participated in 100% of national clinical audits and 100% of national confidential enquiries that it was eligible to participate in. The national clinical audits and national confidential enquiries that Royal Brompton & Harefield NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2014-15 including actual participation rates, are listed below:

Clinical Audit Topic	National Clinical Audit	Did the Trust participate in 2013-14 / 2014-15?	Clinical Audit Lead
Peri-and Neo-natal			
Perinatal mortality	MBRRACE-UK	✓ / ✓	Sue Peterson
Children			
Paediatric asthma	British Thoracic Society	✓ / ✓	Ian Balfour-Lynn
Paediatric intensive care	PICANet	✓ / ✓	Duncan Macrae
Paediatric cardiac surgery	NICOR Congenital Heart Disease Audit	✓ / ✓	Rodney Franklin
Acute care			
Emergency use of oxygen	British Thoracic Society	✓ / ✓	Nick Hopkinson
Non invasive ventilation -adults	British Thoracic Society	x[7] / ✓	Anita Simonds
Pleural procedures	British Thoracic Society	✓ / ✓	Simon Jordan
Cardiac arrest	National Cardiac Arrest Audit	✓[8] / ✓	Wayne Hurst
Adult critical care	ICNARC CMPD	✓ / ✓	Jeremy Cordingley
Potential donor audit	NHS Blood & Transplant	✓ / ✓	Phil Marino
Emergency Laparotomy	NELA	✓ / ✓	Lakshmi Kaupparao Tom Pickering
Long term conditions			
Bronchiectasis	British Thoracic Society	✓ / ✓	Diana Bilton
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	✓ / ✓	Vias Markides
Cancer			
Lung cancer	National Lung Cancer Audit	✓ / ✓	Eric Lim
Blood transfusion			
Bedside transfusion	National Comparative Audit of Blood Transfusion	✓ / ✓	David Cummings
Medical use of blood	National Comparative Audit of Blood Transfusion	✓ / ✓	David Cummings
End of life			
Care of dying in hospital	NCDAH	✓[9] / x	Jayne Wood

National Confidential Enquiries; Gastro-intestinal bleeding / Sepsis

These two projects started in 2014/15 and the Trust is involved in both. They are currently at the data collection stage and the reports are scheduled to be published in 2015-16.

In 2014/15 the Trust's internal auditors undertook a review of our clinical audit processes. This highlighted areas for improvement around re-auditing following incidents and the accessibility of the clinical audit register. A Trust Clinical Audit Policy is now being drafted and the recommendations made by the auditors have been incorporated into the policy.

[7] Was not collecting data in 2013-14, so no trust was required to participate
[8] Started data collection in October 2013 onwards
[9] This audit finished in 2013-14, and will not be continuing into 2014-15

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 2012, the Trust revised and renewed its three year Research Strategy. It set out four key objectives aimed collectively at further extending and enhancing the national and international research profile of the organisation. The four research goals are:

- 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 – 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 onto all areas of research activity within the Trust and will be achieved by working in collaboration with partners from the academic and industry sector.

The Research Strategy is currently in the process of being updated.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Brompton & Harefield NHS Foundation Trust during 2014-15 that were recruited during that period to participate in research approved by a research ethics committee was 5400. These patients were recruited into over 175 clinical research projects. Of these accruals, 3149 were into NIHR portfolio studies.

In addition 2227 patients were consented to donate their tissue for retention within the Trust's ethically approved Biomedical Research Unit Biobanks during 2014-15.

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:

- Fortnightly batch tracing of service user records against Patient Demographics Service (PDS)
- Routine back office cleansing of difficult to trace records against 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

GP Details and NHS number coding

The Trust scores are above the payment by result (PBR) targets for GP details (98%) for outpatients and for both Outpatients and Inpatients for NHS number (95%). The NHS contract target for NHS number coding is 99% and this has not been met. Levels for both indicators are monitored retrospectively and prospectively.

Data from PAS (April 2014 - March 2015)

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	95.99%	98.7%
	Outpatients	97.07%	99.0%
Inclusion of patient's valid general medical practice code	Inpatients	96.79%	99.9%
	Outpatients	99.30%	99.7%

Information governance toolkit attainment levels 2014-15

During 2014/15, the Trust achieved the minimum level 2 compliance against all of the elements of the Information Governance Toolkit as required by Monitor. The Information Governance Team undertook a thorough review of the evidence supporting the declaration made on 31st March 2015. An overall score of 67% was achieved.

The top level, Level 3 was achieved with regards to the Information Governance Toolkit with regards to management of requests made under the Freedom of Information Act 2000.

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.

Clinical coding error rate

Royal Brompton & Harefield NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2014/15.

Performance against key healthcare targets 2014-15

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.

Indicator	Target/ threshold	2014-15 Q1 Score	2014-15 Q2 Score	2014-15 Q3 Score	2014-15 Q4 Score	2014-15 score	Indicator met
Clostridium difficile - Cases due to lapses of care	12	1	0	0	0	1	Yes
MRSA – Trust attributable to Trust	0	0	0	0	0	0	Yes
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	94%	96.1	100%	100%	94.2%	-	Yes
Cancer – 62-day wait for cancer first treatment (aggregated to include Consultant upgrade)- post local breach re-allocation	85%	83.3%	71.4%	78.0%	77.8%	-	No
Maximum 62 day wait from GP referral to treatment for all cancers	85%	88.5%	84.2%	74.4%	72.0%	79.7%	
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	100%	100%	<5	100%	-	Yes
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	100%	98.9%	100%	100%	-	Yes
Percentage of patients seen within 18 weeks for admitted, incomplete and non-admitted pathways	Admitted: 90%	91.1%	92.8%	92.6%	92%	-	Yes
	Non-admitted: 95%	97.9%	97.9%	97.6%	96.7%	-	Yes
	Incomplete pathway 92%	94.4%	95.9%	96.0%	94.1%	-	Yes

18 Week Referral to Treatment Time Data Considerations

Basis of preparation

The Trust is required to report performance against three indicators in respect of 18 week Referral-to-Treatment targets. For patient pathways covered by this target, the three metrics reported are:

- "admitted" – for patients admitted for first treatment during the year, the percentage who had been waiting less than 18 weeks from their initial referral;
- "non-admitted" – for patients who received their first treatment without being admitted, or whose treatment pathway ended for other reasons without admission, the percentage for the year who had been waiting less than 18 weeks from the initial referral; and
- "incomplete" – the average of the proportion of patients, at each month end, who had been waiting less than 18 weeks from initial referral, as a percentage of all patients waiting at that date.

The measurement and reporting of performance against these targets is subject to a complex series of rules and guidance published nationally. However, the complexity and range of the services offered by the Trust mean that local policies and interpretations are required, including those set out in the Trust Access Policy. [As a tertiary provider, receiving onward referrals from other trusts, a key issue is reporting pathways for patients who were initially referred to other providers.]

Under the rules for the indicators, the Trust is required to report performance against the 18 week target for patients under its care, including those referred on from other providers. Depending on the nature of the referral and whether the patient has received their first treatment, this can either "start the clock" on a new 18 week treatment pathway, or represent a continuation of their waiting time which begun when their GP made an initial referral. In order to accurately report waiting times, the Trust therefore needs other providers to share information on when each patient's treatment pathway began.

Although providing this information is required under the national RTT rules, and there is a standard defined Inter Provider Administrative Data Transfer Minimum Data Set to facilitate sharing the required information, the Trust does not always receive this information from referring providers despite [extensive] chasing. This means that for some patients the Trust cannot know definitively when their treatment pathway began. The national guidance assumes that the "clock start" can be identified for each patient pathway, and does not provide guidance on how to treat patients with "unknown clock starts" in the incomplete pathway metric.

The Trust's approach in reporting the indicators is as follows:

Incomplete	The Trust excludes these patients from the calculation of the indicator.
Admitted	The Trust excludes from the calculation and reports as "unknown clock starts" in national data submissions.
Non-Admitted	The Trust excludes from the calculation and reports as "unknown clock starts" in national data submissions.

During the year, 89 of the Trust's admitted patients (1.16%) and 24 of non-admitted patients (0.33%) had unknown clock starts (0.76% overall). Due to how the incomplete indicator is calculated, it is not possible to give an equivalent percentage figure of the impact of "unknown clock starts", but it will be similar to the overall level for patients treated for the year. The absence of timely sharing of data by referring providers impacts the Trust's ability to monitor and manage whether patients affected are receiving treatment within the 18 week period set out in the NHS Constitution, and requires significant time and resource for follow-up.

Data assurances and actions for improvement

The assurance work undertaken by Deloitte LLP in respect of the Quality Report 2014/15 led to a qualified conclusion on the accuracy of the reported 18 week Referral to Treatment incomplete pathway indicator. Their findings indicate related issues with the admitted and non-admitted indicators.. The Trust has put in place an action plan in order to address the concerns identified. This plan includes a review of processes and procedures based on the existing Patient Administration System (PAS) and inclusion of referral to treatment time data quality requirements in the project planning for the implementation of the new PAS system.

Short term actions include:

- Reminding staff of data entry procedures and national RTT guidance
- Identification and investigation of data anomalies
- Undertaking sample audits in the form of cross checks between RTT teams

The Trust has also invited the referral to treatment Intensive Support Team to review its processes and provide advice.

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

- Medication errors for Children's Services (see page 15)
- 7 day working (see page 13)
- Percentage of admitted patients assessed for venous thromboembolism (see page 19)

Clinical Effectiveness

- Lung cancer review (see page 9)
- Quality and productivity programmes (see page 8)
- Participation in Clinical Audit (see page 25)

Patient Experience

- Family Satisfaction Survey in Intensive Care (see page 12)
- Theatre Cancellations (see page 11)
- Friends and Family Test (see pages 20 and 21)

In addition, a summary of the indicators which have been included in our Commissioning for Innovation and Improvement Framework is given on page 24 of this report.

Part 4: Statements from our stakeholders

Statements from Healthwatch

Statement from Healthwatch Hillingdon

Healthwatch Hillingdon's response to Royal Brompton and Harefield NHS Foundation Trust (RB&H) Quality Account 2014-2015
Introduction

Healthwatch Hillingdon wish to thank RB&H for the opportunity to comment on the Trust's Quality Accounts (QA) for the year 2014-2015 and for the way in which they continued to involve Healthwatch Hillingdon in the setting of their priorities.

Healthwatch Hillingdon engage with Harefield Hospital patients, carers and their families through a quarterly presence at the Trust in main reception. We also co-hosted the patient participation day at Harefield Primary Angioplasty 8 in September 2014

Quality Account
Healthwatch Hillingdon found the Quality Account to be user friendly and easy to read. The reporting format offers a clear explanation for each priority, setting out its aim and how it will be measured. This helped the reader to clearly understand each priority area.

Trusts are required to follow Monitor's technical guidance when determining the information required to be submitted in their annual quality accounts. This makes it difficult to produce an account in a format which is easily accessible for the general public. We would say that RB&H have gone a long towards producing a report for the audience it is intended.

It was also noted that a number of acronyms are used throughout the report and that these are not always explained, or do they feature in the glossary. Quality priorities 3 and 5 on page 17 are a prime example of this.

Attention to these in future years may improve the understanding of the account and its readability by the general public.

Quality Priorities
In general from the qualitative feedback it feels like there has been a good effort to meet the 2014-15 quality priorities. It is however very difficult to determine the progress of the quality priorities, or if they have been met without quantitative data. This is a general disappointment which we have outlined in previous responses. There are no specific targets listed under the priority areas. It is not clear what the benchmarks are and what targets the Trust is working towards. Lack of specific targets makes it difficult to measure progress and the results of what has actually been achieved are not shown.

The areas in which qualitative data is shown give much greater clarity.

The Friends and Family Test (FFT) scores are excellent and the response rates are good. The Trust should also be congratulated on the results of the NHS Staff Survey results and the majority of the national priorities. These results are a positive reflection of the care provided within the hospitals.

Healthwatch Hillingdon would like to see a greater explanation within the account of why the targets for '62 day wait for cancer treatment' and 'elective operation cancelled' have not been attained and what the Trust has put in place to rectify these.

Conclusion
Healthwatch Hillingdon would conclude that the Trust has produced a Quality Account which is easy to read and shows its commitment to provide high quality, patient centred care. We feel however that the Trust needs to further demonstrate how it is achieving its priorities with the inclusion of qualitative evidence.

We would also suggest that targets are set for 2015-16 priorities to enable them to be measured and reported upon accurately.

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
11th May 2015

Statement from Healthwatch Central West London

As at 22nd May 2015 – no statement had been received. If a statement is received after this date, but before publication to NHS Choices on 30th June 2015, the statement will be added here, but no amendments will be made to the body of the report.

Statement from Local Authority Oversight and Scrutiny Committees

Statement from Councillor Robert Freeman (Chairman, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea) on the Quality Account 2014/15

I am pleased to provide this brief statement for the Royal Brompton and Harefield NHS Foundation Trust's Quality Account for 2014/15. 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. 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, over the years. 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.

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 14/15.

14 May 2015
Councillor Robert Freeman

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 2014/2015 Quality Account report and acknowledges the Trust's commitment to attend its meetings when requested. The Committee is reassured that the recent Intelligent Monitoring report, published by the Care Quality Commission (CQC) in December 2014, states that the Trust has been assessed as being in band 4. Additionally, the Committee notes that the Trust has maintained full compliance with the CQC registration requirements.

Members are aware that the Trust's six Quality Priorities during 2014/2015 were:

1. *Quality & Productivity Programmes*
2. *Lung cancer review*
3. *Theatre cancellations*
4. *Family Satisfaction Survey in Intensive Care*
5. *7 Day Working*
6. *Medication errors for Children's Services*

The Committee notes that the Trust is participating in the North West London Commissioner and Provider Action Plan for the 62 day pathway in relation to cancer treatment. Although the 62 day cancer target has not been met, it is acknowledged that this will continue to be a key area for improvement in 2015/2016. Members would like to be updated on the progress of meeting this target later in the year to ensure that cancer patients receive the best possible experience, appropriate interventions and information at the right time.

Members are pleased to note that the Friends and Family Test scores continue to be consistently high with 99% of patients who completed this survey being extremely likely to recommend the Trust to friends and family (against a target of 90%). The Committee noted that, since 2013, there have been 230 feedback questionnaires completed by patients (or their relatives) who had been in the intensive care unit for longer than 48 hours to gain a better understanding of their experience during such a difficult time. The Committee notes that the feedback gained has highlighted and identified ways to make improvements, e.g., the palliative care team has started to take responsibility for providing regular updates to families in the waiting room when a patient is acutely unwell.

Additional concern has been raised with regard to the increase in length of stay due to the acuity of patients; the Committee would like to be updated during the course of the year on any steps taken to monitor and reduce this.

Members have previously expressed concern with regard to medication errors for Children's Services, which is one of the main categories of incidents reported nationally and within the Trust. Whilst Members are aware that the majority of errors resulted in either minor or no harm to the patient, it is concerning that there are mistakes. The Committee has acknowledged the Trust's commitment to improving this issue by implementing mechanisms to reduce/eliminate these errors.

Following consultation, it is noted that the Trust has developed six key areas for improvement in 2015/2016 on which the following draft Quality Priorities for 2015/2016 have been based:

1. *Improving our Organisational Safety Culture*
2. *Improving the Patient Experience and Co-Ordination of Admission and Discharge*
3. *Improving the Identification and Management of Patients at Risk of Pressure Ulcers and Falls in Hospital*
4. *Improving the management of patients with Cancer*
5. *Improving the Management of the Deteriorating Patient – Reducing Acute Kidney Injury, Effective Sepsis Identification and Management, Appropriate Escalation of NEWS and PEWS Scores*
6. *Safer Use of Medicines and Medical Devices*

The Committee is reassured to know that the Trust will continue to commit to improving the management of patients with cancer. Additionally the Committee is pleased to see that one of the priorities for 2015/16 is to improve the patient experience and the co-ordination of admission and discharge, as this was an additional area in need of improvement.

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 2015/16.

Statement from NHS England

NHS England is the majority commissioner for the Royal Brompton & Harefield NHS Foundation Trust and has been working with the quality and safety team throughout the year on a range of areas.

Review of progress against the 2014/15 quality priorities has been taken up through various contractual mechanisms but in the main through the clinical quality review meeting.

QIPP
We welcome quality and productivity proposals which deliver pathway transformation and challenge traditional way care is delivered. In particular the trust has been building on the commitment to improve enhanced recovery in first time elective coronary artery bypass graft procedures a model we see being rolled out across organisations.

Lung cancer review
NHS England identified cancer waiting times as a priority focus area for 2014/15. The trust has been working with the transforming cancer services and service specialist teams to further develop their role as system leader in this specialised pathway. The trust has now submitted an action plan and trajectory for improvement in this area and we continue to work with the Trust and the regulator, to achieve pan-regional progress in this area.

Theatre Cancellations
This has been reviewed in a wider context with the trust on improving patient experience by reducing the 18 week pathway referral time to treatment, a waiting list initiative was implemented in year and as part of the scrutiny theatre cancellations were reviewed. There remains room for improvement at specialty level and we will continue to work with the trust during 15/16.

7 Day Working
The Trust has made improvements on this quality priority and it has been a CQUIN during 2014/15 for which this year we have monitored progress.

2015/16 Quality priorities
The trust has set some useful and challenging priorities for 2015/16 and we will continue to work with them on the monitoring and progress of these. In addition NHS England will work with the trust through the CQRG on reviewing and implementing actions from Francis, Berwick and the Lampard reviews.

Duty of candour, safer staffing and the staff survey; have all been a focus during 2014/15 and we will work with the trust to further develop these areas.

Improvement culture: NHS England will increase focus on mixed sex accommodation and HSMR rates throughout 2015/16 and continue to collaborate with the trust to understand their performance in these areas.

14th May 2015

Statement from Hillingdon Clinical Commissioning Group

As at 22nd May 2015 – no statement had been received. If a statement is received after this date, but before publication to NHS Choices on 30th June 2015, the statement will be added here, but no amendments will be made to the body of the report.

Comments from our Governors

Individual comments were received from a number of governors and these were universally positive. In addition the following general comments were made:

(The report) reads very well. It looks like the response from friends and family has picked up which is pleasing.

This quality review catalogues the continuing success of the clinical and support services at both our hospitals. The two performance targets that have not been met this year have both been sensibly reviewed and addressed with coherent action plans. Outside the targets and statistics for Monitor, the focus on safety continues to pervade the staff with ongoing programmes for audit and quality improvement.

It is clear and well balanced.

Overall the performance of the RBH and its commitment to improvement is impressive. The specialist nature of the RBH results in an expectation that some figures are likely to be higher than for DGH's and others may well be lower. The reader has to discern which applies to particular figures.

This document is most comprehensive and I cannot add to it.

11th May 2015

Glossary

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

Coronary artery bypass graft (CABG)	A type of heart surgery where the blocked or narrowed arteries supplying the heart are replaced with veins taken from another part of the patients body.
D	
Department of Health (DH)	The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk
E	
Eighteen (18) week wait	A national target to ensure that no patient waits more than 18 weeks from GP referral to treatment. It is designed to improve patients' experience of the NHS, delivering quality care without unnecessary delays.
ECMO	Extracorporeal membrane oxygenation (ECMO) is an technique of providing both cardiac and respiratory support oxygen to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function.
Elective operation/procedure	A planned operation or procedure. It is usually a lower risk procedure, as the patient and staff have time to prepare.
Emergency 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.
F	
Foundation trust (FT)	NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Royal Brompton and Harefield became a Foundation Trust on 1st June 2009.
(FFT) Friends & family Test	A questionnaire that service users and carers are asked to complete on discharge and within 48 hours of discharge about their experience of the care they have received and whether they would recommend the organisation to others. In addition, staff are asked to complete the questionnaire about whether they would recommend the organisation to others and be happy to receive care by the organisation.
G	
Governors	Royal Brompton & Harefield NHS Foundation Trust has a council of governors. Most governors are elected by the Trust's members but there are also appointed governors. http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/

H	
Hospital episode statistics (HES)	The national statistical data warehouse for the NHS in England. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations.
Healthwatch (Formally LINks)	Healthwatch are made up of individuals and community groups working together to improve health and social care services. http://www.healthwatch.co.uk/
Hospital standardised mortality ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares trusts against a national average.
I	
Indicator	A measure that determines whether the goal or an element of the goal has been achieved.
Inpatient	A patient who is admitted to a ward and staying in the hospital.
Inpatient survey	An annual, national survey of the experiences of patients who have stayed in hospital. All NHS trusts are required to participate.
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: http://www.cqc.org.uk/sites/default/files/media/reports/RT3_102v2_WV.pdf

L	
Local clinical audit	A type of quality improvement project involving individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team.
Local Authority Scrutiny Committee	These look at the question of health care delivery and act as a 'critical friend' by suggesting ways that health-related services might be improved. They also look at the way the health service interacts with social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to meet the diverse needs of the area.
M	
MINAP	**M**yocardial **I**schaemia **N**ational **A**udit **P**roject. A national registry of patients admitted in England and Wales who have had a heart attack or have severe angina and need urgent treatment
Monitor	The independent regulator of NHS foundation trusts. http://www.monitor-nhsft.gov.uk/
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.
N	
National clinical audit	A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and all NHS trusts are expected to participate in the national audit programme
National Institute for Health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. http://www.nice.org.uk/
National Early Warning Score (NEWS)	National Early Warning Score – a score that indicates deteriorating physical condition of the patient and a trigger for escalation taken from patient clinical observations such as pulse, blood pressure, oxygen levels, temperature and urine output
Never events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been

	implemented. Trusts are required to report nationally if a never event does occur. The Trust has reported 2 never events in 2013-14.
NHS number	A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
NICOR - National Institute for Cardiovascular Outcomes Research	NICOR is part of the Centre for Cardiovascular Preventions and Outcomes at University College London.
O	
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but is not admitted to a ward and is not staying in the hospital.
Outpatient survey	An annual, national survey of the experiences of patients who have been an outpatient. All NHS trusts are required to participate.
P	
PAS – Patient Administration System	The system used across the Trust to electronically record patient information e.g. contact details, appointments, admissions.
Patient record	A single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information.
Paediatric Intensive Care Unit (PICU)	A special ward for children who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.
Pressure ulcers	Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients than in people who are fit and well, as patients are often not able to move about as normal.
Primary coronary intervention (PCI)	Often known as coronary angioplasty or simply angioplasty. A procedure used to treat the narrowed coronary arteries of the heart found in patients who have a heart attack or have angina.
Priorities for improvement	There is a national requirement for trusts to select three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and patient outcomes.
Paediatric early Warning Score (PEWS)	A modified paediatric early warning score to trigger alerting of physical deterioration in a similar manner to the NEWS

R	
Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge.
Risk Assessment framework	The Risk Assessment Framework sets out the approach Monitor uses to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.
RTT	Referral to treatment.
S	
Safeguarding	Safeguarding is a new term which is broader than 'child protection' as it also includes prevention. It is also applied to vulnerable adults.
Secondary uses service (SUS)	A national NHS database of activity in trusts, used for performance monitoring, reconciliation and payments.
Serious Incidents	An incident requiring investigation that results in one of the following: • Unexpected or avoidable death • Serious harm • Prevents an organisation's ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern • Never events
Surgical Site Infection	An infection that develops in a wound created by having an operation.
Single sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender.
Society of Cardiothoracic Surgeons (SCTS)	http://www.scts.org/
Standard contract	The annual contract between commissioners and the Trust. The contract supports the NHS Operating Framework.