A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality report 2015-16

Contents

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 2015-16 we cared for 190,897 patients at our outpatient clinics and 40,044 patients of all ages on our wards[1].
- 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 12,500 adults who have breathing problems caused by diseases such as COPD (chronic obstructive pulmonary disease) and severe asthma.

[1] 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 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 2015-16. 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 2015-16 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 2015-16
- 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 2016-17.

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 2015-16, as required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

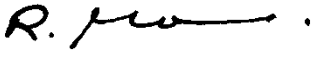
The directors are satisfied that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015-16;
- the content of the Quality Report is consistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to March 2016
  - papers relating to quality reported to the Board for the period April 2015 - March 2016
  - feedback from NHS England dated 25/05/2016
  - feedback from governors dated 17/05/2016
  - feedback from local Healthwatch organisations dated 19/05/2016 and 20/05/2016
  - feedback from Local Authority Scrutiny Committees dated 16/05/2016 and 21/05/2016
  - the national inpatient survey 2015
  - the national staff survey 2015
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 26/04/16
  - the CQC Intelligent Report Monitoring dated May 2015

- 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 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:



Neil Lerner
Deputy Chairman
25th May 2016

Robert J Bell
Chief Executive
25th May 2016

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**

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 2015 to 31 March 2016 has been the sixth 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 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 continues to be registered by the Care Quality Commission without conditions.

Significant events for 2015-16:

- In the Intelligent Monitoring report, published by the CQC in May 2015, the Trust was placed in band 3 which indicated a relatively 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 2015/16 and will continue to be so during 2016/17.

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.

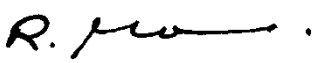
- Data is collected by a large number of teams across the trust, alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably 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 34 of this report.

Signed:



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Robert J Bell
Chief Executive
Royal Brompton & Harefield NHS Foundation Trust **25th May 2016**

Part 2: Review of quality priorities for improvement

Part 2a: Quality priorities for improvement 2015-16

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 2015-16. These areas for improvement are called our quality priorities and were identified in 2015. 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 2015-16 which represent the views of our key stakeholders, but are also in line with the Trust's overarching strategy and priorities for 2015-16. An account of progress against each of the quality priorities is given below.

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 2015-16 were:

What is patient experience?

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

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)

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 did we measure this?

We measured this 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 walk rounds, training staff in Quality Improvement Methodology, Root Cause Analysis and Being Open, human factors and simulation training.

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 is a 6% increase from 2013. The scores shown in the table below are reported as the percentage of staff responding positively to the question posed.

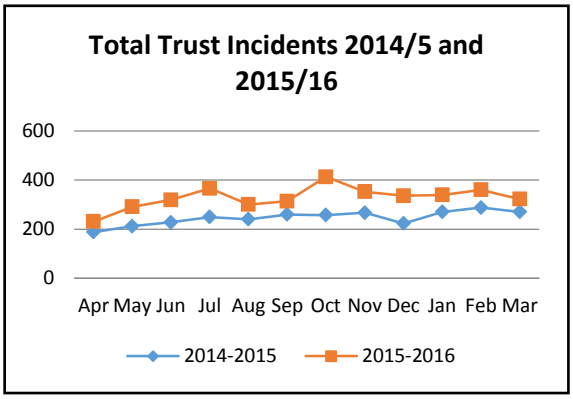
Domain	Overall score 2013	Overall score 2015
Teamwork – the perceived quality of teamwork and collaboration	74%	78%
Safety – The perceived level of commitment to and focus on patient safety	70%	72%
Job satisfaction - Employees' general feelings of positivity regarding their work	77%	80%
Stress recognition - Employees recognition of how stressors impact their performance.	60%	60%
Working conditions - Employees perception of the quality of their work environment.	59%	60%
Perception of departmental and hospital management - Employees perception of the support and competence of hospital and management level management	59%	61%

Each ward/department has selected one area for improvement and will report on progress at the divisional Quality & Safety Group meetings.

Executive patient safety walk rounds

Each clinical ward/department across the trust has quarterly executive led patient safety walk rounds. Staff are informed of the dates and encouraged to attend and raise any patient safety concerns they may have. Staff on the children's wards are also invited to attend regular Pizza nights with the executive to discuss patient safety.

An increase in reporting of incidents via the DATIX system



	2014/15	2015/16
April	188	231
May	212	291
June	228	319
July	249	366
Aug	240	300
Sept	260	314
Oct	257	413
Nov	267	352
Dec	223	336
Jan	270	339
Feb	288	360
March	270	322

The graph and table show an increase from 2014/15 to 2015/16 of 24% of incidents reported

Training

Quality Improvement Methodology, Root Cause Analysis and Being Open, human factors and simulation training sessions are held throughout the year. Dates are published on the intranet. All staff are encouraged to attend.

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 did we measure this?

We measured 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.

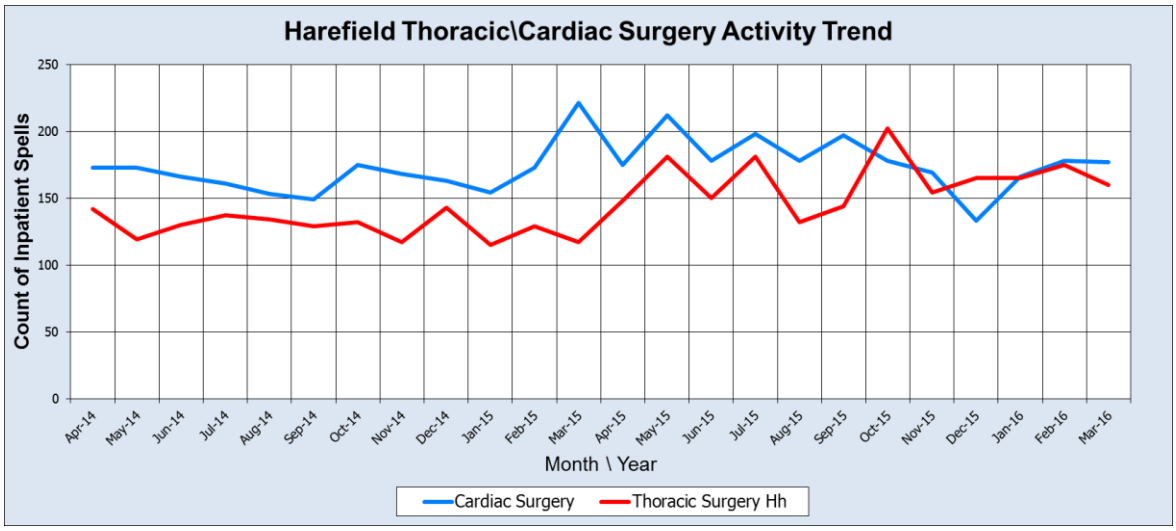
Progress and Outcomes

At Royal Brompton Hospital:

- Between April 2015 and February 2016 there was a greater focus on reducing the number of cancelled operations. In this period there were 48 cancellations of cardiac surgical operations (for non-clinical reasons) compared to 94 in the same period 2014/15, a 49% reduction. This improvement is a result of focused effort and education to the clinical teams on the need to improve patient experience, productivity and efficiency. The daily theatre schedule is scrutinised to ensure every effort is made to avoid cancellations, with a weekly review of performance to analyse any cancellations and their causes.
- For patients on the 18-week cardiac surgical pathway, there has been a slight (6%) increase in the number of patients exceeding the 18-week target when compared to 2014/15 (from 174 to 184 patients). This was a consequence of reduced theatre capacity for redevelopment works for part of 2015.

At Harefield Hospital:

- Between April 2015 and February 2016 there was a significant (43%) increase in cancellations of cardiac surgery for non-clinical reasons, 294 in 2015/16 compared to 205 in 2014/15. The main cause of the increase was additional pressure on ward-beds (i.e. hospital admissions being cancelled) as a consequence of growing thoracic surgical activity as we strive to admit cancer patients promptly for surgery (see chart below), thus restricting the number of beds available for cardiac surgery. In response to these pressures, a regular cancellations review meeting has been initiated and the team are aiming to increase the number of 'day-of-surgery' admissions in order to reduce length of stay where possible.
- There was a small (5%) reduction in 2015/16 in the number of patients whose pathway exceeded the 18-week target (from 276 to 261).



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 did we measure this?

We utilised 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.

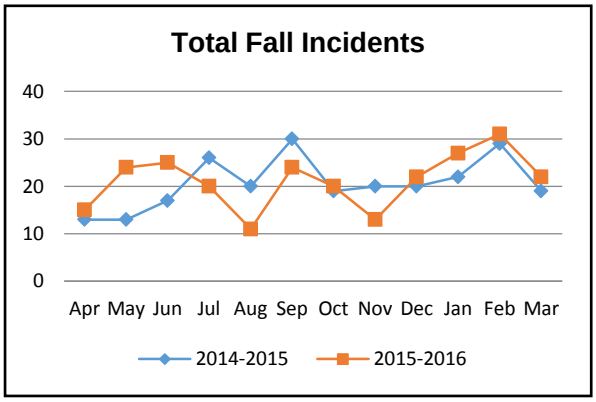
Pressure Ulcers

- Cross-site Skin Integrity Steering Group
- Tissue Viability Nurse (TVN) champions on the wards
- Pressure ulcer care audit undertaken monthly on all wards, recording the following information:
    - Waterlow risk assessment (WRA) performed within 6 hours of the patient admission to your ward under the nursing care.
    - Evidence of established plan on frequency of Waterlow risk assessment: as per protocol /as per patient condition – improvement or deterioration/ weekly if <10
    - If the patient is at risk (WRA score 10+) there are appropriate interventions relating to the risk factors documented.

In 2014/15 - 138 hospital acquired pressure ulcers were reported cross-site. In 2015/16 this number decreased to 88. This is a 36% reduction in the number of hospital acquired pressure ulcers in the last 12 months.

Patient Falls

- Monthly audits and point prevalence – link to safety thermometer;
- Regular falls prevention incident reporting feedback sessions with nursing staff;
- Yellow wrist bands have been introduced and are being piloted on wards on both sites to highlight patients who following the risk assessment are assessed as being high risk of falls;
- Falls group- looks at all falls trust-wide;
- Weekly reports of patient falls to ward sisters, charge nurses, matrons. Report includes a section on whether or not the falls risk assessment was completed ;
- Of the 254 falls reported in 2015/16, the falls risk assessment was completed for 203 (80%) of patients.



	2014/15	2015/16
April	13	15
May	13	24
June	17	25
July	26	20
Aug	20	11
Sept	30	24
Oct	19	20
Nov	20	13
Dec	20	22
Jan	22	27
Feb	29	31
March	19	22
Total	**248**	**254**

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 did we measure this?

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

Progress and Outcomes

A 2015/16 Performance Overview report was completed by the Cancer Manager in March 2016 in order to provide an update on quality priority 4 – "Improving the management of patients with cancer". The report concluded that, whilst the cancer waiting-time target is a challenge, we need to continue to work with our network of referring hospitals to assist in improving the lung cancer referral pathway for all patients. The external Cancer Service Review (being undertaken by Dr Pallav Shah (RB&H) and Dr Sanjay Popat (Royal Marsden) as a follow-up to their 2014 review) is being updated and will focus on the parts of the lung cancer pathway that can be improved so that patients can be seen and diagnosed earlier, and then referred promptly for treatment, thus reducing overall waiting-times.

In addition to waiting-time performance, there are various clinical and patient experience indicators that are considered part of the overall quality and safety of the service. For example, in terms of lung cancer resections alone, the Trust is in the top four performing hospitals in the country, with a better-than-average in-hospital mortality rate, as well as a better-than-England-average rate for 30- and 90-day post-operative mortality for first time primary lung cancer resections. It is therefore important that these indicators are also monitored on a regular basis and form part of the overall assessment of the lung cancer service going forward.

One of the areas of progress the Trust has focused on this year has been trying to improve the cancer waiting times performance. In 2015/16 a total of 178 patients on the 62 day pathway were referred to Royal Brompton and Harefield Hospitals. Across all 178 patients, including those referred after day 62, the average day of referral was day 48. Referral on day 48 leaves (on average) only 14 days, to arrange additional outpatient appointments for clinic review, diagnostics, further investigations and an admission date for surgery.

The Trust has been working collaboratively with the North West London Clinical Commissioning Group Cancer Performance Manager and the NHS England lead for Cancer in order to shorten the time between referral and treatment with the aim of reducing this to 24 days. This in itself was an ambitious target however there was a concerted effort by the thoracic surgeons to work toward this.

Over the last three years there has been an average overall reduction from 30 days between referral and treatment in 2013/14 to 27 days in 2015/16 across all patients on the 62 day pathway.

Table 1 – All patients (treated within 62 days and patients who breached the target)

	Ave day of referral	Ave day from referral to treatment
2013/14	38	30
2014/15	46	28
2015/16	48	27

If this is broken down further to look at the improvement in referral to treatment turnaround in patients who are referred in time, there is a marked and significant improvement from 22 days to 16 days on average for the last two financial years.

Table 2 - All patients referred and treated in time only

	Ave day of referral - treated in time	Ave day from referral to treatment - Treated in time
2013/14	29	22
2014/15	35	16
2015/16	35	16

What is noticeable however is that the day of referral is increasing and has risen from 29 days to 35 days over the past 3 years. This demonstrates that patients who are fit for surgery, and have had all the relevant diagnostic tests and investigations by day 35, can be operated on within the 24 day target set out in the National Breach Allocation Guidance published in March 2016.

The Trust has been involved in leading a system wide approach to improve waiting times internally and externally by working with our referring organisations. However cancer waiting times remain a challenge and it is essential that the Trust continues its collaborative work with referring partners, the NWL Clinical Commissioning team and NHS England cancer leads. The Cancer Service Review led by Dr Shah and Dr Popat for 2016 will assess the appropriateness of which parts of the lung cancer pathway can be improved so that patients can be seen, diagnosed earlier and referred quickly for treatment, this will ultimately lead to improving overall waiting times.

Quality priority five

Improving the Management of the Deteriorating Patient (AKI, SEPSIS, NEWS and PEWS)

What are the aims?

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

A cross site group has met on several occasions to discuss this aspect of the safety Improvement plan.

Automated alerts for Level 1 ,2,and 3 kidney injury were switched on in November 2015 and are reported on a monthly basis cross site. Once this is established we will consider how to address monitoring of appropriate actions in response to alerts

Data on patients requiring renal replacement therapy (RRT) is currently being sourced from the clinical data warehouse but will also be reported monthly once automated reporting has been established.

Snapshot audits of AKI risk assessment prior to coronary interventions / devices and before CT scanning will be carried out 6 monthly once staff and resources have been identified

Work on consent, appropriate prescribing and monitoring of aminoglycosides remains under discussion with the antibiotic pharmacist.

How are we measuring this?

For AKI – incidence of Renal Replacement Therapy, 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.

- Group convened cross site late September to discuss plan and review baseline data from Clinical Data Warehouse
- Software switched on in Labs to highlight abnormal results – 02/11/2015
- Monthly reporting agreed -commenced end of November 15

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

- The introduction of the revised NEWS observation charts pilot was undertaken in February and March 2106. Minor amendments to the chart are required.
- Education initiative for medical staff at Jan 16 Governance day. Nursing staff education to be arranged.
- Roll out of the observation chart to all other areas will commence when staff training has been completed.
- Monthly audits to commence June 2016 (5 charts per ward) initially as the modified charts are being introduced and once we have assurance that the forms are being used

correctly and NEWS scores calculated appropriately quarterly audits will be undertaken by the resuscitation team.

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.

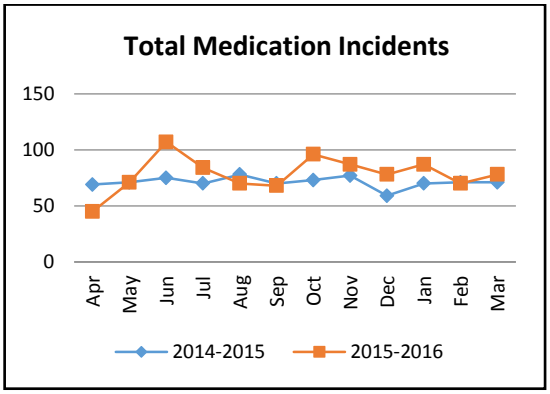
How did we measure this?

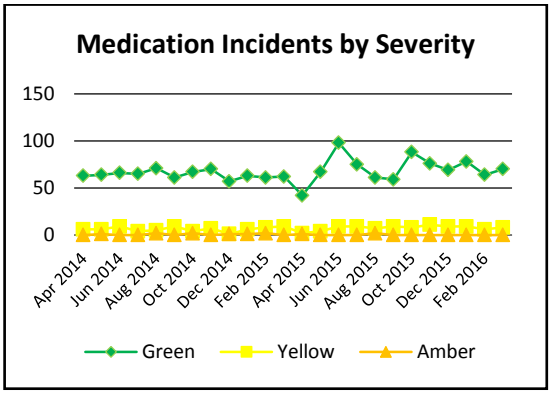
We monitored the number of medication and device incidents reported by severity per month

Medicines

Medication safety groups in place for wards and critical care. The groups meet quarterly and consist of a consultant, pharmacist, Q&S lead and nursing staff. Members of the groups receive details of all medication related incidents reported for their ward and are responsible for helping to investigate the incidents and feeding back lessons learned at handover and team meetings; newsletter to be agreed. Medication related incidents are also discussed at incident reporting feedback session

The graph and table show an increase from 2014/15 to 2015/16 of 10% of medication related incidents reported.
The incidents reported for 2015/16 were graded:
3 Amber- Moderate harm
92 Yellow - minor harm and
846 Green - no harm





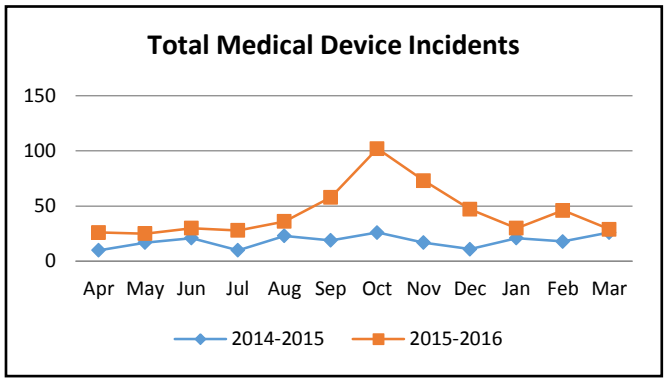
Total Medication Incidents

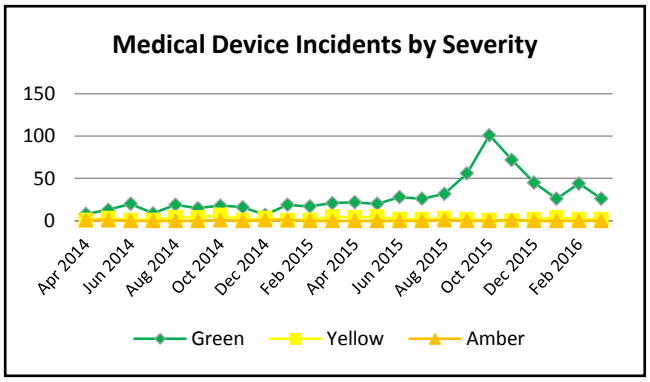
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014-2015	69	71	75	70	78	70	73	77	59	70	71	71	854
2015-2016	45	71	107	84	70	68	96	87	78	87	70	78	941

Medical Devices

Cross-site Medical Devices Safety Group is in place, having quarterly meetings. A report of all medical device related incidents is presented and discussed at these meetings. Regular incident reporting feedback sessions also take place with ward staff.

The graph and table show an increase from 2014/15 to 2015/16 of 9.5% of medical device related incidents reported. This increase has been due to promoting the importance of reporting medical device related incidents. In September, October and November 2015 Harefield Hospital reported a large number of incidents relating to inadequate sterile servicing of medical equipment by our external providers and this is reflected in the increased number of incidents reported for these 3 months.





Total Medical Device Incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014-2015	10	17	21	10	23	19	26	17	11	21	18	26	219
2015-2016	26	25	30	28	36	58	102	73	47	30	46	29	530

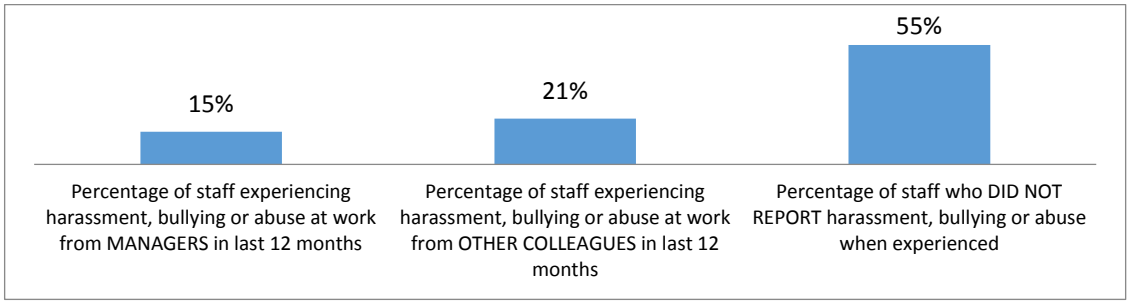
Duty of Candour

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.

Incidents are initially logged onto DATIX, and Adverse Incidents that meet the requirement to be reported onto STEIS are lodged and automatically reported to NHSE. Where an incident has taken place and been reported on DATIX, the relevant Quality & Safety lead for the Division is informed within 24 hours of an amber or red incident taking place. An appropriately senior member of staff (preferably the responsible consultant) involved in the patient's care ensures that they meet with the patient/representatives within 10 working days to explain what has happened, offer an apology and document this discussion in the notes. The relevant Q&S lead is present at this meeting together with the named nurse. Following the meeting and conclusion of any investigation, the patient/ representative receives a letter. The time frame will be agreed with the patient / representative at the time of preliminary disclosure that an incident has occurred. This letter is uploaded into the DATIX system and on to the EPR, allowing for monitoring of compliance with the policy. Training in Duty of Candour is run as an hour long taught session on 'Being Open/ Duty of Candour'. Courses are held monthly at each site and whilst not mandated, are advisory. In the last 12 months, 195 staff have undertaken the course. Slides are available on the staff intranet.

Staff Survey

When looking at harassment and bullying, 15% of staff surveyed reported harassment or bullying by a manager, and 21% by another colleague. The overall harassment and bullying score for the Trust is 28% due to the fact that some respondents will have answered yes to both questions. However, 55% of these staff stated that they did not report the issue. In fact only two bullying and harassment claims were raised with HR in the last 12 months.



The 'Working Together Better for Patients' initiative has now been running for three 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 areas that report higher levels of harassment and bullying from managers, refresher courses in leadership and management could become mandatory for all team leaders. Alternatively, a refresher course could be made mandatory for all managers across the Trust every 3 years.

The Learning and Development department are also writing an e-learning module on 'working together better for patients' to be included as part of mandatory training for all staff, which will be going live in the next month.

KF27 that asks what percentage of staff believes the Trust provides staff with equal opportunities for career progression shows 85% of staff answering positively, which is only 3% below the national average for Acute Specialist Trusts.

The Trust offers all full time permanent staff up to £2000 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.

Five of the areas reporting the lowest scores in this key finding are Surgery at Harefield, Surgery at the Brompton, Anaesthesia at the Brompton, Estates and Information and Technology. HR teams will be working particularly closely with these departments to make sure staff are aware of the training opportunities available to them.

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.

Part 2b: Quality Priorities for improvement in 2016-17

Although this section of the report is designed to identify the quality priorities for improvement in 2016-17, the Trust has developed a three year plan, and has reviewed its progress after the first year as identified in section 2a of this report.
The priorities identified cover all three areas of quality as mandated by the Department of Health: patient safety, patient experience and effectiveness / patient outcomes. The plan also incorporates the Trusts commitment to 'Sign Up To Safety'.

AIMS
We aim to reduce avoidable harm by 50% and continuously improve and measure the quality of care we provide throughout the next 3 years and beyond.

1. **Leadership**
    - We will continue our programme of executive patient safety walkrounds encouraging supporting and focusing all staff on safety and quality of care building a dialogue across the Trust from board to ward
    - We will become active participants in the Imperial College Healthcare Partners Patient Safety collaborative contributing to its vision to its vision 'to support its partners to embed safety in every aspect of their work'
    - We will continue to undertake staff safety climate surveys to ensure we understand the safety culture within the trust and take action to enhance this
    - We will fully promote and deliver on our 'Duty of Candour' ensuring that we are open and honest with patients in all aspects of their care and treatment particularly when things have not gone as planned.

2. **Building Capacity and Capability**
    - We will develop a Quality Improvement training programme enabling staff at all levels and from all professions to undertake quality improvement projects
    - We will continue to enhance our Root Cause Analysis and Being Open & Duty of Candour training programmes so that staff are equipped to investigate patient safety incidents and explain their findings to patients / carers in an open and transparent way.
    - We will initiate Human Factors Training for all professional groups and increase opportunities for multiprofessional groups to undertake simulation training
    - We will join the Institute for Healthcare Improvement (IHI) Open School and encourage staff to improve and develop their knowledge and professional development in relation to patient safety and quality improvement.

3. Projects

- Review and analysis of our patient safety incidents , complaints, PALS contacts together with local audits has identified a number of areas for improvement on which we will focus over the next 3 years;
    - **'Big 6'**
        1. Reducing acute kidney injury particularly in diabetic patients
        2. Reducing sepsis including surgical site infection
        3. Improving detection and management of the deteriorating patient
        4. Reducing the incidence of pressure ulcers
        5. Reducing in-patient falls
        6. Improving medication and device safety
    - **Reducing cancellations**
    - **Reducing complications of interventions and procedures.**

The context and detail for these priorities is identified in the Safety Improvement Plan (updated March 2016) in appendix A. The Trust's sign up to safety initiative is set out in Appendix B.

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
	2014-15	2015-16	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	0.20%	0.32%						
% of patients aged over 15 readmitted within 28 days	3.06%	2.72%						
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]	98.10%	96.98%	97.61%	Feb 2015-16	100%	74.17%	95.67%	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Percentage of staff who would recommend the provider to friends or family needing care *Source: national NHS staff survey*	97%	91%	91%	Q2 2015-16	96.48%	58.36%	78.96%	https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/data/
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%	95.59%	2015-16	100%	61.5%	95.48%	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2015-16/
Rate of *clostridium difficile* (number of infections/100,000 bed days)	0.5[3]	0.73	No benchmark available					
Patient safety incidents reported to the National Reporting & Learning System					Benchmarked against Acute Specialist NRLS Cluster			http://www.nrls.npsa.nhs.uk[4]
• Number of patient safety incidents	2469[5]	3716	3716	2015-16	2137	347	1096.37	
• Rate of patient safety incidents (number/100 admissions)	13.4	19.9	28.02	Q1+Q2	117	15.9	Cluster median = 36.3	
• Percentage resulting in severe harm or death	0.16%	0.054%	0%	2015-16	0%	0.8%	0.%	

[2] For 2014/15 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 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.

[4] The Benchmarking is against our 'cluster' which is other Acute Specialist Trusts, not national comparison

[5] This is the total number of patient safety incidents that were reported to the National Reporting & Learning System in 2014-15, not the number of patient safety incidents which occurred in 2014-15. This also includes some incidents which occurred late in 2013-14, where the investigations could not be completed by year-end. Equally, some of the incidents that occurred at the end of 2014-15 were still under investigation, and were be submitted in 2015-16, so that the learning can be shared collectively with other centres.

Friends and Family test

Patient feedback comments:

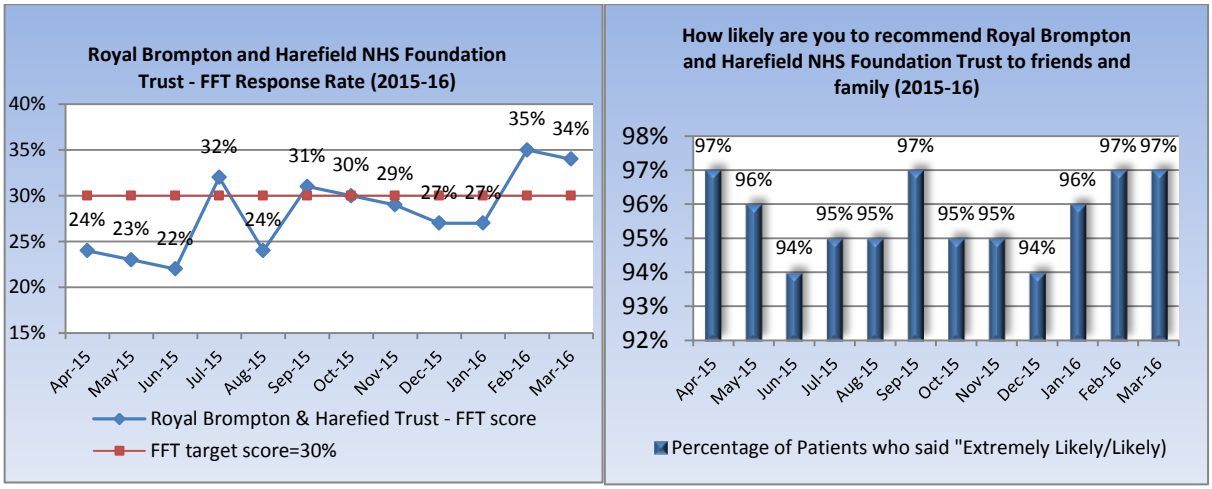
> *"Very pleasant staff, always someone in attendance or near at hand. Staff very willing to help and provide or seek answers to questions, Catering was very good and a plentiful supply of hot drinks available."*
> *"The patience of the professionals on the ward to understand the needs of complaints of my illness and the support they have given me is terrific thank you so much."*

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 2015-16 (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 2016 (Source NHS England)

a) National Benchmarking – 153 trusts in England
   - Royal Brompton & Harefield Trust FFT response rate = 35% (ranked 23rd).
   - 98% of patients would recommend the Trust to friends and family.

b) Local Benchmarking – 57 hospitals in London
   - Royal Brompton FFT response rate = 35% (ranked 18th).
   - Harefield Hospital FFT response rate = 34.1% (ranked 22nd).

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

"Nursing care was of the highest standard with excellent support for patients from all staff."

"Everybody treated me with respect and I felt everything was positive in the way they conducted the tests."

"Patient's care was great all procedures were fully explained. Staff were caring and helpful."

"Staff extremely diligent & caring in looking after my treatment."

"Have had 1st class care from the whole team. Top to bottom. From the receptionists smile when I arrived to the charm of the lady in departure lounge."

"The staff could not do enough for you. Nurses very professional and kind. I actually enjoyed my stay felt some times I was in hotel."

"Very pleasant ward staff that care and have time for you plus good food- what more could you ask for. Doctors are lovely and willing to talk about conditions."

"The skill and kindness and care was wonderful during my stay on Oak Ward in July. You all deserve the MBE. Many thanks to you all."

Actions taken as a result of patient feedback in 2015

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

1. Facilities

A conservatory was built next to the Transplant unit where patients and relatives could meet others in similar situations and share experience and a pantry has been refurbished for patients' use to heat their meals and eat in the conservatory.

2. Information & Communication

From a focus group run by the team earlier this year, one outcome was that adolescent patients wanted someone they could contact during times that fit around their school and home life. The iccteenagers mailbox was created so patients could contact a member of the team with their questions at any time and receive a response.

3. Compassion in Practice

To address the issue of patients' comments about receiving cold food, Maple ward is having Health Care Assistants and Housekeeping staff help with the delivery of dishes to patients to speed up the process.

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 2015 – 31st January 2016[6]			
	Within 25 days	Over 25 Days	Total	%
Royal Brompton Hospital	40	6	46	87.0
Harefield Hospital	20	11	31	69.0
Trust Total	**60**	**17**	**77**	**77.9**

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 2015/2016 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.

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

For the year 2016-2017 Datix has been amended and we will now be recording when a complaint response time is individually negotiated with the complainant and if that target date is met.

The Trust received a total of 91 Complaints during the year 1st April 2015 to 31st March 2016. This included complaints from 8 Private Patients and 2 complaints led by other organisations.

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
51	Royal Brompton Hospital	28	12	10	7	1
40	Harefield Hospital	18	10	9	3	3
91		46	22	19	10	4

*Table represents the status of complaints received during the year 1st April 2015 to 31st March 2016 and the outcome if not “still open”.

Of the 51 complaints received at Royal Brompton Hospital during the year 2015/2016 79% were upheld or partially upheld and 21% were not upheld. 7 complaints were reopened at

[6] The Trust reported 97 formal complaints received during the period 1st April 2014 – 31st March 2015.

the complainants request (14%) and they were provided with a further written response or meeting. 1 complaint received in March 2016 has not yet been responded to.

Of the 40 complaints received at Harefield Hospital during the year 2015/2016 70% were upheld or partially upheld and 22% not upheld. 3 complaints (8%) were reopened at the complainants request and they were provided with a further written response or meeting. 3 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 25 working day performance statistics and the outcomes are also measured.

The complaints data return to the Health and Social Care Information Centre is now 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. A focus on finding effective ways of identifying whether the response was helpful for the complainant has led to the involvement of the Director of Patient Experience and a pilot of telephone interviews post complaint, which will be used to improve our processes.

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 2015-16. 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.

The Trust is scheduled for inspection by the CQC June 2016 and the inspection team will be on site from 14th – 17th June 2016. The Trust has complied with the information requests from the CQC in advance of the inspection these have included a self-assessment of the core services against the CQC standards: Safe / Effective / Caring / Response / well-led.

Provision of NHS services

During 2015-16 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 38 of these NHS services.

The income generated by the NHS services reviewed in 2015-16 represents 100% of the total income generated from the provision of 36 NHS services by Royal Brompton & Harefield NHS Foundation Trust for 2015-16.

Use of the CQUIN Payment Framework

There were no CQUINs schemes in place in 2015/16 as the Trust had been moved to a tariff system in 15/16 with NHS England where no CQUINs were applicable.

RBHFT have continued to upload and support the VTE and dementia national information collections and supply information into the national portals. Also the trust has been working closely on an enhanced response involving the local referring hospitals for lung cancer pathways, which have formed a significant work stream in year to deliver improvements to the cancer waiting times.

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.

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

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 2015-16 are listed below:

Clinical Audit Topic	National Clinical Audit	Did the Trust participate in 2015/16	Clinical Audit Lead
Peri-and Neo-natal			
Perinatal mortality	MBRRACE-UK	√	**Val Hedley**
Children			
Paediatric asthma	British Thoracic Society	√	**Ian Balfour-Lynn**
Paediatric intensive care	PICANet	√	**Margarita Burmester**
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	√	**Anita Simonds**
Cardiac arrest	National Cardiac Arrest Audit	√	**Richard Young**
Adult critical care	ICNARC CMPD	√	**Jeremy Cordingley**
Emergency Laparotomy	NELA	√	**Lakshmi Kaupparao** **Tom Pickworth**
Elective procedures			
Coronary angioplasty	NICOR Adult cardiac interventions audit	√	**Charles Ilsley** **Simon Davies**
CABG and valvular surgery	Adult cardiac surgery audit	√	**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	√	**Wajid Hussain** **Julian Jarman**
Lung cancer	National Lung Cancer Audit	√	**Eric Lim**
Blood transfusion	Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery	√	**David Cummings**
End of life			
Care of dying in hospital	NCDAH	√ (RBH)	**Lauren Berry**

National Confidential Enquiries; Mental Health and Non-invasive ventilation

These two projects started in 2015/16 and the Trust is involved in both. They are currently at the data collection stage and the reports are scheduled to be published in 2016/17

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 has been published and the recommendations made by the auditors have been incorporated into the policy.

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 on to 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 science and strategic direction of the Trust's clinical research activity will largely be determined by the outcome of the NIHR Biomedical Research Centre application process and the Research Strategy will be updated accordingly at the end of 2016.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Brompton & Harefield NHS Foundation Trust during 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 4,400. These patients were recruited into over 140 clinical research projects.

Of these audits, 2,161 were into NIHR portfolio studies and 1,347 patients were consented to donate their tissue for retention within the Trust's ethically approved Biomedical Research Unit Biobanks during 2015-16. In addition 47 patients have consented to participation in the National 100k Genome project for rare diseases.

Education

The Trust's vision is to be the UK's leading specialist centre for heart and lung disease in the UK. Education, and in particular the dissemination of knowledge and skills, underpins this vision, not only by ensuring that staff have the expertise to deliver these services but also by enhancing external reputation and influence so as to secure both a strong referral base and high-calibre clinical talent.

The Trust is currently working to develop a five year strategic plan for education. Delivery of the plan will be overseen by an Educational Board with members drawn from the medical consultant body, nursing, allied health professions and the learning and development team. The Educational Board will enable the Trust to draw together the various strands that make up the Trust's educational activities. This will enable existing activities to be co-ordinated and will facilitate the exploration of new income generating opportunities such as exist in online education, promotion of existing in-house courses and the development of a visitors and observers programme.

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 NHS contract target for completion of valid general medical practice code and NHS number is 99%. This standard has been met for the general medical practice code. However, the standard has not been met for the NHS number.

Data published by Health & Social Care Information Centre (April 2015 - March 2016)

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	95.9%	99.2%
	Outpatients	97.5%	99.4%
Inclusion of patient's valid general medical practice code	Inpatients	97.2%	99.9%
	Outpatients	99.8%	99.8%

Information governance toolkit attainment levels 2015-16

During 2015/16, 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 2016. An overall score of 69% was achieved.

4 of the 45 requirements were assessed at the maximum 'Level 3'. These related to the information governance management framework and policies, information risk management arrangements, and compliance with the Freedom of Information Act.

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 carried out an internal audit in February 2016. This was based on 200 randomly selected records from June to August 2015 data.

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 %
98.0%	97.61%	96.95%	97.34%	100%

The 2014/15 Reference Cost Audit Report published by PricewaterhouseCoopers on 12th 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.

Performance against key healthcare targets 2015-16

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	2015-16 Q1 Score	2015-16 Q2 Score	2015-16 Q3 Score	2015-16 Q4 Score	2015-16 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	94.0%	100.0%	100.0%	100.0%	96.7%	98.8%	Yes
Maximum 62 day wait from GP referral to treatment for all cancers (post local breach re-allocation)	85.0%	50.0%	70.9%	46.0%	60.3%	55.6%	No
Maximum 62 day Consultant upgrade to first definitive treatment	85.0%	30.7%	56.2%	72.2%	61.5%	51.7%	No
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93.0%	100.0%	<5	<5	<5	100.0%	Yes
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96.0%	100.0%	99.0%	95.9%	96.9%	97.7%	Yes
Percentage of incomplete patients waiting less than 18 weeks	92.0%	92.4%	92.1%	92.1%	90.2%	91.7%	No

Updated: 23rd May 2016[7]

18 Week Referral to Treatment Time Data Considerations

As a result of the 2014/15 audit findings and recommendations, the Trust has been pursuing remedial actions, engaging the Elective Care Intensive Support Team during 2015/6 in a review of RTT pathway management and data quality. The actions include adoption of a new Waiting-List Policy to reflect latest (October 2015) DH guidance; regular sample audits; investigation of data anomalies; development of new Standard Operating Procedures (SOPs) and associated staff training programmes. Importantly, this is directly linked to implementation of a new Patient Administration System (PAS) from July 2016 as part of the Trust's Digital Care Transformation Programme, which will combine enhanced data validation checks and data entry processes. The on-going actions have also been reviewed by and agreed with our commissioners, NHS England. Finally, the Trust is considering 3rd party evaluation in late 2016/7 of the PAS implementation and its impact on RTT pathway and data management.

[7] The cancer waiting time figures quoted during the consultation period were the interim positions.

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 13)
- Improving the management of the deteriorating patient (see page 15)
- Participation in Clinical Audit (see page 30)

Patient Experience

- Improving the patient experience for the cardiac surgery pathway (see page 10)
- Percentage of in-patients who would recommend the provider to friends or family needing care (see page 22)
- Friends and Family Test; for patient feed-back comments (see page 23)

In addition, a summary of our performance against key national healthcare targets are given on page 34 of this report.

Part 4: Statements from our stakeholders

Statements from Healthwatch

Healthwatch Hillingdon's response to Royal Brompton and Harefield NHS Foundation Trust (RB&H) Quality Account 2015-2016

Healthwatch Hillingdon wish to thank RB&H for the opportunity to comment on the Trust's Quality Accounts (The Account) for the year 2015-16.
Healthwatch Hillingdon always find the Quality Account produced by RB&H to be 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. This is illustrated perfectly by the excellent Friends and Family Test (FFT) scores. Which positively reflect both patient experience and the care provided within both the Royal Brompton and Harefield Hospitals.

The Account sets out plainly an explanation for each priority, its aim and how it will be measured. This format gives greater clarity and helps in the understanding of each priority area. In previous years we have recommended that the public's understanding of how the Trust has performed against its priorities could be enhanced by the inclusion of target setting and quantitative data. We are therefore pleased to acknowledge the efforts taken by the Trust to include these where appropriate, which improves the Account's accessibility for the general public.

Healthwatch Hillingdon would point out, that in our opinion, there are other opportunities the Trust could take to improve the Account further and strengthen assurances of quality for the audience. In reporting 'quality priority six' (p16) the Trust displays graphically that it has achieved its aim of improving incident reporting for both medication and devices. We would recommend that in addition the Trust outlines what is being reported and the action plans being put in place to prevent incidents occurring. We would suggest a similar approach to complaints (p 26). Explaining the learning from these complaints and how the Trust is responding will give the reader confidence and assurance of quality and the Trusts culture.

Although generally the results from the National NHS Staff Survey 2015 are good, and they are on par, or better than the comparator Acute Specialist Trusts, there are a few areas that require a deeper focus by the Trust. RB&H are in the bottom quartile for; percentage of staff witnessing potentially harmful errors, near misses or incidents in last month; percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months; and the percentage of staff appraised in last 12 months. For which it is an outlier.

Although we encourage a culture of reporting errors and near misses, as we have explained above this needs to parallel with a learning culture. Staff's reporting of harassment and bullying is a concern. The National Survey score is higher than the comparator average and 55% of staff also said they did not report harassment and bullying. When you also factor in an indecisive 'could be' approach to re-training of management, stated in the Account and 25% of staff not receiving an annual appraisal with the opportunity to raise their concerns, the Trust needs to look seriously at this issue. We would seek an explanation from the Trust on whether there are any mitigating factors for these results and also seek assurances of the actions that are being taken to investigate this further.

Conclusion
We would acknowledge that in large parts the Quality Account does illustrate RB&H is committed to and delivering high quality care. We feel however that in a number of areas there are further opportunities which the Trust should consider to demonstrate a greater quality assurance, and action should be taken to reassure itself and others, of the culture within its workforce.
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
20th May 2016

Statement from Healthwatch Central West London

Healthwatch Central West London (HW CWL) welcomes the opportunity to provide this statement on the draft Royal Brompton & Harefield NHS Foundation Trust Quality Account for 2015/2016, 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.

Our members look forward to working with Royal Brompton on the new borough based visions to achieve enhanced quality and service delivery objectives on a local basis.

COMMENTS

1. **Staff**

   Our members commend Trust staff for the many examples of care and professionalism. We would also commend the Trust on its high score for the Friends, Family and staff test (page 23). We note there has been a decrease in both percentages from last year, especially in the staff survey and our members would like to understand why this has been the case.

   We would also like to understand the Safety Climate Survey results (page 8); whilst teamwork, job satisfaction and safety score well, stress recognition, working conditions and perception of departmental and hospital management score low. It would be useful to further understand how the Trust will address this and engage with its staff on these issues.

Domain	Overall score
Teamwork – the perceived quality of teamwork and collaboration	78%
Safety – The perceived level of commitment to and focus on patient safety	72%
Job satisfaction - Employees' general feelings of positivity regarding their work	80%
Stress recognition - Employees recognition of how stressors impact their performance	60%
Working conditions - Employees perception of the quality of their work environment	60%
Perception of departmental and hospital management - Employees perception of the support and competence of hospital and management level management	61%

   In relation to the Duty of Candour (page 18) we note that the course on Being Open/Duty of Candour is not mandatory for staff. Our members would ask if this should not be mandatory, particularly as we note that 55% of staff respondents said they "did not report harassment, bullying or abuse when experienced". On the face of it this is a very concerning statistic.

   We welcome the Trust's continuing "Working better for patients" initiative (page 19) and to make it a mandatory course for hotspot departments. However, our members feel that this should be mandatory for all staff as a preventative measure.

2. **Waiting times & Patient Experience**

   Waiting times have been highlighted by both our members and by the Trust's report as an issue. The Trust states that the 62 day cancer wait target and the 18 week referral treatment time target for complete pathways have not been met. We would like to understand what the Trust has done to inform patients of why this is the case and what they are doing to improve on this issue.

   We welcome the news that cancellations for Cardiac Surgery have fallen by 49% in comparison to last year. However as noted in the report, there has been a 6% increase for patients on the 18

week cardiac pathway (page 10). We note this was due to redevelopment work. Our members would like to know if patients were informed in advance that the redevelopment work would/might affect their treatment time and where appropriate, were they offered suitable alternative treatment elsewhere?

We look forward to reading the external Cancer Service Review being undertaken by Dr Pallav Shah (RB&H) and Dr Sanjay Popat (Royal Marsden) and would ask that the conclusions of this report be incorporated into the Quality Accounts especially in relation to improving the lung cancer pathway for all patients. We also look forward to seeing the results from the first National Cancer Patient Experience survey for patients with secondary cancer to be carried out in August 2016 (page 13).

We welcome the Trust's work to date with patient engagement through the various surveys mentioned in this report including its efforts to ensure patient participation in research. However, we are keen to see what the strategy for patient engagement for 2016-17 will look like.

3. **Safety & Incidents**
   The number of incidents has increased from 2469 in 2014-15 to 3716 in 2015-16. Our members would like to understand the reason/s behind this increase (page 22).Our members would also like to understand how these incidents are broken down i.e. what type of incidents are they and the severity rating for these incidents.

4. **Mandatory Priorities**
   We commend the Trust on reducing pressure ulcers by 36% this year (page 12).

5. **Complaints**
   We look forward to seeing the full figures in due course, so we cannot comment on this for the time being.

6. **Improvement on report presentation**
   We would suggest the abbreviations content page is brought to the front of the report. We also suggest that when abbreviations are first introduced into the body of the text that the full wording is used and then abbreviated in brackets as standard, as we believe this will improve clarity; for example, in particular the paragraph on Acute Kidney Injury on page 15.

   Page 13, table 5 - The writing and figures are hard to read even when it is magnified.

   Page 16 & 17 – Tables are not numbered. Also the table on page 17 - "Medication incidents by severity" - is confusing. You have a green, amber, yellow coding but it is not clear what it is representing.

   Page 17 - The "Medical Device Incidents by Severity" table is also confusing as the green line is grey, and again it is difficult to understand what the colours are representing.

   Page 30 – "Participation in Clinical Audit" table headings are difficult to read with current background colour.

CONCLUSION

Once again our members would like to commend the Trust staff on the many examples of excellent care and professionalism. However, as recognised by the Trust, waiting times are a key issue and our

members would like to understand how the Trust has been and will continue to communicate with patients about this issue as well as how it will improve on them. We would also like to understand what ongoing patient engagement the Trust has in place for 2016-17 and how it will improve on elements of staff satisfaction. It would also be useful to understand what type of incidents and severity of incidents are being reported.

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

19th May 2016
Ben Collins
Interim Director - Healthwatch Central West London

Statement 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 Quality Account 2015/16

I am pleased to provide this brief statement for the Royal Brompton and Harefield NHS Foundation Trust's Quality Account for 2015/16. 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.

16 May 2016
Councillor Charles Williams

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 2015/2016 Quality Account report and acknowledges the Trust's continued commitment to attend its meetings when requested. Although Cancer and Coronary Heart Disease networks were disbanded as a result of NHS funding cuts, the Committee commends the hospitals involved for attempting to revive the networks at their own volition. However, Members are concerned and disappointed that NHS funding has not been made available to these specialist Trusts to enable them continue these valuable fora.

Members are aware that the Trust's six Quality Priorities during 2015/2016 were:

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 commends the Trust for achieving all of its governance targets and indicators set out in the Risk Assessment Framework, apart from the indicator relating to the 62 day cancer wait target and the 18 week referral to treatment time target for incomplete pathways. As these target failures 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 Committee is reassured that the Trust will continue to work with its referring partners to assist in improving the lung cancer pathway for all patients. Indeed, Members are aware that the Trust has already worked with these hospitals to speed up the diagnostic part of the pathway and that a new system of breach allocation will be introduced during 2016/2017, which will focus on the Trust's performance for its part of the pathway. The Committee looks forward to receiving an update on the effectiveness of these measures in due course.

Members have expressed concern that the number of patients being seen by the Trust has increased as a likely consequence of the UCL Heart Hospital moving to St Bartholomew's Hospital. However, they are reassured to know that NHS England has recognised the additional pressure and has provided the Trust with additional funding to help alleviate the 18 week pressure. Furthermore, it is pleasing to note that local GPs do not perceive the Trust to be a slow operator, despite the challenges that the organisation is facing.

Between April 2015 and February 2016, there was a 43% increase in the cancellations of cardiac surgery for non clinical reasons, which was largely due to pressure on ward beds as a consequence of growing thoracic surgical activity. Regular cancellations review meetings have been initiated and the Trust aims to increase the number of 'day-of-surgery' admissions in order to reduce length of stay where possible. The Committee looks forward to receiving an update on the impact of these initiatives.

With regard to improving the organisational safety culture, 865 members of frontline Trust staff completed the Safety Climate Survey, with the results used by each ward/department to select one area of improvement. Members are pleased to note that quarterly executive patient led safety walk

rounds have taken place, there has been an increase in the reporting of incidents via the DATIX system and a range of training sessions have been held.

The Committee is reassured that there has been a 36% reduction in the number of hospital acquired pressure ulcers during 2015/2016. Furthermore, although there has been no improvement in the number of falls in hospital (248 in 2014/2015 and 254 in 2015/2016), the Trust will be continuing a number of initiatives with a view to reducing patient falls. The Committee looks forward to receiving an update on the impact of these initiatives and is pleased to note that this continues to be a priority for the coming year.

Following consultation, it is noted that the Trust has developed six key areas for improvement in 2016/2017 on which the following draft Quality Priorities for the forthcoming year have been based:

1. *Reducing acute kidney injury particularly in diabetic patients*
2. *Reducing sepsis including surgical site infection*
3. *Improving detection and management of the deteriorating patient*
4. *Reducing the incidence of pressure ulcers*
5. *Reducing in-patient falls*
6. *Improving medication and device safety*

The Committee is aware that the CQC will be undertaking an inspection of the Trust in June 2016 and looks forward to receiving an update on the outcome of the 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 2016/17.

20th May 2016

Statement from NHS England

NHS England specialised services has continued to work with the Royal Brompton & Harefield NHS Foundation Trust throughout 2015/16 on a number of quality improvement areas.
They have made really good progress in improving patient experience and improving safety culture. In particular we note the programme for human factors training and the other initiatives to support this priority. Executive safety walkrounds have been introduced to provide leadership, and support frontline staff in their roles.

There remains a challenge in two patient experience areas one around the 18 week referral to treatment pathway and the lung cancer pathway. Both areas gave been a significant focus for the trust with NHS England providing a supportive and challenging focus to these areas.
Serious incident reporting has increased and there is a greater emphasis on reviewing themes and trends for serious incidents.

We will be working with the trust on the new priorities forn16/17 and reviewing the embedding of the 15/16 priorities into usual practice.

25/05/2016
Sue Sawyer
Regional Program of Care Manager (Internal Medicine)
NHS England

Statement from Hillingdon Clinical Commissioning Group

We confirm that we have reviewed the information contained within the report and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and it is accurate in relation to the services provided. In terms of the quality priorities for 2015/6 the Trust set itself, we note the following;

Priority 1 – Improving your organisational safety culture. The CCG are encouraged by the Trust's 24% increase in the numbers of incidents reported. The Trust report a good range of training available to staff for quality improvement, root cause analysis and human factors. We have seen presentations from staff in relation to the training and programmes in relation to this work at the Clinical Quality Review Group. The Trust state as part of this priority, they will implement a formal communications strategy, it is not evident from the report that this has occurred yet.

We are disappointed to note there is no mention in the report of information in relation to serious incident reporting, the themes and trends and what the Trust has learnt and what changes you have made as a result of this learning. In addition to serious incident reporting, further information on the themes and trends from patient complaints with associated learning would be appreciated.

Priority 2 – Improving the patient experience for the cardiac surgery pathway. This priority has looked at the improved management of the 18 week pathway and reducing the number of operations cancelled for non-clinical reasons. We note the Trust has had varying levels of achievement between the Royal Brompton Hospital and Harefield Hospital sites and would like to have seen some information on what is being done to improve performance across all sites.

Priority 3 - Improving the identification and Management of Patients at Risk of Pressure Ulcers and falls in hospital. The Trust have set out what work has been done in these areas. We acknowledge that the Trust has seen a reduction in hospital acquired pressure ulcers, however there has been a rise in the number of falls reported. This may be as a result of increased awareness of falls and the need to report, we would like to the quality account to have provided more information on the actions the Trust is taking to address this. The Trust stated there would be care bundles implemented in these areas, the report mentions the bundle for pressure ulcers, however there is no mention of a bundle for falls.

Priority 4: Improving the management of patients with Cancer. The Trust has identified that it needs to do further work to meet the 62 day pathway with the network of referring hospitals. The Trust report that they are in the top four Trust in terms of mortality in patients with lung cancer. The CCG would recommend that this part of the account is reviewed as the section is not easily readable and it is difficult to identify what messages the Trust are giving. Given the on-going poor performance in this area, we would expect a greater analysis by the Trust as to why this is occurring and what the plans are for 2016/17 to improve in this area.

Priority 5: Improving the Management of the Deterioration Patient (AKI, SEPSIS, NEWS and PEWS). This section of the report does not give any data or indicator of how well the Trust is doing. It is disappointing that none of the points under NEWS/PEWS were commenced before December 2015 with most of the points not being actioned prior to the end of the financial year.

Priority 6: Safer use of medicines and medical devices. The graphs in this section demonstrate increased reporting medication and medical device related incidents. However, there is no discussion in the report of what types of incident were being reported and how the Trust were learning from these, this level of information would be useful for the reader.

We note that the Trust has reported against the national quality indicators of which Domain 1 and 2 are not relevant. We are satisfied that the Trust is performing better in these indicators than the national average and aim to see this continued performance through 2016/17.

We are aware of the issues the staff survey found and are concerned by the level of staff reporting bullying and harassment. We acknowledge the actions taken locally in an attempt to address this. However, we would expect the Trust to provide assurance that a Trust-wide action plan is being developed to look at the organisation as a whole, as well as focussing on the specific areas identified in the survey.

Priorities for 2016/17

The CCG note the Trusts proposed priorities for 2016/7 under the 4 headings. We acknowledge that these are part of a three year plan, however, we are disappointed that a number of the areas described are the same as those for 2015/16 with little further development. We would expect to see a more detailed description of the milestones for these pieces of work and a timeline for their achievement.

Yours Sincerely,

17 May 2016
Dr Ian Goodman
Chair, Hillingdon CCG

Statement from our Governors

Individual comments were received from a number of governors and these were very positive (see below).

One Governor specifically asked the following questions:

What does the 865 people who responded to the Safety Climate Survey represent as a response rate?
What are the response rates for different areas?
What is considered an excellent response rate?

In response the Trust provided details of the response rate by clinical areas. This list has been used to provide feedback to the departments, which will enable them to plan their local priorities for quality improvement.

The Governor also commented on the following section - When looking at harassment and bullying, 15% of staff report harassment or bullying by a manager, and 21% by another colleague. The overall harassment and bullying score for the Trust is 28% due to the fact that some respondents will have answered yes to both questions. However, 55% of these staff stated that they did not report the issue. In fact only 2 bullying and harassment claims were raised with HR in the last 12 months. The Governor asked why the team think 55% of staff did not report the issue and only 2 claims were raised?

The Trust's response is: it is quite difficult to comment without speaking to the individuals, who are obviously anonymous, but many issues are dealt with informally, either within the department or with HR's involvement, so are therefore not escalated to an official bullying and harassment claim. There are also Trust Ambassadors that champion the Working Together Better for Patients initiative, that staff can speak to for advice on an informal level, meaning that official claims are kept to a minimum.

Another Governor commented and asked the following questions (with the Trust's response to each point in turn recorded)

Number of cancelled ops – Harefield: The number is huge! 294 cancelled! It mentions day to day action, meetings etc. – but what are we doing about long term planning to reduce? This is developed in the Appendix A re QI priorities for 2016-7 but would be good to link that in here.

Trust response: a detailed report on cancelled operations is being presented to the Trust's Board at its meeting on 25th May 2016. This will address short and long terms plans to address these concerns. The report will be shared with the Trust's Governors.

Again in QI priorities. Very brief on falls vs several pages on cancer. More info re falls prevention? Any new strategies? Any comment in trend upwards during the year? No significant improvement from previous years?

Trust response: to reduce the number of falls we have introduced yellow wristbands for patients who are assessed as being a high falls risk, this initiative has been introduced as a pilot on wards on each site. The patients wear the wristband in addition to their patient ID band. The yellow wristbands will be rolled out to all other areas when the pilot is completed. Falls incidents reported show that 80% of patients had the falls risk assessment completed, we aim to have 100% completed by 2017/18. This information has now been included in the quality report.

QI priority 6 is sparse – what happens next? What sort of incidents are they? Meds AND device incidents increase from 2014/5 to 2015/6…any more comment? Is this better reporting or a developing problem? Suggest needs more comment

Trust response: the aim is to improve the reporting levels for devices and medication errors. For medication incidents we have the divisional medication safety groups. The groups meet quarterly and consist of a consultant, pharmacist, Q&S lead and nursing staff. Members of the groups receive details of all medication related incidents reported for their ward and are responsible for helping to investigate the incidents and feeding back lessons learned at handover and team meetings. There has been a 10% increase in the number of medication errors reported 941 in total for 2015/16, of these 846 were graded green, no harm to the patient

Medical devices – we have a Cross-site Medical Devices Safety Group in place with quarterly meetings. A report of all medical device related incidents is presented and discussed at these meetings.
Regular incident reporting Feedback sessions also take place with ward staff. There has been a significant increase in the number of medical device related incidents reported in 2015/16 and this is mainly due to due to promoting the importance of reporting medical device related incidents. In September, October and November 2015 Harefield Hospital reported a large number of incidents relating to inadequate sterile servicing of medical equipment by our external providers and this is reflected in the increased number of incidents reported for these 3 months. This information has now been included in the quality report.

Staff survey:. The CQC inspector at the Governor Conference said they focus on the staff survey results very closely so I suggest this section needs developing. It would be good to include – what survey, when survey done, how many respondents (number/%). Were there any positive outcomes from the survey?? All the comments here are on negative aspects.

Trust response: this is covered in the narrative section of the Annual Report (2. Accountability Report, 2.3 Staff Report) and there is a detailed analysis of the Trust's response to the staff survey and describes the actions planned.

Complaints: What are the numbers in the table – presumably number answered within X days, but it doesn't say so

Trust response: we have added a line below the table to help explain the numbers in the complaints table ("Table below includes the number of complaints received and number of complaints handled with outcomes to report").

In addition the following general comments from Governors were made:

The 2015/16 (Quality) report, is clear, comprehensive and balanced. Good progress has been made on the six quality priorities, and the Staff survey and family and friends sections were particularly useful.

This is an honest and open report. Through involvement in Executive Safety walk Rounds, I have observed the openness of staff and safety priorities being discussed.

The report reads very well.

This is a comprehensive report containing much that it to be applauded in performance terms. Noteworthy among the six quality priorities for improvement 2015-16, improving the patient experience for the cardiac surgery pathway at Royal Brompton showed good results in terms of the reduction (49%) in cancellations of cardiac surgical operations (for non-clinical reasons) and, although there was a slight increase in the 18-week cardiac surgical pathway, this was a consequence of reduced theatre capacity for redevelopment works during part of 2015. The corresponding statistics for Harefield Hospital showed a significant increase (43%) in cancellations of cardiac surgery for non-clinical reasons, the main cause being the consequence of admitting cancer patients promptly for surgery. Despite this, there was a small reduction in the number of patients whose pathway exceeded the 18-week target. Overall more proactive monitoring and review of cancellations is to be welcomed. In addition, the focus on improving the management of patients with cancer is very evident and will be informed by the soon to be concluded external Cancer Service Review. It is commendable how much management attention is being devoted to liaison and coordination with the Trust's network of referring hospitals in this area.

Very well written document detailing achievement of Trust's priorities/targets and a quality patient care in a safe environment.

Both hospitals are global leaders in the health care that they provide. They should be commended and supported for the amazing quality of patient care that they provide. As a result, I am delighted to be involved with the trust for the last four years as a governor and last 25 years as a patient.

Regarding the Quality Report 15/16, I am pleased to see that RBHT continues to focus on those areas where it can improve its performance vs the national indicators. A very thorough and well presented report.

17 May 2016

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 patient's 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
K	
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.

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.
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.

NHS Improvement	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.
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.
RRT	Renal replacement therapy.
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.

Appendix A

Royal Brompton and Harefield NHS Foundation Trust
SAFETY IMPROVEMENT PLAN (SIP) Updated March 2016

Introduction

The Royal Brompton and Harefield NHS Foundation Trust aspires through its overall vision to be ***'the UK's leading specialist centre for heart and lung disease'*** and has set out its strategic goals of;

- Service excellence in clinical practice, research, education and training
- Organisational Excellence
- Productivity and investment

These are underpinned by a set of key objectives to continually develop leading edge services, deliver effective and efficient treatment in core specialist services and to deliver routine services in partnership with other centres thus releasing capacity for innovation. Most important is our aspiration to continuously improve the patient experience with the aim of supporting and delivering transformational change in the way our hospitals provide care. The Trust Quality & Safety strategy 2015-2018 set out our commitment to providing the highest quality care for all our patients and ensuring that this is provided in a safe way at the right time, in the right way, by the right people. This was submitted to the NHSLA for consideration of funding which was not successful and as a result the original Safety Improvement Plan has been adjusted to reflect this. The Trust aims to;

1. Create a **culture** within the organisation which prioritises **patient safety, clinical effectiveness** and **continuous quality improvement** at every level and ensures that **leaders** create an appropriate environment and model behaviours which facilitate safe care and **motivate staff** to be **caring and responsive** to patient needs and enhance patient experience.

2. Ensure **transparency** so that **data on quality and safety** is readily available to staff and patients and is used to **drive change and improvement**

3. Improve the **reliability of care** by increasing the capability of staff to undertake safety and quality improvement work through development of appropriate skills and application of best practice.

The Quality & Safety Strategy (Appendix 1) describes how the trust will focus its attention to ensure that patients receive care that is **Safe, Effective, Caring, Responsive and Well Lead**. The Trust has developed a clear statement of vision and values driven by quality & safety with a credible strategy and well defined objectives supported by quantifiable and measureable outcomes.

As part of the Trust Quality and Safety Strategy 2015-2018 the Royal Brompton and Harefield NHS Foundation Trust has joined the NHS England 'Sign up to Safety' initiative and this document sets out our aims and aspirations, identifies the leaders and teams involve, how we will engage with patients as partners and our implementation and communication strategy. We have submitted and published our pledges as the first step in re-iterating out commitment to delivering safe and effective care . Our Safety Improvement Plan is constructed around the domains of leadership, building capacity and capability and projects with measurable outcomes.

AIMS

We aim to reduce avoidable harm by 50% and continuously improve and measure the quality of care we provide throughout the next 3 years and beyond.

1. **Leadership**
    - We will continue our programme of executive patient safety walkrounds encouraging supporting and focusing all staff on safety and quality of care building a dialogue across the Trust from board to ward
    - We will become active participants in the Imperial College Healthcare Partners Patient Safety collaborative contributing to its vision to its vision 'to support its partners to embed safety in every aspect of their work'
    - We will continue to undertake staff safety climate surveys to ensure we understand the safety culture within the trust and take action to enhance this
    - We will fully promote and deliver on our 'Duty of Candour' ensuring that we are open and honest with patients in all aspects of their care and treatment particularly when things have not gone as planned.

2. **Building Capacity and Capability**
    - We will develop a Quality Improvement training programme enabling staff at all levels and from all professions to undertake quality improvement projects

- We will continue to enhance our Root Cause Analysis and Being Open & Duty of Candour training programmes so that staff are equipped to investigate patient safety incidents and explain their findings to patients / carers in an open and transparent way.
- We will initiate Human Factors Training for all professional groups and increase opportunities for multiprofessional groups to undertake simulation training
- We will join the IHI Open School and encourage staff to improve and develop their knowledge and professional development in relation to patient safety and quality improvement.

3. **Projects**
    - Review and analysis of our patient safety incidents , complaints, PALS contacts together with local audits has identified a number of areas for improvement on which we will focus over the next 3 years;
        - **'Big 6'**
            1. Reducing acute kidney injury particularly in diabetic patients
            2. Reducing sepsis including surgical site infection
            3. Improving detection and management of the deteriorating patient
            4. Reducing the incidence of pressure ulcers
            5. Reducing in-patient falls
            6. Improving medication and device safety
        - **Reducing cancellations**
        - **Reducing complications of interventions and procedures**

TEAM

1. The Executive leads for the Safety Improvement Plan are the Director of Nursing and Governance and the Medical Director
2. The Sign up to Safety Lead is the Head of Quality & Safety who will work directly with the Lead Clinicians in Clinical Risk on both sites
3. The Implementation team will be led by the Head of Quality and Safety supported by the Q&S leads within the divisions and designated clinical leads for each project
4. Administrative support will be provided by the Co-ordinator to the Lead Clinician in Clinical Risk (RBH)

PATIENT PARTNERS

1. We will continue to engage with patients, their families and carers through a variety of media
2. We have posted our pledges (Appendix 2) on our website and share our plans and progress with staff, governors, patients, the public and our partner organisations.

3. We will continue to enhance our patient experience feedback work building on the national surveys and FFT to develop opportunities to collect real time feedback about wards, departments and services

COMMUNICATION & IMPLEMENTATION STRATEGY

1. We will use a variety of quality improvement methodologies to implement our plan linked to the nature of the project and the goals and measures within it. Updates will be provided regularly via the Divisional Quality & Safety Groups and the Trust Governance and Quality Committee.
2. The SIP and project leads will work with the Trust Communication team to design and develop an effective communication strategy based around regular provision of information , updates and messages about progress and improvement across the Trust , for governors, patients and the public.

SAFETY IMPROVEMENT PLAN PROJECTS (outline Driver Diagram see Appendix 3)

The following descriptions, tables and driver diagrams set out the detail of specific projects within the SIP 2015-2018

ACUTE KIDNEY INJURY (AKI)

AIM; to reduce the incidence of avoidable new onset AKI by 50% by 2018

AKI injury is hospitalized patients is common and is associated with increased morbidity, mortality and prolonged hospital stay. The development of AKI following cardiac surgery is also associated with increased mortality and morbidity and new haemofiltration or dialysis (RRT) is associated with mortality rates of 15-30%. Contrast –induced kidney injury is also a recognized complication of interventional procedures requiring the use of intravenous contrast. The Trust performs >8000 interventional procedures per annum with many patients at risk of this complication. Policies and guidelines are in place for pre-procedural assessment and peri and post-procedural intervention to reduce the risk of AKI and need for RRT within the Trust and the recent 2009 NCEPOD report 'Adding insult to injury' further emphasized the importance of prompt review of emergency admissions to prevent onset of AKI. The overall plan for reducing AKI is shown in driver diagram 1.

DETERIORATING PATIENT (Adult and Paediatric)

AIM; to achieve > 95% compliance with NEWS/ PEWS for all relevant patients with >95% accuracy in scoring, documented escalation and management plans by 2018.

Failure to recognize, intervene, escalate and manage the deteriorating patient is a well-recognized cause of prolonged hospital stay, requirement for transfer to a higher level of care and avoidable cardiac arrest in both adult and paediatric patients . The Trust was an early adopter of an EWS following NICE guidance 50 in 2008 and has since moved to the NEWS based on the 2012 joint RCP/ RCN document[8] . In Paediatrics the trust is a partner in an NHS adopted international portfolio study (22 centres) and has developed a bespoke score matched care algorithm. Failure to recognize deterioration and or escalate has been a feature of both incidents and claims within the Trust and the SIP will act as a driver of continued improvement in this cross-cutting theme. The overall plan for improving recognition and management of the deteriorating patient is shown in driver diagram 2.

SEPSIS (including Surgical Site Infection)(adult and Paediatric Patients)

AIM; to achieve > 95% compliance with the SEPSIS 6 System for the identification and management of sepsis in adult and paediatric patients
To reduce all wound infections to a rate of <2% across the Trust by 2018

The recent NHS England patient safety alert[9] set out a series of actions required to improve the recognition and management of sepsis. Which unless treated quickly can lead rapidly to death (50% mortality from septic shock) .Recent epidemiological studies(3),(4) and data from the Intensive Care National Audit and Research Centre (ICNARC)(5), estimate that 35,000 people die from sepsis in England each year. The mortality rate for sepsis in children is estimated to be 10 – 15%. The following are said to be key to reducing these figures; Timely recognition and diagnosis of sepsis, Fast administration of intravenous antibiotics, Quick involvement of experts including intensive care specialists. The Trust currently lacks robust data on the overall incidence of sepsis, including hospital acquired (CRBSI, VAP, HAP) although there is detailed surveillance of surgical wounds which is regularly analysed and reported resulting in the development of a Brompton Harefield Infection Score (BHIS[10]) which is being piloted with the aim of reducing SSIs in high risk patients (current rate for 2014 3.2%). The SSI reduction programme will be extended to include all wounds during the lifetime of this plan. This project will aim to acquire baseline data on the incidence of sepsis, the impact of introducing the

[8] https://www.rcplondon.ac.uk/resources/national-early-warning-score-news
[9] Alert reference number: NHS/PSA/R/2014/015
[10] Nursing Times Infection Control Award 2013

SEPSIS 6 system and compliance with it as well as improving antimicrobial stewardship. The overall plan for improving recognition and management of the Sepsis is shown in driver diagram 3.

ELDERLY CARE (>75years)

AIM: to improve the care and experience of elderly patients (and their carers / families) by reducing falls (30%), ensuring 95% compliance with agreed tools for management of dementia/ delirium and frailty by 2018.

The elderly are a recognised at risk group for many reasons. In particular our own data indicates that falls, dementia / delirium and overall frailty are key areas for attention. Between October 2013 and April 2014 there were 168 reported falls within the Trust. Management of frailty is especially pertinent when planning care and interventions and prevention of delirium and falls can be particularly challenging during the post-procedure period. We aim to address all three areas by re-convening a multi-disciplinary 'older people's steering group' which will manage this element of the SIP as part of its remit ensuring access to relevant data, appropriate literature review to seek solutions, implementation of best practice and use of QI methodology to develop interventions to reduce harm and improve patient experience in this vulnerable group. Whilst work is ongoing in relation to falls reduction, use of frailty scoring and prevention of delirium is inconsistently applied across the trust so the SIP will build on current activity in this area. The overall plan for improving elderly care is shown in driver diagram 4.

PRESSURE ULCERS

AIM; Zero new grade 3 or 4 pressure ulcers and 95% compliance with the SSKIN care bundle for relevant patients.

Pressure ulcers are major cause of distress, morbidity and prolonged hospital stay. Our overall pressure ulcer rate is significantly below the national average but in financial year 2013 136 new pressure ulcers were reported across the Trust and between April 2013 and December 2014 21 met the criteria for reporting as serious incidents. Whilst a proportion occur on sacrum, buttocks and heels a significant proportion occur in unusual body locations including the face (nose and ears from NIV masks) and nostrils and mouth (from endotracheal tubes) and occur in critical care areas. The SSKIN care bundle has been introduced across the trust with variable uptake and although some areas are performing very well with very few pressure ulcers reported other areas are finding it more challenging. Root causes analysis using the contributory factor framework shows that key areas for attention include assessment of pressure areas on admission (particularly for in-patient transfers), appropriate handover, documentation and review as well as ensuring preventive measures are implemented promptly. This element if the SIP will help us drive towards reducing all pressure ulcers with zero grade 3 or 4. The overall plan for zero grade 3 or 4 pressure ulcers is shown in driver diagram 5.

MEDICATION AND DEVICES SAFETY

AIM; to improve the trust medication incident reporting rate > 7.5 / 100 admissions, improve content of incident reports for devices and medication by 30%, ensure >95 % medication and devices incident reports meet reporting timescales, zero red & amber events

Medication incidents are the most frequently reported incident across the Trust and although harm is rare serious incidents and claims have resulted from avoidable medication related incidents. Within the acute specialist NRLS reporting group our trust reports higher than average numbers of medication related incidents. There is a close link between medication and devices particularly in relation to the use of infusion devices and so a joint approach is proposed to improve awareness of medication and device safety, enhance reporting in terms of content and timeliness and ensure feedback is provided so that staff get information and advice on how to reduce the risk of recurrence. In paediatrics a 'zero harm from medication incidents' has already been launched and we will link with this work to ensure a consistent and sustained approach. This work demonstrated that designation of a staff nurse as a medication safety champion was linked to a >50% reduction in omitted doses over a 3 month period in 2014 (local audit). Specific multidisciplinary training and education programmes are in development and link to the SIP will add impetus to this. In relation to devices 528 incidents were reported between Jan-Dec 2014 with at least one incident a contributory factor in a patient death. The Trust is implementing the recent NHS England Alerts on improving medication and device safety and will use these as a platform to improve, increase and enhance our understanding of the risks and opportunities to find solutions. The overall plan for improving medication and device safety is shown in driver diagram 6.

CANCELLATIONS

AIM; reduce avoidable cancellations for surgical intervention by 30% by 2018.

The trust has struggled to reduce cancellations for surgical interventions (over 8000 procedures performed pa across two hospital sites).Theatre and cardiac catheterization capacity together with effective pathway management, decision making and scheduling as well as staffing, beds and logistics all contribute to cancellations causing distress to patients, staff and the organisation as a whole. Currently the number of externally reportable cancellations is low but overall numbers are higher than acceptable (approximately 950 during 2013/14 between the two sites). This major project to reduce avoidable cancellations by 30% in the next 3 years will require robust data collection, analysis and feedback and a careful assessment and implementation of appropriate interventions and efficiency measures. The overall plan for reducing cancellations is shown in driver diagram 7.

PROCEDURAL COMPLICATIONS

AIM; to reduce avoidable complications of procedures and interventions by 30% by 2018

As a tertiary centre we undertake both routine and complex, well established and innovative procedures on patients of all ages from birth onwards. We are a recognized training centre for cardiac and respiratory specialties and have a significant research portfolio. We aim to ensure that patients are well informed about interventions and procedures and their expectations in relation to what can be achieved appropriately managed. Our claims history indicates that a proportion of our claims (low value) have failure to warn or intra-procedural complications as underlying causes. Whilst specific interventions to prevent recurrence may not be obvious it is clear that there are 2 key areas worthy of exploration and development; communication training particularly in relation to consent and human factors training for interventional teams. The Trust has initiated generic human factors training in some areas particularly PICU with significant success but we wish to expand this to other areas and groups. The overall plan for reducing avoidable complications of procedures and interventions is shown in driver diagram 9.

Appendix B

Royal Brompton and Harefield NHS Foundation Trust

'SIGN UP TO SAFETY' Pledges

'Listen, Learn, Act'

'Sign up to Safety' is a national initiative hosted by NHS England with the aim of delivering harm free care to every patient and halving avoidable harm over the next 3 years. All healthcare providers, individuals and organisations, are eligible to join and membership requires commitment to develop a **Safety Improvement Plan** (SIP) based on 5 pledges; **putting safety first, continually learning, honesty, collaboration and supporting staff and patients when things go wrong**. Within RBHNFT, development and implementation of a Safety Improvement Plan based on the 5 pledges will contribute to the Safety Domain of our **Quality and Safety Strategy 2015-18.**

By joining the '**Sign up to Safety'** Initiative the Trust confirms its commitment to improving quality and safety by;

- Describing the actions we will undertake linked to the five pledges
- Developing a Safety Improvement Plan to reduce avoidable harm and death
- Identifying those areas on which we will focus our improvement efforts
- Setting out how we will engage with and involve patients, staff and the public
- Making our Safety Improvement Plan public and regularly providing updates on our progress

Over the next 3 years the Royal Brompton and Harefield NHS Foundation Trust pledges to;

1. **Put Safety First- commit to reduce avoidable harm and make public our goals and plans**
    a. Achieve significant reduction in the incidence and impact of **acute kidney injury** through a suite of measures to improve recognition, prompt early **documented consultant review** and appropriate management especially in at risk groups e.g. **diabetic patients**.
    b. Further develop the **NEWS & PEWS** systems for monitoring adult and paediatric patients to ensure prompt identification, escalation and management of deteriorating patients
    c. Implement national guidance for the identification and management of **sepsis** by integrating a sepsis scoring system into our adult and paediatric EWS protocols and continue work to reduce **Surgical Site Infections and Hospital Acquired Infections**
    d. Improve care of the elderly (>70 yrs) with emphasis on reducing falls and improving care and management of delirium, dementia and frailty.
    e. Set stretch goals of **zero never events** and 30% reduction in **procedural complications**
    f. **Zero new grade 3 & 4 pressure ulcers**
    g. **Improve reporting** of incidents relating to **medication & devices** as part of a program to improve medication and device safety

h. Develop a comprehensive approach to accessing and acquiring **patient experience feedback** on all aspects of their care

2. **Continually Learn- make our organisation more resilient to risks by acting on feedback from patients and continuously measuring how safe our services are**
    a. Make the Trust more resilient identifying areas of risk through review of SIs and incidents linked to PALS, complaints, claims, inquests and patient experience feedback
    b. Ensure recommendations and action plans from SIs, complaints & clinical audit are realistic , implemented in a timely manner, monitored through continuous tracking of recommendations and actions and reported regularly
    c. Improve capacity & capability for quality improvement by providing access to training for staff
    d. Develop Q&S dashboards for hospitals and divisions
    e. Make quality, performance and outcome data available through divisional reports, intranet and internet pages

3. **Honesty- be transparent with people about progress tackling patient safety issues and support staff to be candid with patients and their families if something goes wrong.**
    a. Acknowledge when things go wrong – between staff, colleagues, teams, management and clinicians and with patients.
    b. Promote awareness of our Duty of Candour as an organisation and as healthcare professionals ensuring openness and transparency with patients supported by appropriate documentation & correspondence
    c. Support for staff in relation to writing of statements, psychological & professional support and training and education
    d. Provide training in Being Open for relevant staff

4. **Collaboration - take a leading role in supporting local collaborative learning so that improvements are made across all the local services that patients use.**
    a. Work with Commissioners to ensure safe high quality care
    b. Work with, engage and involve patients through bespoke events, committees and patient panels to ensure their views are acknowledged and used to guide service delivery and development
    c. Commit to the NHS England 'Sign up to Safety' initiative
    d. Become an active participant in the Imperial College Health Partners Patient Safety Collaborative
    e. Open an Institute for Healthcare Improvement (IHI) Open School chapter at RBHNFT with plans to spread across the Trust and partner organisations.
    f. Continue to develop links with Liverpool Heart and Chest NHSFT via ICMS
    g. Continue to share our experience of innovation and research

5. Support

a. Continue to develop and implement Human Factors and Simulation Training for all staff groups
b. Continue to promote reflective practice and feedback through clinical governance sessions and Schwartz Rounds
c. Continue to use a Staff Safety Climate Survey and ensure each clinical unit addresses one action for improvement.
d. Develop clear guidance for Junior staff (all professions) for reporting and investigation of incidents
e. Enhance new consultant induction, mentoring and introduction to the Trust

Driver Diagram for Safety Improvement Implementation Plan

Safety Improvement Plan RBHNFT 2015-18