A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality report

2018-19

Contents

Part One

Statement from the Chief Executive

This quality report sets out the approach we are taking to improve the quality and safety of services we provide at Royal Brompton and Harefield NHS Foundation Trust. Our overarching priority is to provide all of our patients with high quality, safe care and to learn from any mistakes that we make.

We work hard to achieve improvements and are proud of our culture of excellence. We believe that this can be demonstrated by the successes of our staff over the last year:

- 95% of the patients who completed the Friends and Family Test told us that they would recommend our services to their family and friends
- We have increased the number of patients completing the Friends and Family Test by extending the use of technology to help collect information from patients
- We achieved a rating of 'Good' in our Care Quality Commission inspection undertaken in 2018
- During 2018-19, the cardiac rehabilitation programme based at Harefield Hospital was certified as achieving compliance with all the minimum standards for cardiac rehabilitation
- Our Clinical Genetics and Genomics team have joined a new genetic testing network that is set to revolutionise the way rare genetic diseases are identified across South London and the South East
- Our pulmonary rehabilitation programme at Harefield Hospital, the largest single-site programme in the UK, now receives more than 1000 patient referrals per year
- More of our patients (53%) now undergo a catheter lab procedure in one day, rather than staying overnight and our staff are committed to making this service available to more of our patients
- The average length of time children wait in outpatient clinics has been reduced by 15% following a project by Royal Brompton teams to identify and solve problems that result in delays
- More than 120 cardiac and thoracic patients have so far benefited from a project that means they have surgery on the day of admission rather than arriving at hospital the night before
- Harefield's new day of surgery unit is proving popular with patients – with 100 per cent positive feedback in its latest patient survey
- Lind Ward, at Royal Brompton Hospital, has transformed into a day case-only ward and the introduction of new "one-stop shops" for interstitial lung disease (ILD) and asthma clinics has dramatically reduced the number of patients needing to stay in hospital overnight

We know that the open and supportive culture across our organisation is key to helping us ensure that we continue to learn as an organisation. Knowing how important it is for us to maintain this culture, our Health and Wellbeing Improvement Plan initiative will focus on creating a positive work place environment.

We are proud of the work our clinicians have undertaken to ensure that learning from deaths is shared across the whole organisation. Over the next year we will build on this work and fully implement the Royal College of Physicians (RCP) 'Structured Judgement Review' process to review the care of adult patients who die at Harefield Hospital.

During the last year our operational and informatics teams focussed on improving the quality of our performance, particularly Referral to Treatment Time (RTT) data. We made significant improvements in this area and will continue to make further improvements in the year ahead.

During 2019-20, our multi-disciplinary teams will continue to work together to ensure we learn from incidents and near misses and to ensure that our reporting rates are above the national average.

This year, during Infection Control Awareness week our infection control team led a targeted programme looking at hand hygiene and catheter care with education and support for all staff groups. During 2019-20 our infection control team will lead our work to maximise our learning from our reviews of reportable infections.

Finally, all that remains for me to say is that I am confident that the information in this quality report accurately reflects our achievements during 2018-19 and reflects the quality of the services we provide to patients.

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Robert J Bell
Chief Executive

23rd May 2019

Part Two

Our quality priorities

Our ambition to provide world-class clinical services, education and research is embedded in our strategic objectives and organisational values. We recognise that our work with our partners is essential in helping us improve the health of the patients that we serve, and we are committed to continuing to strengthen this work during 2019-20.

Our quality priorities have been developed to reflect the goals of our organisation and the emerging picture of specialist healthcare delivery.

Our chosen priorities for 2019-20 have been developed and agreed by our clinically led Governance and Quality Committee and agreed by our Risk and Safety Committee, which acts on behalf of our Trust Board.

The chosen priorities to support the key national quality themes are:

Patient Safety

Implementation of NEWS2

Identification and management of patients with sepsis

Identification and management of patients with acute kidney injury (AKI)

Clinical effectiveness

Learning from deaths – implementation of a new mortality database in Datix

Learning from deaths – use of Structured Judgement Review (SJR) tool to review inpatient deaths

Avoidable cancellations for surgery – reduction in the number of avoidable cancellations for surgery

Patient experience

Staff welfare – implementation of a Health & Well-being Improvement Plan

Learning from deaths – implementation of a Medical Examiner role for the Trust

Avoidable cancellations for surgery – improvement in the views of patients and families with regards to the communication around cancellations for surgery

Progress against our priorities for 2018-19

Patient safety: Managing the acutely ill patient

Our quality priorities and why we chose them	What success would look like	How did we do
NEWS[1] This was chosen as a quality priority following our Care Quality Commission (CQC) inspection in 2016, which highlighted that the Trust should have a more robust approach to the identification and management of the deteriorating patient.	Achieve above 95% accuracy in recording and calculating of NEWS scores.	All wards have consistently achieved above 90% accuracy in the recording and calculating of NEWS scores, and this improvement was recognised by the CQC inspection team in 2018. In addition, funding was agreed for a new electronic patient observation system, which we anticipate will help us quickly to identify if the clinical condition of a patient is deteriorating.
Sepsis This was chosen as a quality priority following our CQC inspection in 2016, which highlighted that the Trust should have a more robust approach to the identification and management of the deteriorating patient.	Achieve above 95% compliance with meeting the national sepsis 6 standards for managing patients suspected of sepsis	We started our work on monitoring compliance with Sepsis 6 in August 2018. Our audits show us that we have achieved above 90% compliance in 5 of the standards and 83% compliance with the fluid challenge standard. Whilst our audit results do show that we are recognising the signs of sepsis in a timely way, we recognise that we still have improvements to make in meeting all of the Sepsis 6 standards.
Acute Kidney Injury[2] This was chosen as a quality priority following our CQC inspection in 2016, which highlighted that the Trust should have a more robust approach to the identification and management of the deteriorating patient. In addition, the Getting it Right First Time[3] report for Cardiothoracic Surgery identified the Trust as an outlier in its use of renal replacement therapy post-surgery.	Reduce the use of renal replacement therapy to bring the Trust in line with other, similar centres	We have examined how we care for patients with acute kidney injury and identified areas requiring improvement. Over the last year our clinical teams have been working to make the improvements that we agreed but we are aware that we need to continue this work during the coming year. The need for this is also reflected in the latest national results published by the national case-mix audit (ICNARC)[4] which does show that we continue to have a higher rate of renal therapy after surgery than other centres.

[1] National Early Warning Score (NEWS) Royal College of Physicians
[2] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Adding Insult to Injury 2009
[3] https://gettingitrightfirsttime.co.uk/
[4] Intensive Care National Audit & Research Centre, https://www.icnarc.org/

Clinical effectiveness: Developing our culture

Our quality priorities and why we chose them	What success would look like	How did we do
5 steps to safer surgery in theatres[5] This was chosen as a quality priority following our CQC inspection in 2016, which highlighted that the Trust should have a more robust approach to implementing this programme, especially the approach to briefing (step 1) and debriefing (step 5).	Achieve above 90% compliance consistently with all 5 steps, across all theatres in the Trust.	Our monthly compliance audits told us that in all theatres we did achieve above 90% compliance with the 5 steps to safer surgery. Although we didn't achieve the 90% target consistently, there has been a significant improvement in the approach to completing this by staff across all areas. This was recognised by the CQC inspection team when they visited in 2018. We will continue to undertake regular audits to review our performance and our local quality teams will continue to support the clinical teams to consistently achieve the 90%. Because of the improvements we have achieved this will not be a one of our quality priorities in 2019-20.
5 steps to safer interventions in catheter laboratories. The 5 steps for safer surgery programme was developed specifically for the theatre environment. However, recognising that the catheter laboratory is a similar environment to theatres, with similar potential risks to patient safety, the Trust has developed a similar programme and set of standards for patients going through the catheter laboratories.	Achieve above 90% compliance across all catheter laboratories in the Trust	The catheter laboratories have been consistently achieving above 90% compliance with all 5 steps for the majority of the year. We will continue to undertake regular audits to review our performance and our local quality teams will continue to support the clinical teams to consistently achieve the 90%. Because of the improvements we have achieved this will not be a one of our quality priorities in 2019-20.

[5] 5 Steps to Safer Surgery, Royal College of Surgeons

Patient experience

Our quality priorities and why we chose them	What success would look like	How did we do
Bullying and harassment We believe for patients to have the very best experience with us; our staff must also be well supported. This was a priority for us in 2018-19.	The plan for 2018-19 was to continue to support the initiatives started in 2017-18 ensuring that there is awareness of them and that we track progress against them as we educate and transform. This is tracked predominantly through the NHS Staff Survey but also through local measures specific to individual teams. As we collect more granular data on absence, turnover, exit logic and workplace stress we can combine data streams to provide a richer data picture of the organisation and its culture in this regard.	In December 2017 we launched a series of initiatives beginning with education through a programme called 'The way we treat each other at work' structured as a value-led workshop for teams. It was launched at governance days across the Trust and over 400 people underwent training. At the same time, we transformed our policies and processes for harassment and bullying and invested in an independent case management team that handled the complaints to make it easier for people to raise an issue and for the complaint to be investigated in a timely and transparent way. The new policies guiding the management of such complaints offer a formal and "informal" route for resolution. Informal means a mediation to resolve the problem that is private and confidential. We invested in ACAS-led training to establish a mediation service to ensure the mediations were delivered professionally and fairly. 17 employees were trained to deliver the service. In 2017-18 64% of staff who said they had experienced harassment and bullying did not report it. Over the past year the case management team has seen a significant increase in the number of harassment and bullying cases reported, the majority of them are resolved through mediation. Staff tell us they feel far more confident to report an issue when it arises and challenge behaviour when is unaligned to our values. When a formal complaint is made and upheld there is a further training called 'Coaching for Bullies' that is available to change behaviour as well as the more formal disciplinary sanctions. As expected, the reported incidence of harassment and bullying has shown only a slight worsening of the position in two of the harassment and bullying questions (from service users, relatives, members of public; colleagues) but has seen a slightly improved

		position in terms of staff saying they have experienced bullying from their manager. The new Employee Assistance Programme continues to provide counselling to staff 24 hours a day, and a new, "time to change" pledge underlines the Trust's commitment to mental health. Our Freedom to Speak Up Guardian[6] has continued to help us promote an open and honest reporting culture within the Trust. In addition to the work of our Freedom to Speak Up Guardian, our Chief Executive holds regular staff forums where staff can raise issues and concerns. Content from these sessions is published on Trust intranet. Our Directors hold 'town hall' style events where staff can raise issues and concerns. Our Directors also undertake a formal program of Executive Walk Arounds; each Director is assigned a specific area or department where they meet staff and listening to concerns, as well as ask about staff wellbeing. We have a programme of Schwartz Rounds in place. These are confidential and are an arena where staff can raise issues and concerns about clinical care. In addition to all of the above, we have a robust whistleblowing policy that incorporates freedom to speak up and sets out the guiding principles that ensure staff don't suffer detriment when they speak up.
	Continue to deliver Human Factors training	The Human Factors training course has continued to run once a month on each site and is highly regarded with 100% of staff who have attended saying they would recommend it. A further cohort successfully completed the Human Factors training course, ensuring the faculty now has enough staff to deliver the programme. As well as the monthly sessions open to all staff, a bespoke session was arranged for intensive care and surgical staff at Royal Brompton, which was very well-received.

[6]Freedom to speak up: whistleblowing policy for the NHS

Our quality priorities for 2019-20

Patient safety

Our quality priorities and why we chose them	What success will look like
Implementation of NEWS2 There is a new national tool identifying and managing deteriorating patients called NEWS2, which will be identical in all trusts, to support staff who work across multiple organisations. This was rolled out in the Trust late in Spring 2019, and implementation will be a key focus in 2019-20.	Achieve above 90% accuracy in recording and calculating of NEWS2 scores. Undertake a successful tender process for the purchase of a new electronic patient observation system. Using NEWS2 is an important development, as this national tool has been developed to improve patient safety by ensuring the same tool is used in all hospitals. Therefore staff who work across multiple sites are always familiar with it and are able to use it correctly to identify if a patient's condition is deteriorating and take appropriate action. Having an electronic patient observation system will provide a real step-change in the delivery of high-quality care to patients, by minimising the chance of human error in using the NEWS2 tool; and by the use of prompts to guide staff into taking appropriate action when necessary.
Identification and management of patients with sepsis This quality priority is continuing from 2018-19, as part of the Trust's ongoing commitment to improvement the identification and management of the deteriorating patient.	Appointment of a Sepsis Clinical Lead for the Trust, development of an approved plan for identifying and managing sepsis across the Trust, successful implementation of the first steps of that plan. Achieve above 90% compliance with the sepsis 6 standards for patients suspected of sepsis. Patients suspected of sepsis should have 6 actions taken within one hour of sepsis being suspected. Completing these actions reduces the chance of the patient dying from sepsis.
Identification and management of patients with acute kidney injury (AKI) This quality priority is continuing from 2018-19, as part of the Trust's ongoing commitment to improvement the identification and management of the deteriorating patient.	Appointment of an AKI Clinical Lead for the Trust, development of an approved plan for identifying and managing AKI across the Trust, successful implementation of the first steps of that plan. Reduce the number of patients requiring renal replacement therapy post-surgery.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like
Learning from deaths The Trust has a policy of reviewing all inpatient deaths across the organisation. The approach to this varies across the different clinical specialties, although the key information is stored on the Trust's mortality database. A review of these systems in 2018-19, found that the mortality database was not fit for purpose, and could not easily link to other related information such as incidents and complaints. This has limited the Trust's ability to look holistically at the care provided to identify themes and areas for improvement. In late 2018-19, funding was approved to purchase a new mortality database, which is fit for purpose.	Implementation of the new mortality database in Datix. By the end of 2019-20, mortality review documentation from all areas of the Trust is stored electronically on this database. This means that we will have all the data in one place and cross-referencing with other sources of information about care such as incidents and complaints will be much easier and quicker. It will be easier to identify any common themes across different clinical specialities where we could improve our care.
Use of Structured Judgement Review (SJR) tool to review care of patients who have died in hospital This tool has been nationally developed by the Royal College of Physicians to give a standardised approach to the review of patients who have died in hospital, focusing on assessing each phase of care, and identifying any improvements in management that could have been made. In 2018-19 this tool was successfully trialled in some areas of the Trust.	By the end of 2019-20, the SJR tool is used across all areas of the Trust. This means that we will be using a consistent approach to reviewing our care of patients who have died in hospital, and it will be easier to identify any common themes across different clinical specialities where we could improve our care.
Avoidable cancellations for surgery Occasionally surgery for a patient has to be cancelled at short notice. The Trust has identified this as an area where it would like to do better, and will be looking at the whole pathway to identify where the current approach could be improved and will lead to the service being more efficient and effective.	A reduction in the number of avoidable cancellations for surgery in 2019-20, compared to 2018-19. This will benefit patients and families directly, as having a procedure cancelled can be very difficult when arrangements have been made around a particular date.

Patient experience

<table>
<tr><th>Our quality priorities and why we chose them</th><th>What success will look like</th></tr>
<tr><td>Staff welfare – implementation of a Health & Well-being Improvement Plan
The Trust will continue with the approach taken in 2018-19 and promote Values-led leadership through the Trust. When incidents do arise, staff will continue to have confidence in their claims being taken seriously and investigated.</td><td>Like most NHS organisations harassment and or bullying continues to be a concern for us and is an element of our culture that we are focused on removing. Our staff continue to report that they experience bullying and harassment at work and this is reflected in our 2018 annual staff survey, show in the table below.
<table>
<tr><th>Question No.</th><th>Item</th><th>2018</th><th>2017</th></tr>
<tr><td>15a</td><td>Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public</td><td>78%</td><td>79%</td></tr>
<tr><td>15b</td><td>Not experienced harassment, bullying or abuse from managers</td><td>87%</td><td>85%</td></tr>
<tr><td>15c</td><td>Not experienced harassment, bullying or abuse from colleagues</td><td>76%</td><td>76%</td></tr>
<tr><td>15d+</td><td>Last experience of harassment/bullying/abuse reported</td><td>41%</td><td>40%</td></tr>
</table>
We started a programme of work to reduce bullying and harassment in 2017 and will continue our work for many years as we recognise that this type of cultural change takes a significant amount of time to achieve. We will continue with the approach taken in 2018 and promote values led leadership through the Trust. When incidents do arise, staff will continue to have confidence in their claims being taken seriously and investigated.
The most significant further initiative for 2019-20 will be in the implementation of a Health and Wellbeing Improvement Plan. This will be a wide-ranging plan that will deal with issues within the workplace that affect staff's health and wellbeing. It will be look at team development and how teams can support each other; management development and how to create a positive work environment and have difficult conversation with staff in the right manner; supporting staff by helping them to deal with the emotional demands of work; individual development and supporting staff to progress.
This initiative is primarily concerned with developing and maintaining a supportive and developmental working environment. Within that environment there is much</td></tr>
</table>

	reduced incidence of harassment and bullying but if it does occur then staff feel confident to report it and for it to be addressed. This is a significant initiative that will require time to implement and embed but it is essential to build on the recent developments to tackle Harassment and Bullying creating a safe working environment for all our staff.
Medical Examiner role Following a successful pilot in 3 hospitals, there is a national requirement to look at improving the way death certificates are written to ensure there is a consistent, accurate approach and that they are produced in a timely manner. The key part of this will be the creation of the role of a Medical Examiner for the Trust, who will have a number of responsibilities, including liaising with the bereaved family or next of kin within 24 hours of a patient dying in hospital, and before the death certificate is written.	By the end of 2019-20, a Medical Examiner post is in place. Monitoring of number of death certificates produced within 24 hours of death. This will directly benefit bereaved families, by ensuring we have a consistent, standardised approach in line with national requirements, for reviewing patient care, identifying cause of death and liaising with families in the first 24 hours after a patient has died.
Avoidable cancellations Occasionally surgery for a patient has to be cancelled at short notice. This can cause disruption and distress for patients and families who have planned around a specific timeframe. The Trust would like to do better in this area and will be looking specifically at how we communicate with patients and families about their surgery and cancellations.	Improvement in the views of patients and experience of families in relation to avoidable cancellations. This will benefit patients and families directly, as having a procedure cancelled can be very difficult when arrangements have been made around a particular date. Understanding the challenges from the patient/family perspective will help us improve how we communicate information.

We will monitor the implementation of our quality priorities through the governance structures that we have in place within the Trust and we will ensure that we update our Council of Governors on our progress during the year.

Statement of assurance from the Board of Directors

This section of our annual quality report contains the statutory statements about the services we provide at Royal Brompton and Harefield NHS Foundation Trust. These statements are required in all quality reports and can be used to compare us with other organisations.

A review of our services

During 2018/2019, Royal Brompton and Harefield NHS Foundation Trust provided and/or subcontracted 37 relevant health services.

We have reviewed all the data available to us on the quality of care in 37 of these relevant health services through our management and assurances processes. The income generated represents 100% of the total income generated from the provision of relevant health services by the Royal Brompton and Harefield NHS Foundation Trust for 2018/2019.

Seven-day services

Providing seven-day hospital services is one component of achieving NHS England's ambition to ensure that patients receive consistent high-quality safe care every day of the week. The ten national clinical standards essential for providing a seven-day hospital service were developed with the support of the Academy of Medical Royal Colleges. Four of these standards were made a priority nationally for acute and specialist Trusts to achieve:

- Standard 2: Time to initial consultant review (first consultant review within 14hrs)
- Standard 5: Access to diagnostics (consultant-directed diagnostics)
- Standard 6: Access to consultant-led interventions
- Standard 8: Ongoing daily consultant-directed review (based on job plans, robust MDT and escalation protocols, local audits)

During 2018-19, we have been working with our clinical and management teams to implement the priority standards and the additional six standards. This work has been guided by an initial assessment that we undertook in the Spring of 2018.

NHSE and NHSI have recently changed how we report our compliance with the standards, and we are now in the process of fully implementing the new national assurance framework. We will report a full, self-assessment of our compliance with these standards to our Trust Board during 2019-20.

Freedom to Speak Up

We recognise how important it is for staff to be able to raise concerns without the worry that they will suffer detriment. To help us ensure that we have a healthy culture in which staff can raise issues and concerns, we undertook a self-assessment during 2018 to see how well we were doing and to identify areas for improvement. To help us with this self-assessment we used the assessment tool published by NHS Improvement and the National Freedom to Speak Up Guardian.

Our self-assessment confirmed that Freedom to Speak Up is embedded in the Trust's strategy and policies and is not a standalone initiative. However, our self-assessment also confirmed that we need to look again at the arrangements we have in place to ensure that all of our staff have easy access to someone who they can speak with when they have concerns.

We detailed earlier in this report some of the different ways that we have been working with staff to help them speak out about concerns and our plans for how we will continue this work during 2019-20. The learning from our Freedom to Speak Up self-assessment has helped inform our plans to implement a Health and Wellbeing Improvement Plan during 2019-20.

Participation in clinical audit and national confidential enquiries

Every year a list is published by Healthcare Quality Improvement Partnership on behalf of NHS England. This list details the national clinical audits, clinical outcome review programmes and other quality improvement projects which NHS England advises Trusts to prioritise for participation. We are then required to detail these in our Annual Quality Report.

Because of the specialist nature of the services we provide, not all audits, programmes and initiatives are relevant to us and we therefore do not participate in these.

A clinical audit reviews services against agreed standards of care and identifies any improvements that may be necessary

National confidential enquiries review clinical practice, in areas where standards may not exist, and recommend areas for improvement

During 2018-19 there were 30 national studies that were relevant to us as they related to the health services we provide. The list of the national clinical audit studies that we participated in is shown below, including the percentage of our eligible cases that we submitted to the study.

National Clinical Audit Programme	% of eligible cases submitted
Adult Cardiac Surgery	100%
Cardiac Rhythm Management (CRM)	100%
Case Mix Programme (CMP)	100%
Learning Disability Mortality Review Programme (LeDeR)	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	100%
Myocardial Ischaemia National Audit Project (MINAP)	100%
National Asthma and COPD Audit Programme	100%
National Audit of Cardiac Rehabilitation	100%
National Audit of Care at the End of Life (NACEL)	100%
National Audit of Percutaneous Coronary Interventions (PCI)	100%
National Audit of Pulmonary Hypertension	100%
National Cardiac Arrest Audit (NCAA)	100%
National Comparative Audit of Blood Transfusion programme	100%
National Congenital Heart Disease (CHD)	100%
National Diabetes Audit – Adults	100%
National Emergency Laparotomy Audit (NELA)	100%
National Heart Failure Audit	100%
National Lung Cancer Audit (NLCA)	100%
National Neonatal Audit Programme (NNAP)	100%
National Vascular Registry	100%
Non-Invasive Ventilation – Adults	100%
Paediatric Intensive Care (PICANet)	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	100%
Seven Day Hospital Services	100%
Surgical Site Infection Surveillance Service	100%
UK Cystic Fibrosis Registry	100%
Child Health Clinical Outcome Review Programme	100%
Medical and Surgical Clinical Outcome Review Programme	100%

All national clinical audit reports published during 2018-19 are reviewed by clinicians from the relevant specialist services and actions for improvement are developed as required. One of the national clinical audit reports that our teams are currently reviewing is:

National Lung Cancer Audit:	This study looks at the care of patients with lung cancer and results are used to drive improvements in the quality of care for people with lung cancer

We submitted a full data set to this study in 2017. No key national recommendations have been produced at the time of writing our annual quality report. However, the Lung division have received the national audit report and are considering how our results compare with other Trusts and how we can work to improve our services for patients with cancer.

During 2018-19, two National Confidential Enquiry studies into Patient Outcome and Death (NCEPOD) related to services provided by us. These were:

Long Term Ventilation	The aim of this study is to identify remediable factors in the care of patients before their 25th Birthday who are receiving, or have received, long-term ventilation (LTV). Data collection is currently underway for this study; and the Trust intends to submit a full dataset. The final report is due to be published in November 2019.
Pulmonary Embolism	The aim of this study is to identify and explore avoidable and remediable factors in the process of care for patients diagnosed with pulmonary embolism. The Trust submitted a full dataset, and the final report is now awaited – due to be published in July 2019.

In addition to the above two National Confidential Enquiry studies undertaken during 2018-19, the following two study reports were published:

Acute Heart Failure – failure to function:	This national study looks at care for patients admitted to hospital with acute heart failure.

We submitted a full dataset to this study in 2017. The key recommendations from this study are shown below.

- Patients need better access to heart failure specialists. Our patients already have access to a highly skilled heart Failure specialist team on both sites. However, we are looking at how we can further improve our working relationship with referring hospitals to better support a wider group of patients.
- There should be improvement in the investigation of these patients, especially in the use of a diagnostic test for serum natriuretic peptide measurement and in the use echocardiogram. We already routinely use both these investigations for patients under our care.
- Patients with advanced heart failure should have access to a specialist, multi-disciplinary palliative care team. We already provide this routinely; but are looking at whether we can do more to support patients and their families at an earlier stage of their disease pathway.

We are currently considering improvements we need to make as a result of these national recommendations and will implement these during 2019-20.

Perioperative Diabetes – High and Lows:	This study looks at the management of with patients with diabetes from elective referral to surgery or admission to hospital as an emergency, to discharge from hospital.

We submitted a full dataset to this study in 2017. The key recommendations from this study are shown below.

- Organisations need to provide better continuity of care for patients with diabetes who undergo surgery. We are looking at whether we can improve our planning and management for patients with diabetes who require surgery by developing a care plan for them as part of their surgery pre-assessment.
- The management plan for a patient with diabetes undergoing surgery should include their prioritisation on the operating list. A review of this will be built into a project for 2019-20 looking at optimising the surgical pathways.
- Patients with diabetes undergoing surgery should have more regular monitoring of their blood glucose. We believe we already provide a high level of monitoring of blood glucose for patients with diabetes requiring surgery – in the pre, intra and post-operative phases. However, as a result of this study, we will look again at this area, to see if further improvements can be made.

We are currently considering improvements we need to make as a result of these national recommendations and will implement these during 2019-20.

In addition to participation in national studies, each clinical care group is also required to take an undertake local clinical audits based on local priorities. Each care group is also required to review, and where appropriate, audit compliance with NICE guidance. This work is supported by the divisional quality and safety teams and performance is monitored through the divisional quality governance structure.

We recognise that we need to strengthen our governance and assurance framework for clinical audit and we will be undertaking this work during 2109-20, including the appointment of a new Chair for our Clinical Effectiveness and Standards Oversight Committee.

Clinical research

Our vision is ...

"... be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world.".

As a specialist 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. Part of the overall mission of the Trust is 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".

We are committed to carrying out pioneering research to help develop the best treatments and cures for complex lung and heart diseases. We believe that, as a specialist centre focusing on heart and lung disease across all age ranges, staying at the forefront of research and innovation is vital to the delivery of our services.

Over 2200 patients have been recruited to participate in research approved by a research ethics committee during 2018/19. At the end of the financial year, the Trust was participating in over 150 research projects including global studies sponsored by industry, trials involving new medicines or devices, and international registry studies compiling research data for better patient outcomes.

Of the 2200 patients, over 2100 were recruited into NIHR portfolio studies (commercial and non-commercial). In addition, patients were consented to donate their tissue for retention within the Trust's ethically approved biobanks (Respiratory Biobank, Cardiovascular Biobank and Diagnostic Archive).

We are proud that we consistently perform well in the sector against our national objectives, consistently ranking second to Imperial College Healthcare NHS Trust for number of open commercial clinical trials in North West London, and exceeding the target set by the NIHR for recruiting to time and on target.

Our National Institute for Health Research (NIHR) Facility helps us to ensure we deliver world-leading research for the direct benefit to our patients. In addition, we are proud that our work with Kings Health Partners, Liverpool Partnership and Imperial College helps benefit individuals both nationally and internationally.

We have worked with our clinicians to integrated research into the day to day work of our clinical teams and each of our clinical care groups has a lead whose role is ensure we meet our strategic research goals:

- To support and develop research-active staff
- To exploit opportunities to attract and retain research funding
- To promote and increase engagement in Trust research
- To provide effective and well managed research facilities, research resources and administrative support.

Our commissioning for quality and innovation (CQUIN) performance

In this section of the report we are required to confirm how much of our income in 2018-19 was conditional on us achieving agreed quality improvement and innovation goals. We are also required to confirm how much of our income last year, 2017-18, was as a result of quality improvement and innovation goals.

We can confirm that we received an income of £4,425,488.00 as a result of achieving quality improvement and innovation goals for 2017-18.

Any provider of healthcare services commissioned under an NHS Standard Contract is eligible for CQUIN payments. The maximum monetary value of a CQUIN is 2.5% of the annual contract to provide services.

We had two CQUIN schemes in place during 2018-19. For both schemes, a proportion of our income was conditional on us achieving quality improvement and innovation goals. One CQUIN was with NHS England and our second CQUIN was with our local Clinical Commissioning Groups (CCGs).

The scheme linked to the services that NHS England contracts us to provide was worth 2% of our annual contract. The scheme linked to services that our local Clinical Commissioning Groups contract us to provide was worth 2.5% of our annual contract. More information about our CQUIN schemes is available on our website https://www.rbht.nhs.uk/about-us/our-performance

Within this report we are showing our 2018-19 Quarter 3 position as final confirmation was not available at the time of writing.

For our CQUIN with NHS England, we have submitted our evidence and are expecting to agree a maximum 96.5% achievement of the CQUIN. For the 'shared decision making' element of the CQUIN we were unable to recruit patients and have therefore only achieved 50% in this element of the CQUIN. The details for this CQUIN are shown in the table below.

NHS England CQUIN				
Scheme	**Weighting**	**Total value £**	**Annual Achievement (estimated)**	**Total claimed to end of Q3**
Clinical Utilisation Review	0.65%	£1,093,010	100%	£820,432
Severe Asthma	0.20%	£336,588	100%	£286,099

Complex Devices	0.26%	£437,564	100%	£328,173
Shared Decision Making	0.12%	£201,953	50%	£75,732
Paediatric Networked Care	0.15%	£252,441	100%	£126,219
CF Adherence	0.10%	£168,294	100%	£126,220
Medicine Optimisation	0.52%	£875,128	100%	£433,188
Enhanced Supportive Care	local	£334,123	100%	£250,592
Total	**2.00%**	**£3,700,000**		**£2,446,659**

The information shown below is our performance against our CQUIN targets with our local Clinical Commissioning Groups. This is the final year of a 2-year CQUIN and schemes for 2019-20 are currently being discussed. The information is based on an estimate to Q4, using Q3 information that we have already received.

At the time of writing, we anticipate receiving 83% of the payment for this CQUIN for 2018-19 (around £880k). We are also eligible to receive £532k for our NWL Sustainability and Transformation Partnership (STP) engagement CQUIN.

Local Clinical Commissioning Groups CQUIN				
Scheme	**Weighting**	**Total annual value £**	**Annual Achievement (estimated)**	**Total funding received (estimate to Q4)**
Improving staff health and wellbeing:		**£133,065**		**Q4 CQUIN only**
(i) improvement in the annual staff survey	0.10%	£44,355	Being confirmed	Being confirmed
(ii) Healthy food for NHS staff, visitors and patients	0.10%	£44,355	100%	£0
(iii) Improving uptake of flu vaccination for frontline clinical staff	0.10%	£44.355	Q4 TBC	£22,178
Sepsis:		**£133, 060**		
(2a) Timely identification of patients with sepsis in emergency departments and acute inpatient settings	0.078%	£33,265	Q4 TBC	£28,274
(2b) Timely treatment of sepsis in emergency departments and acute inpatient settings	0.078%	£33,265	Q4 TBC	£23,285
(2v) Assessment of clinical antibiotic review between 24-72 hours	0.078%	£33,265	100%	£33,265
(i2d) Reduction in antibiotic consumption per 1,000 admissions (Q4 only)	0.078%	£33,265	100%	£33,265
Advice & Guidance	0.31%	**£133,261**	100%	£133,261
Preventing ill health by risky behaviour:		**£133,060**		
(a) Tobacco Screening	0.015%	£6,653	100%	£6,653

(b) Tobacco brief advice	0.062%	£26,612	100%	£26,612
(c) Tobacco referral and medication	0.078%	£33,265	0%	£0
(d) Alcohol screening	0.078%	£33,265	100%	£33,265
(e) Alcohol brief advice or referral	0.078%	£33,265	50%	£8,316
Sustainability and Transformational Plans (STP):		**£532,244**		
Engagement in the NWL STP	1.25%	£532,244	100%	£532,244
Total	**2.50%**	**£1,064,486**		**£880,618**

As the table above shows, there are two schemes within our CQUIN with our local Commission Groups that we have not fully achieved:

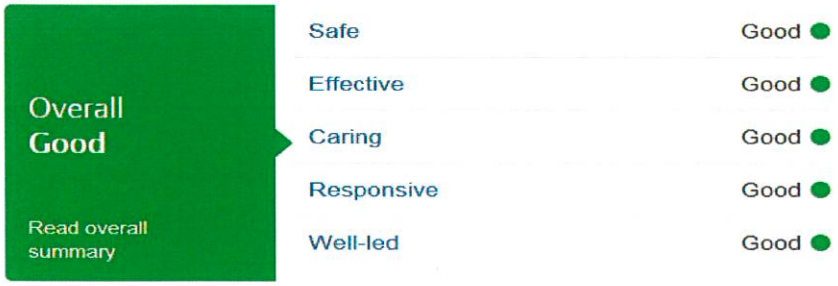
Scheme	Explanation
Tobacco referral and medication	Due to the specialist nature of our services we do not have the ability to refer patients into local smoking cessation services. However, we do provide patients with information on how to stop smoking and we do notify GPs when patients may benefit from accessing a smoking cessation service.
Alcohol brief advice or referral	Due to the specialist nature of our services we do not have the ability to refer patients into local alcohol services. However, we do provide patients with information on how to reduce their alcohol intake and we do notify GPs when patients may benefit from accessing an alcohol reduction service.

Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Royal Brompton and Harefield NHS Trust during 2018-19 and the Trust has not participated in special reviews or investigations by the Care Quality Commission relating to the services we provide during 2018-19.

The Trust was inspected by the CQC in 2016, and some services were re-inspected by the CQC during 2018-19. The 2018-19 inspection confirmed the improvements made since the 2016 inspection and the Trust was awarded an overall rating of 'Good'.



In addition to the Trust receiving an overall rating of 'Good', both Harefield Hospital and Royal Brompton Hospital were also rated as 'Good' in the 2018/19 inspection. The tables below show an overview of the inspection results. The full report can be found on the Trust's website and on the CQC website.

Ratings for Royal Brompton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2017	Outstanding Jan 2017	Good Jan 2017	Good Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017
Surgery	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2020	Good ↑ Feb 2019	Good ↑ Feb 2019
Critical care	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Services for children and young people	Good →← Feb 2019	Good →← Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↓ Feb 2019	Good →← Feb 2019
End of life care	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Outpatients and diagnostic imaging	Good Jan 2017	Not rated	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017
Overall*	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

Ratings for Harefield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Surgery	Good ↑ Feb 2019	Outstanding →← Feb 2019	Outstanding →← Feb 2019	Good →← Feb 2019	Outstanding ↑ Feb 2019	Outstanding ↑ Feb 2020
Critical care	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
End of life care	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Outpatients and diagnostic imaging	Good Jan 2017	Not rated	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017
Overall*	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019

* Footnote from CQC: Overall ratings for hospitals are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

A number of areas of notable practice were highlighted by the CQC, which include:

Surgical services

Rated 'outstanding' at Harefield and 'good' at Royal Brompton with the following highlighted by the CQC inspection team as outstanding practice:

- There was clear and detailed evidence demonstrating improvements made in the use of the World Health Organisation Safer Surgery Checklist. We saw that this was embedded within the culture of the service and managers demonstrated commitment to ensure all staff were part of the process.
- Innovative approaches were used before, during and after surgery to ensure that surgical site infections rates remained low. Surgical site infection rates continued to be below the national average.
- New ways of working were adopted to keep patients safe. For example, staff were given designated roles at the beginning of each shift to adopt in the event of cardiac arrest and wore badges to ensure their roles was clearly identified.
- Harefield was one of two UK specialist centres to start using a specialised aortic valve in aortic valve replacement surgery last year. This new valve is designed to provide younger patients with an alternative to mechanical valves and does not require life-long anticoagulation. The bovine tissue is specially treated to slow its deterioration over time. The longevity of the resilient valve is intended to reduce the likelihood of patients requiring operations in later years of life and can allow patients to remain / regain their active lifestyles.
- Training in human factors is increasingly embedded in clinical practice across the Harefield site. Several members of the team (from a range of disciplines) recently led a multicentre training symposium in human factors under the auspices of the Society of Cardiothoracic Surgeons.
- The service provided us with evidence that they were taking the following action as part of their ongoing quality improvement projects to address the number of cancelled operations;
    - A new theatre scheduling system was introduced in June 2018. The scheduling system worked by using operator times and better predicating the length of time required for each operation. Due to the complexity of work increasing, the service found it difficult to schedule two theatre cases into a day and for this reason the service was also looking as part of ongoing quality improvement work at adjusting the length of the theatre working day and staffing accordingly.
    - In the six months before the inspection, the trust trialled and introduced day of surgery admission (DOSA) for appropriate thoracic and cardiac surgery patients. The focus of this work had been to admit second and subsequent patients on the theatre operating list via the DOSA unit rather than through a ward bed. The service anticipated that the number of patients admitted in this way would increase over coming months and this would in turn reduce the number of cancellations due to lack of ward beds.
    - Due to the nature of transplant services it can be difficult to predict activity. There are times that, due to organ availability, there is no option but to proceed with transplant activity resulting in elective activity cancellations. As part of the Trust-wide Darwin productivity programme the theatre quality improvement work looked at allocating one of the theatres as an emergency theatre. The emergency theatre would also be used to operate on patients that were transferred from other hospitals.
    - The surgery services were developing a virtual reality goggle system which would allow patients to become familiar with the hospital surroundings. The service conducted 360-degree filming and was in the process of purchasing virtual goggles for patients to facilitate this technology. The aim

of this was to allow patients to gain an insight preoperatively into what will happen to them when they are admitted to hospital for their surgery. This will be particularly useful for patients that are anxious and those with learning disabilities. The ambition was to reduce the effects of postoperative delirium.

- The discharge team had introduced a photo discharge protocol which included taking an array of colour pictures of the surgical site and attaching this to a detailed step by step instruction for the patient. The patient was then given verbal instruction in addition to the written guide in how to take care of their surgical site. This process had significantly reduced surgical site infection rates since its introduction in 2014.

Critical care services at Royal Brompton Hospital

Rated 'good' with the following highlighted by the CQC inspection team as outstanding practice:

- The Trust had developed its own accredited intensive care course to offer the qualification in critical care nursing to its' nurses. This enabled the unit to have 63% nurses with the qualification which exceeded the GPICS guidance of a minimum of 50%. The Trust had funded the course to continue to provide the training.
- The service demonstrated excellent multidisciplinary working practices which enabled collaboration in improvement projects and enhanced patient care.
- The unit had since introduced an animal therapy policy to enable dogs to be safely allowed on the unit for patients who wished to have them visit.

Children and Young People services

Rated 'good' with the following highlighted by the CQC inspection team as outstanding practice:

- There was clear evidence of research, innovative and outstanding practice. For example, the Simulated inter-professional Team training (SPRint) had won national awards and the paediatric Extracorporeal Membrane Oxygenation (ECMO) service had positive outcomes. The service had also launched a hypoplastic left heart pathway which included a social element for long stay patients.
- Staff spoke very highly of the culture of the service and the staff survey results were consistently high for workplace satisfaction.
- The service went above and beyond for its patients and patient families, including the creation of social clubs for patients of all ages.
- The service took a consistently holistic approach to the care and wellbeing of parents and provided basic nursing training skills to patient family members.
- Since our last inspection the service had developed clear pathways for rare diseases, e.g. Kawasaki disease.

During the 2018-19 CQC inspection the inspectors identified two areas of corporate governance that we need to improve;

- The Trust must ensure that Fit and Proper Person checks are fully completed.

  NHS organisations must able to provide evidence that appropriate systems and processes are in place to ensure that all new and existing chairs and non-executive directors are, and continue to be, fit for purpose and that no appointments meet any of the 'unfitness' criteria set out in the regulations.

We recognise the importance of the Fit and Proper assessment for employees. We believe that we do have a robust process in place and are continuing to develop this approach in line with industry best practice.

- The Trust does not have a Board Assurance Framework document

  A Board Assurance Framework document brings together, in one place, all the relevant information that board members need to gain assurance on how our key strategic risks are being managed.

  We accept a Board Assurance Framework document is one of the means by which the Board can hold itself to account. We believe that we do have a Board Assurance Framework in place but accept that we do not have this detailed in one document. We are committed to developing a Board Assurance Framework document during the coming year.

The 2018-19 CQC inspection did also highlight a number of specific areas within individual clinical service where some improvement are needed. Our clinicians and service managers are working together to achieve these improvements.

The quality of our data

Royal Brompton & Harefield NHS Foundation Trust submitted records during 2018/19 financial year to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data[7] which included the patient's valid NHS number was:	The percentage of records in the published data[8] which included the patient's valid General Medical Practice Code was:
• 97.0% for admitted patient care; • 97.2% for outpatient care.	• 95.8% for admitted patient care; • 100% for outpatient care.

The Trust uses the following initiatives to maintain and improve data quality, thereby ensuring a high quality of service to all service users:

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

Clinical coding is how we translate the medical terminology written by clinicians into a coded format for statistical, clinical and financial purposes. We use clinical codes to describe a patient's diagnosis and treatment.

Every year we carry out an audit to check how accurate our clinical coding is and identify where we need to make improvements.

In February 2019 we randomly selected 200 clinical records for patients we had treated between June 2018 and August 2018:

	Our performance	Level of attainment	
		Mandatory	Advisory

[7] Data Source: NHS Digital (April 2018 - November 2018)

[8] Data Source: NHS Digital (April 2018 - November 2018)

Primary diagnosis	95%	>=90%	>=95%
Secondary diagnosis	91.2%	>=80%	>=90%
Primary procedure	95.3%	>=90%	>=95%
Secondary procedure	93.4%	>=80%	>=90%

During 2019-2020 we will continue our work to ensure that our clinical coding is as accurate as possible.

Information Governance

In 2018/19 NHS Digital replaced the Information Governance Toolkit with the Data Security and Protection Toolkit. All organisations with access to NHS patient data and systems are required to complete the Data Security and Protection Toolkit self-assessment, testing their policy and processes against the National Data Guardian's ten data security standards.

The new assessment is far reaching and covers personal confidential data, staff responsibilities, training, managing data access, process reviews, responding to incidents, continuity planning, unsupported systems, IT protection and the management of suppliers.

In the previous toolkit the self-assessment included levels of compliance and a scoring system. In the new toolkit, this has been replaced by a requirement to submit evidence for 100 mandatory questions.

In March 2019 we submitted our evidence for all of these questions. Our responses will work as a baseline for future years and we are currently developing a detailed work plan to ensure that we continue to strengthen our policies and practice for all aspects of information governance.

Learning from Deaths

Learning from the deaths of people in our care helps us improve the quality of the care we provide to patients and their families. Even if the death of a patient is expected, the information we collect during the review process helps us identify aspects of our care that we could improve.

During 2018-19 we have reviewed and revised our processes to help us learn from deaths and we have built on the systems we had in place. The impact of this work is reflected in the quality of information we now present to our Risk and Safety Committee.

Things we have changed during 2018-19 include:

- Updating our Learning from Deaths Policy;
- Ensuring our Governance and Quality Committee receives quarterly reports on deaths and what we have learnt from these;
- Linking learning from Coroner's Inquests, clinical claims and complaints into learning from deaths to ensure that we maximise our opportunities to learn;
- Implemented the Royal College of Physicians (RCP) 'Structured Judgement Review' process when we review the care of adult patients who have died under the care of the heart and lung clinical teams at Royal Brompton Hospital;
- Established a Trust Mortality Surveillance Group (TMSG), with multi-disciplinary and multi-professional membership, to identify themes and lessons learned from deaths that we review.

During 2019-20 we will continue to strengthen our processes including:

- Fully implementing the Royal College of Physicians (RCP) 'Structured Judgement Review' process to review the care of adult patients who die at Harefield Hospital;
- Undertaking more timely reviews of deaths that occur in our hospitals;

- Implement a systematic process to link clinical outcome data that we collect for our services to the work we undertake on learning from deaths;
- Upgrade our software to help us more easily link learning from Coroner's Inquests, clinical claims and complaints into learning from deaths;
- Utilise the Trust Mortality Surveillance Group to share learning across the Trust.

Table 1: Whole Trust including adult and paediatric deaths

Year	Quarter	Number of Deaths	Number deaths with initial review	Number deaths with detailed Clinical Notes Review (CNR) (eg SJR)	Number of deaths subject to SI investigation	Total number deaths with any type of review	Total number deaths with detailed Clinical Notes Review (CNR) &/or SI review	Number considered more likely than not due to problems in care Bristol grade 1/2 or TBA[9] (% of total number of deaths for the quarter)
2018-19	**Q1**	115	115	115	1	115	115	2 (2%)
	Q2	102	101	102	2	102	102	4 (4%)
	Q3	91	91	86	1	86	86	4 (4%)
	Q4	105	104	104	0	104	104	6 (6%)
	Total YTD	**413**	**411**	**407**	**4**	**407**	**407**	**16 (4%)**

Table 2: Patients with Learning Disabilities (included in table 1 but separated out)

Year	Quarter	Number of Deaths	Number deaths with initial review	Number deaths with detailed Clinical Notes Review (CNR) (eg SJR)	Number deaths subject to SI investigation	Total number deaths with any type of review	Total number deaths with detailed Clinical Notes Review (CNR) &/or SI review	Number considered more likely than not due to problems in care Bristol grade 1/2 or TBA
2018-19	**Q1**	4	4	4	1	4	4	0
	Q2	4	4	4	0	4	4	0
	Q3	0	0	0	0	0	0	0
	Q4	0	0	0	0	0	0	0
	Total YTD	8	8	8	1	8	8	0 (0%)

All deaths are reviewed the following month. Therefore, deaths that occurred in March 2018 are included in the Q1 2018-19 information shown above.

Things we have learned and actions we have taken based on this learning during 2018-19

[9] Either awaiting inquest outcome or full M&M review

Learning	Actions taken
We needed to reduce the number of errors on death certificates	We have re-educated our junior doctors and ongoing training will continue to take place
For adult patients in intensive care, we needed to review the occurrence of bowel complications as the final event prior to death	We are currently undertaking audit of patients with this complication and we will then look at the changes that we need to put in place
For patients diagnosed with infective endocarditis, we needed to further optimise care management	We are currently re-evaluating the concept of an infective endocarditis multi-disciplinary team meeting (MDT)
We needed to look at ways that we can further strengthen our consent to treatment process required	We are using MDT discussions to identify alternatives and material risks, leading to education and training of clinicians
There was a need for us to review and update our naso-gastric tube policy	We have reviewed our policy and it is currently being updated

The actions we have taken have increased clinical and multi-disciplinary engagement in reviewing the quality and experience of care at the end of life. We anticipate that clinical audits being undertaken will help us to further improve the quality of care that we provide.

National core set of quality indicators

Since 2012 a core set of quality indicators came into effect for hospitals providing acute services in England. In this section of our quality report we report our performance against those indicators that are relevant to the specialist services we provide.

For each indicator we show our performance, together with the national average and the performance of the best and worst performing trusts, where this is available.

Royal Brompton & 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 validation 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.

Readmissions within 28 days of discharge

Our clinical teams are committed to reducing the number of patients requiring readmission and we closely monitor readmission rates at a local level and at an organisational level. As the table below shows, the percentage of emergency readmissions to our own hospitals occurring within 28 days of the last, previous discharge from hospital after admission is significantly lower than the national average but is slightly higher than previous years.

Our clinical and operational teams will continue to monitor the number of patients who requiring readmission and ensure that improvements are made where required. In addition to this work, we will report 28-day admission information in our monthly Trust Board Clinical Quality Report.

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons				
	2016-17	2017-18	2018-19		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average
Percentage of emergency readmissions to our own hospitals occurring within 28 days of the last, previous discharge from hospital after admission. [10]									
% of patients aged 0-15 readmitted within 28 days	7.3%	6.8%	6.6%	In accordance with NHS Digital definitions.	6.6%	Apr18-Dec18	0%	19.6%	8.9%
% of patients aged over 15 readmitted within 28 days	6.3%	6.2%	6.8%		6.8%		2.5%	16.8%	8.6%

[10] Benchmarked against all acute trusts. Figures have been adjusted from the 2017-18 annual quality report where 30-day readmission rates were reported and benchmarked against specialist trusts

Responsiveness to the personal needs of patient

In this section of the report we would usually report our score for the five questions in the national inpatient survey relating to responsiveness and personal care. As this information has not yet been published, we will ensure that the results, and any actions we need to undertake to achieve improvements, will be reported to our Trust Board and made available on our website.

Recommendation to Friends and Family

The number of staff who would recommend us to their friends and family remains above the national average and remains consistent with previous years. As described in Part 2 of this annual quality report, we will continue to work with our staff to address areas of concern.

Our patient experience and clinical team have worked extremely hard during 2018-17 to increase the number of patients completing the Friends and Family Test. This work, which has included the increase in electronic solutions, will continue into 2019-20.

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons				
	2016-17	2017-18	2018-19		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average
Percentage of staff who would recommend the provider to friends or family needing care.	92.57%	94.86%	91%	In accordance with NHS England guidance.	91%	Apr18-Mar19	94.8%	77.5%	89%
Percentage of Inpatients who would recommend the provider to friends or family needing care	96.89%	95.68%	95.33%		95.33%	Apr18-Feb19	100%	75.67%	95.4%

Venous thromboembolism (VTE)

Venous thromboembolisms (VTE), or blood clots, are a major cause of death in the UK. Adult patients admitted to a hospital may be more at risk of developing a blood clot and it is therefore important that we risk assess patients on admission to hospital.

Our clinical staff undertake more blood clot risk assessments, at the time a patient is admitted to our hospital, than the national average. We review our risk assessment data monthly and report performance quarterly to NHS England.

In line with national guidance, from April 2019 we will report the percentage of blood clot risk assessments we undertake on 16 and 17-year-old patients.

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons				
	2016-17	2017-18	2018-19		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average
Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)	95.29%	95.88%	97.25%	In accordance with NHS England guidance.	97.25%	March 2018 – January 2019	100%	54.86%	95%

Infection control – Clostridium difficile

We undertake post-infection reviews for all clostridium difficile infections. Findings of reviews are discussed at our Infection Prevention and Control Committee and our local quality groups are responsible for overseeing the implementation of any improvement action plans. We reported 12 Clostridium difficile infections during 2018-19, 7 of these were classed as hospital onset but no lapses in care were identified.

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons				
	2016-17	2017-18	2018-19		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average
Rate of *clostridium difficile* (number of infections/100,000 bed days)	11.03	5.45[11]	6.02	In accordance with DH guidance.	6.02	Apr18-Mar19	No benchmark available		

Patient safety incidents

During 2019-20 we will continue to work with our staff to ensure that all patient safety incidents are reported and that appropriate changes are made as a result of learning from our investigations into these incidents. Some improvements we have made during 2018-19 include:

[11] 2016-17 and 2017-18 figures have been adjusted from previous years to present infection rate rather than hospital acquired infections

- Changes to Cystic Fibrosis genetic testing procedures
- Changes to the routine monitoring of all individuals with a permanent (epicardial or transvenous) pacing systems
- Reviewing and updating our naso-gastric tube policy

NHS Improvement is the national body responsible for reviewing patient safety incidents. Their view is that Trusts which report a high number of incidents have a strong culture of being open about mistakes and near-misses and learning from them. Within the Trust we very much support this view, and we pleased to report an increase in the number of incidents being reported across the Trust in 2018-19, compared to previous years. Although there is an increase in the overall number of incidents reported by staff, the number of incidents graded red and amber (more serious incidents) remains consistent with previous years.

Indicator	From local Trust data			Data Governance Arrangements	Benchmark Comparisons				
	2016-17	2017-18	2018-19		Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average
Patient safety incidents reported to the National Reporting & Learning System									
Number of patient safety incidents	3,925	3,956	5,910*	In accordance with National Patient Safety Agency guidelines.	5,910	Apr18-Feb19	40,855	267	4,120
Rate of patient safety incidents (number/1000 bed days)	17.52	18.47	34.36*		34.36		Not available	Not available	Not available
Percentage resulting in severe harm or death (red incidents)	0.04%	0.07%	0.05%*		0.05%		0.00%	8.53%	0.74%

*Data correct as at 25th March 2019

Part Three

Other information

Review of quality performance 2018-19

Our quality priorities for 2018-19 are shown below and a full review of what we did to achieve these priorities is located on pages 7 - 14 of this report.

Patient Safety

Implementation of NEWS

Identification and management of patients with sepsis

Identification and management of patients with acute kidney injury (AKI)

Clinical effectiveness

5 Steps to Safer Surgery – theatres

5 Steps to Safer Surgery – catheter laboratories

Learning from deaths

Patient experience

Bullying and harassment

Our performance against NHS Improvement's Single Oversight Framework

The Single Oversight Framework[12] details a number of performance targets to help NHS Improvement oversee NHS trusts and NHS foundation trusts in England, using one consistent approach. The framework is seen as a supportive mechanism to help NHS Improvement identify if trusts need any help or support.

The overarching purpose of the Single Oversight Framework is for NHS Improvement to be able to help NHS providers achieve and maintain Care Quality Commission ratings of 'Good' or 'Outstanding', meet NHS constitution standards, manage their resources effectively and work alongside local partners.

Our performance against key performance targets within the Single Oversight Framework is shown in the table below.

Indicator	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19	Target
Clostridium difficile	1	2	1	0	0	4	1	1	1	0	1	0	12	23
MRSA Bacteraemia	0	1	0	0	0	0	0	0	0	0	1	0	2	0

[12] https://improvement.nhs.uk/resources/single-oversight-framework/

Maximum time of 18 weeks from point of referral to treatment (RTT)	92%	94%	93%	93%	93%	92%	93%	94%	93%	95%	94%	93%	93%	92%
Cancer – 62-day urgent GP referral to first definitive treatment (NHSD May 9 2019)	71%	64%	56%	56%	67%	31%	39%	55%	100%	64%	57%	50%	59%	85%
% of breaches Maximum 6 – week wait for diagnostic procedure	0%	0%	0%	0%	0%	0%	0%	0%	0%	0.61%	0%	0%	0.07%	1%
Never Events	0	0	0	0	0	0	0	1	0	0	0	0	1	0

The 62-day cancer target (the time from GP consultation to first definitive treatment) did not meet the national standard of 85%. However, it should be noted that this national standard is designed for use in hospitals delivering a broad range of cancer services involving both long and short pathways. The 85% standard is intended to be an average set across both long and short pathways. The Trust is a specialist centre providing surgical treatment for lung cancer patients. This is an inherently long pathway. It starts with the initial GP referral, usually made locally to a hospital to carry out the diagnostic portion of the pathway, before referring the patient on to our Trust. Choices made by patients regarding the taking of treatments and operations can adversely affect the calculation this target.

Details of the range of work underway to help us improve the quality of services we provide to our patients referred for surgery for cancer is shown on pages 36-37 of this report.

Referral to Treatment times (RTT)

In the summer of 2017 we completed a self-assessment of our data telling us the length of time patients were waiting from their referral time to time of treatment. We undertook this self-assessment because, after we started using our new electronic patient administration system, we were not confident that our information was always accurate.

The NHS Constitution gives you the right to access services within minimum waiting times, or for the NHS to take reasonable steps to offer you a range of suitable alternative providers if this is not possible.

We monitor the length of time between your referral and your time to treatment to help ensure that you receive treatment as quickly as possible.

Our self-assessment confirmed our concerns and in January 2108 we invited the NHS Improvement Elective Care Intensive Support Team (IST) to undertake a more in-depth review of our referral to treatment information, reporting systems and administrative processes. This review resulted in a range of recommendations on how we could improve. During 2018-19 we have been working hard to implement these recommendations and improve the quality of information about the referral to treatment times of our patients. We believe that the improvements we have made so far have helped us to improve how we manage the time between referral and treatment and, therefore, improve the experience of our patients.

To help us start making the necessary changes, we initially seconded an expert from NHS Improvement to support us in developing and implementing an improvement plan. Our improvement plan focused on the following four areas:

- Development and implementation of an RTT staff training package;
- Development of a comprehensive suite of reports to allow us to track every stage of a patient's journey from referral to treatment;
- Development of an internal RTT data quality monitoring programme;
- Ensuring the Trust has the appropriate meetings and governance structure to provide oversight of performance and management of issues.

What we achieved during 2018/19

RTT staff training package:	We commissioned a comprehensive, e-learning programme for our staff to assist them to: • raise their knowledge in the complex area of referral to treatment times; • raise their knowledge on how each interaction with a patient should be recorded within the patient administration system. Our managers monitor the progress of their staff through the training programme and ensure that individual staff members receive additional support and training as required.
Comprehensive reports:	We designed and implemented an electronic suite of reports that our staff now use to track the journey of every patient from referral to treatment. These reports show every interaction between us and a patient such as out-patient appointments and diagnostic tests. In addition, managers can quickly spot any issues that need resolving, such as cancelled appointments.
Data quality monitoring:	We undertook three data quality audits which have confirmed that we have made some improvements and that we still have improvements to make. For example, we know that in 2019-20 we need to focus on accurately recording the referral date (clock start date) for patients, and the date that treatment finished, or the patient chose not to undergo the treatment (clock stop date). We also know that we need to reduce the number of non-RTT pathways recorded as RTT pathways. The rules for referral to treatment times are complex and not every patient referred to us needs to receive care under these rules. Our data quality audits have confirmed that we need to get better at only entering a clock start date for patients whose condition and treatment are included within the referral to treatment rules.
Governance and oversight:	We have improved our management systems and processes to help us ensure that we have oversight and scrutiny of the time between referral and treatment for all patients whose condition and treatment are included within the referral to treatment rules.

Our clinical teams now review their patient tracking lists every week and the managers working with these teams ensure that actions are taken to address any issues that need resolving, such as cancelled appointments.

In addition, we now have an fortnightly organisation-wide assurance meeting where local teams escalate issues and concerns that they have not been able to resolve.

Our Chief Operating Officer has oversight of our referral to treatment time improvement programme and, on behalf of the Board, through our governance structure, holds our managers and clinicians to account for delivering the improvements required.

Our next steps for 2019-20

Over the next 12 months, we will continue to work on the quality and accuracy of our referral to treatment data and information and will seek external audit qualification on our performance.

Staff training will continue and, where we identify it is necessary, we will provide individuals with focussed support and one to one training so as to significantly reduce the volume of data input errors.

NHS Improvement will undertake a review of our achievements to date, our plans to continually improve and the degree to which our new processes are fully embedded across the organisation.

As part of our required Operational Plan for 2019/20, we have confirmed that we will continue to meet the national target that requires at least 92% of our patients must not wait more than 18 weeks for the start of their treatment.

Patients who waited more than 52 weeks before the start of their treatment during 2018-19

Unfortunately, during 2018-19, four of our patients waited more than 52 weeks for their treatment to start.

Each of these cases were investigated by a senior manager and the impact of the delay to start treatment was assessed by a lead clinician. Where appropriate, patients were offer alternative choices for treatment.

Learning from our investigations has been shared across the organisation to help us improve the experience of other patients.

Cancer 62-day urgent GP referral to first definitive treatment

Our patients are often referred to a local hospital first, where they undergo a number of necessary investigations and tests before they are referred to us for treatment. We therefore work in partnership with these referring hospitals to help ensure that patients are ready to have surgery when they are referred to us and are jointly responsible for ensuring that a patient receives their first definitive treatment within 62 days of their referral being received.

This performance measure requires NHS organisations to ensure that all patients who have been referred by their GP, on a suspected cancer pathway, receive their first definitive treatment within 62 days of their referral being received.

In addition to working to meet the above national target, we have a range of work underway to help us improve the quality of services we provide to our patients. Examples of this are shown below.

National Lung Cancer Optimal Pathway

In the summer of 2017 Professor Chris Harrison, NHS England's National Clinical Director for Cancer, issued guidance on a new diagnostic and treatment pathway. All NHS Trusts are required to work towards fully implementing the new pathway 2020.

The aim of the new pathway is to ensure that all patients undergo the necessary diagnostic tests and have a definitive diagnosis within 28 days of referral from their GP. Following this, the organisation providing treatment has 24 days with which to then offer an outpatient appointment and a curative treatment.

We have been working towards achieving the treatment target of 24 days since 2016/17 because we believe that our patients should not wait longer than necessary for their surgery. We have also been shadow reporting against this performance metric in anticipation of the full implementation of the National Lung Cancer Optimal Pathway.

We are pleased to confirm that in 2018/19, from April to December, the average time from referral to Royal Brompton and Harefield hospitals to surgery was 24 days.

The National Lung Cancer Optimal Pathway team are working with GPs and acute Trusts to improve referral times, in order to reduce the overall waiting time for lung cancer treatment. In order to help improve earlier referral times to us, we will continue to work those hospitals who refer patients to us.

Patient Experience

Every year we take part in the annual National Cancer Patient Experience Survey. We were extremely pleased with the feedback our patients provided in the 2017 survey.

National Cancer Patient Experience Survey

When asked 'how they would rate their care on a scale of zero (very poor) to 10 (very good)', our patients gave us an average rating of 9 out of 10.

In addition to participating in the national survey, we also run yearly patient and staff events using the principles of experience-based co-design. Experience-based co-design (EBCD) is an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together.

This approach has resulted in positive changes, particularly in helping us improve the information we give to patients. A great example of the results of this work includes videos we have commissioned to support patients who are coming to us for their lung cancer surgery. These videos were created as a result of a patient working group and two patients who had recently had lung cancer treatment shared their experiences in the videos. We now share these videos with other patients before they are admitted for surgery.

In September 2019, there will be a patient experience-based co-design event at the Harefield Hospital site.

Health Lung Project – funded by RM (Royal Marsden) Partners Vanguard

We are proud to be a partner of the RM Partners Cancer Vanguard programme.

The Vanguard New Care Models Programme is intended to redesign the NHS and was set out in the NHS Five Year Forward View

A total of 17 hospital Trusts are members of the Vanguard and our aim is to improve survival rate, quality and safety of services, patient experience and

improved recruitment to clinical trials. Together, we cover a population of 3.5 million people.

This is an exciting partnership that helps us test and explore new ways to deliver care locally for people with cancer. Members include public health services, GPs, acute hospitals and other specialist hospitals.

In 2018 we were successful in securing £1 million of funding from the RM Partners Cancer Vanguard programme to run a Health Lung Project.

The aim of the project was to diagnose patients with lung cancer earlier through identifying the population at "high risk" of lung cancer that are eligible for screening. Working with GPs from the Hillingdon and Hammersmith and Fulham Boroughs, we invited people considered to be 'at risk' of developing lung cancer to come and have a health check and, if appropriate, these people then were offered a 'low dose' lung CT scan.

For patients from the Hillingdon Borough, we parked a mobile CT scanning unit in carparks at Tesco and Sainsbury supermarkets. People from Hammersmith and Fulham Borough had their scans at our Fulham Road Hospital site.

The project finishes in March 2019 but we are hoping to be able to undertake a further follow up study August 2019. Results from the project are currently being analysed, however, initial findings are positive and the people who attend the health checks all provided excellent feedback about their experience.

Transcatheter aortic valve implantation (TAVI) mortality

A TAVI (transcatheter aortic valve implantation), is a valve which is fitted in the heart to treat a condition called aortic stenosis. Made from the natural tissue of a cow or pig's heart, the new valve is fitted on top of the old, damaged valve.

A TAVI takes one to two hours and is usually carried out under a local anaesthetic (patients are awake, but do not feel pain), although it can also be carried out under a general anaesthetic, depending on what's best for the patient.

Most people come into hospital the day before their operation, or on the day of their TAVI procedure, and stay for between two to five days. During 2018-19 we performed 325 TAVI procedures.

One of the performance measures we use to constantly monitor the quality of this services is our TAVI mortality rate. This is the number of patients whose death is a result of the procedure. As you would expect, we monitor this very closely.

Because this is an important quality measure for us, our Council of Governors chose to include this quality measure in our annual quality report this year as our local quality indicator. The accuracy of how we measure our performance has been tested by our external auditors and the records for all 7 deaths recorded during 2018-19 have been reviewed by the external auditors.

Friends and Family Test

Results of the test are published monthly on the NHS England[13] and NHS Choices websites, allowing you to measure our performance against other trusts.

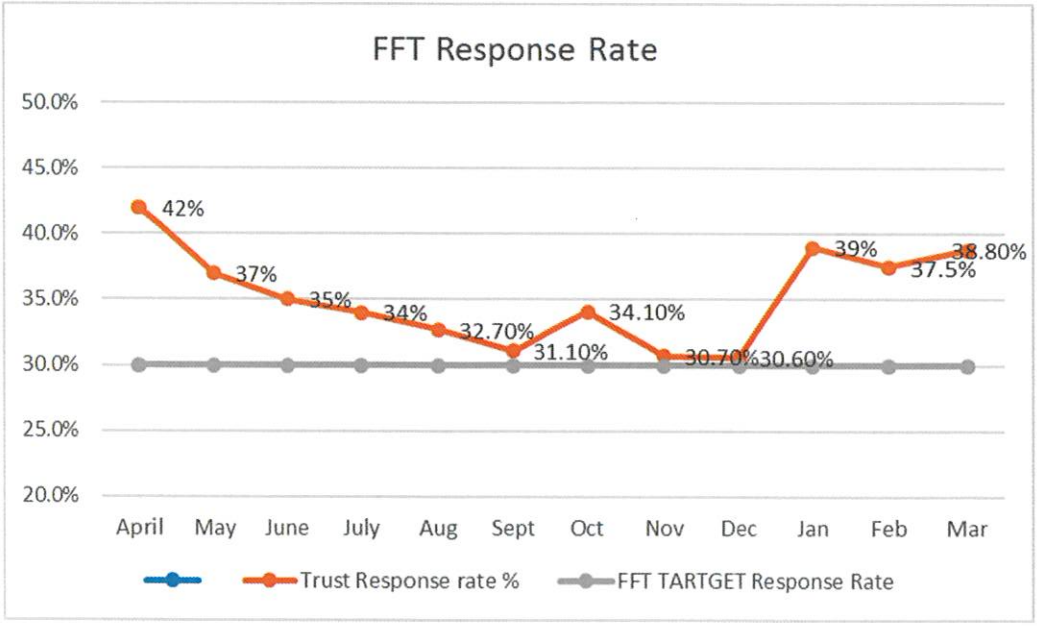
We have reported our performance against the Friends and Family Test on page 28 of this annual quality report. In this section of our report we will share how we collect this information form our patients and how we use the information we have received.

NHS England launched the Friends and Family Test in 2013. The test was introduced as a key measure to improve patients' experiences of care across the NHS. All hospital Trusts are mandated to ask all inpatient and day-case patients: "How likely are you to recommend our ward/clinic to friends and family if they needed similar care or treatment?"

When the Friends and Family Test was first launched there was a national target for us to get 15% of our inpatients and patients attending as a day-case to complete the Friends and Family Test. In 2015 this target was increased to 30%.

During 2017-18 and 2018-19 we have consistently achieved this target. However, during 2018-19 we did notice a reduction in the number of patients completing the Friends and Family Test. This can be seen in the graph below.

FFT response scores for 2018-2019 (March 19 data to follow mid-April)



As a result of this our patient experience team have introduced new ways of collection information from patients and, as the graph above shows, this has resulted in an increase in the number of patients completing the Friends and Family Test.

We currently collect information in the following ways:

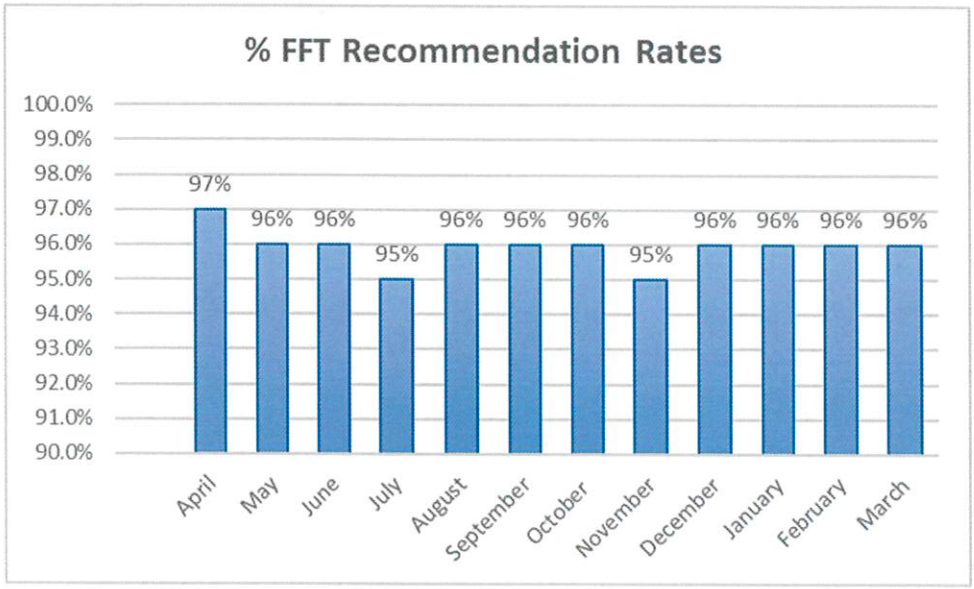
- Paper questionnaires given to all patients on the day of discharge
- Online via tablet devices

[13] https://www.england.nhs.uk/fft/friends-and-family-test-data/

- Via text message sent 48 hours post discharge.

As the graph below shows, during 2018-19 95% or more of our patients would recommend our services to their friends and family.

FFT recommend scores for 2018-19 (Source: NHS England)



We are also able to confirm that the negative response rate to the Friends and Family Test has consistently been 2% throughout 2018-19.

Friends and Family Test scores are not published in a way that enables direct comparison with other Trusts. However, once published, we will use the National Patient Survey[14] to benchmark our performance against the NHS trusts in England and against the NHS Trusts in London. Tis work will be presented to out Trust Board and will be available on our website.

Some of the comments we have received from patients during 2018-19:

"The staff were excellent, from the paramedics to the nurses to the surgeons. The hospital was clean. The hospital looked well maintained. The food was high quality. The staff went above and beyond to explain the procedure to me. I felt very safe and cared for".

"Harefield is a fantastic hospital. There is feeling there that you are in the hands of the very best people. There is a mix of quiet and confident efficiency coupled with a nursing team who demonstrate that they genuinely seem to care".

"This was an outstandingly good patient experience for which I am extremely grateful Staff throughout the RBH were professional, kind, courteous and clearly team players. An exemplary hospital. Many thanks. Staff took endless time to explain simply what was going on".

"Every single member of staff - medical and support staff - were friendly, caring, knowledgeable and welcoming. We always felt confident in the care our son received and loved the kindness and support shown to us too".

[14] https://www.cqc.org.uk/publications/surveys/surveys

"The care I received from all members of staff was superlative. The doctors and nurses and HCAs and other auxiliary staff were extremely professional at all times and I was always treated with care and kindness. Nothing was too much trouble".

"Thank you so much for your wonderful service. Thank you so much for your wonderful care and attention. I could not fault the service the staff absolutely fantastic".

"From the minute I was met at the doors to go through for my angiogram and consequent angioplasty and stent the teams in every department ... staff were super-efficient, polite and courteous. I was a very anxious patient and everything was done to make me feel at ease and comfortable. I was also highly impressed with the cleanliness of the hospital - spotless. 10/10".

"I consider that the attitude of the staff was exemplary, the clinical treatment was exemplary. I felt very reassured and safe in the hands of the staff and the clinical staff and would thoroughly recommend them to anybody. Thank you very much".

"All the staff were extremely kind and friendly which makes such a difference if you are feeling nervous or apprehensive".

"Outstanding treatment, amazing friendly caring staff, attention to detail. Always willing to help and give advice. ... everyone was amazing I can't thank them all for helping me through such a difficult time. The hospital was well equipment, clean, organised. I felt very cared for during my stay."

Actions we have taken in 2018-19 after patient feedback

Our Facilities

A garden for patients on transplant wards at Harefield is in development.

An outdoor garden has been created on Victoria Ward.

The Courtyard at Royal Brompton has been refurbished, creating an outdoor space for people of all ages.

Information and Communication

A new patient leaflet with site maps has been created to support way finding between hospital wings.

Royal Brompton Outpatients Department is piloting the use of two-way texting for appointments, creating a simple process for cancelling and rebooking appointments.

Compassion in Practice

Length of time waiting is being addressed at Harefield as part of the Darwin programme with staggered admissions being implemented.

Noise at night was highlighted and staff were reminded to speak quietly. Earplugs are available for patients on Cardiology wards if required due to the disturbance from the emergencies.

In addition to the Friends and Family Test, there are a number of other ways that we collect information from our patients, including the Care Quality Commission Adult Inpatient Survey.

The 2018 Adult Inpatient Survey has recently been published and we are currently reviewing the findings and will be developing an action plan based on these.

Our Patient Public Engagement Group (formerly Patient Advisory Group) meets quarterly and members of the Group advise us on matters of importance to patients. During 2019-20, this important group will help us develop and implement a new Patient Public Engagement Strategy.

We also have a number of clinician-led patient support groups which meet regularly and include:

- Voice of the Upper Airways Group;
- Interstitial Lung Disease (ILD) Support Group; and
- Patient Transition Days for young people with Cardiomyopathy.

We know that these groups are extremely valuable to our patients as they offer additional support to patients, including facilitating peer-support. We also collect a wealth of information from members of the groups and we use this information to help us improve our services.

Complaints

We encourage patients and family members to provide us with feedback to help us improve the services we provide. We receive much of this feedback informally, but we do also receive formal, written complaints.

There are NHS standards[15] guiding how we manage formal complaints and how we provide assurance to our Board that we are learning lessons and making improvements as a result of these complaints.

The table below shows the number of formal, written complaints we received during 2018-19 and the percentage of these that we responded to within the timescale agreed with the complainant.

	Total Number of Complaints	Complaints responded to within agreed timescales	%
Royal Brompton Hospital	75	71	95%
Harefield Hospital	37	35	95%
Trust Total	**112**	**106**	**95%**

In accordance with NHS guidelines the outcome of our investigations into complaints 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.

The table below shows the outcome of our complaint investigation process for all complaints we investigated and closed during 2018-19 and the number of complaints re-opened.

	Upheld	Partially Upheld	Not Upheld	Number of complaints re-opened
Royal Brompton Hospital	30	20	25	11
Harefield Hospital	15	7	15	4
Trust Total	**45**	**27**	**40**	**16**

[15] The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Our annual review of complaints confirmed that some broad themes emerged during 2018-19. We have used this intelligence to improve our services and will continue this work during 2019-20.

- Bereavement support following the death of a family member
- Communication regarding appointment information
- Likely waiting times not being not being made clear to patients
- Discharge procedures which cause delays and quality of information given to patients

In addition to the work in the above areas, we will continue to support staff to undertake investigations into complaints.

Duty of Candour

Within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20 focuses on the need for healthcare providers to be open and transparent with people who use healthcare services. The regulation also sets out some specific requirements that we must follow when things go wrong with care and treatment. This is known as Duty of Candour and includes including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

It is the responsibility of all of our staff to comply with the Duty of Candour requirements and we report our levels of compliance to our Trust Board.

To help us ensure that we meet our regulatory requirements, and to help ensure that we learn from incidents where things go wrong, we have a nominated clinical lead for Duty of Candour. In addition, Adverse Incident Policy makes specific reference to Duty of Candour and details the responsibilities of staff. Our policy is supported by training that is available to all staff.

Duty of Candour relates to any event where things went wrong or didn't go to plan, however there is a focus on moderate and severe levels of harm. We are required to report our compliance with the Duty of Candour regulation for moderate and severe levels of harm.

During 2018-19, 56 incidents occurred that we reported within our Duty of Candour reports. These are shown in the table below alongside our compliance with the Duty of Candour requirements.

	Red and amber incidents declared					
	Moderate harm (amber)	Severe harm (Red)	Total with stage 1 complete	*Total with stage 2 complete	*Total with both stages complete	*Percentage fully compliant
Apr-18	5	0	5	5	5	100%
May-18	9	0	9	9	9	100%
Jun-18	4	0	4	4	4	100%
Jul-18	6	1	7	7	7	100%
Aug-18	7	0	7	7	7	100%
Sep-18	6	0	6	6	6	100%
Oct-18	5	0	5	5	5	100%
Nov-18	4	1	5	4	4	80%
Dec-18	1	0	1	1	1	100%
Jan-19	5	0	5	5	5	100%
Feb-19	1	0	1	1	1	100%
Mar-19	3	0	3	0	0	0%
Cumulative Total	56	2	58	54	54	93%

NB: An incomplete stage 2 is reported when an investigation is ongoing. A letter detailing the results of an investigation will be issued once the investigation has concluded.

Actions we have taken during 2018-19

- We have delivered 41 incident reporting and investigation training sessions which could be attended by all staff groups

- We have delivered 11 training sessions informing staff about Duty of Candour and guiding them on how to be open with patients
- On our intranet, we have made available a range of tools and support resources to help staff be open with patients and meet the Duty of Candour requirements
- Being Open and Duty of Candour is discussed at our divisional quality and safety meetings and in our complaints working group meeting.

As a direct result of the work our divisional quality leads have undertaken this year, our compliance with our statutory obligations has improved significantly from our 2017/18 position.

During 2019-20, we will continue to support our staff to understand and meet the Duty of Candour requirements and will provide intensive support where we identify it is required.

NHS doctors in training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires us to provide "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account".

Our doctors in training report is produced separately to this annual quality report, however we monitor the safe working practices of our junior doctors on a daily basis and we report our findings and actions quarterly to our Risk and Safety Committee. During 2019-20 we will continue to monitor safe working practices of our junior doctors and will continue to escalate risks and mitigating actions to our Risk and Safety Committee.

We hold a monthly junior doctors meeting where our junior doctors can raise any issue concerning them so as these can be reviewed, and action taken as required. During 2019-20 we will continue to meet with our junior doctors and will continue to escalate risks and mitigating actions, linked to their concerns, to our Risk and Safety Committee.

NHS Employee Survey

The NHS employee survey ran from October to December 2018. A total of 3,450 staff in the Trust were eligible to complete the survey and 2,026 staff completed and returned the survey. Survey responses were submitted online and by hard copy for those staff with limited access to computers.

2,026 returned surveys represents a response rate of 59%, an increase from 54% last year and 39% in 2016. This ranks the Trust as having one of the highest response rates within specialist acute Trusts in the country. The rate was achieved through a wide range of actions including a Trust-wide email launch; further reminders in the November Trust newsletter 'What's New'; support from Human Resources (HR) in departmental meetings and an FAQ pack for line managers and weekly humorous screensavers.

The high response rate means that we can have confidence in the issues identified at an organisational and division level. It also means that valid data is much more likely to exist at a departmental or unit level and will therefore support actions to be taken at a more local level.

We achieved some excellent results in relation to response rates to staff survey questions from staff with protected characteristics e.g. gender, race, age. It is common across NHS organisations that staff from these groups respond in fewer numbers and give more negative responses to questions than other staff, particularly

in London. However, in all groups the response rate shows no significant difference to the Trust average and, in many cases, there has been a more positive to the questions. Set out below are some examples:

Black Minority Ethnic:	BME staff accounted for 33% of respondents with the same results as the Trust overall on all measures and 4% more satisfied with 'Your personal development'.
LGBTQ:	Staff who identified as LGBTQ account for approximately 4% of staff. Gay women and men responded more positively than the Trust overall score for 2018 survey, whilst bisexual staff responded slightly less positively.
Religion:	Staff from Buddhist and Sikh groups responded more positively than other groups in both the 2017 and 2018 survey, with Hindus responding slightly less positively on 'your job' and 'personal development'.
Age:	All age groups are the same as the Trust average. Older staff (n=18) are more positive about 'your job' and 'your organisation' but less positive about 'health and wellbeing' and 'personal development'.

The Health and Wellbeing measures continue to challenge us with 63% of staff reporting that the Trust does not take positive action on the health and wellbeing of staff. Additionally, 3 out of 10 staff feel their line manager doesn't take a positive interest in their health and wellbeing. In 2018, we began a programme to focus on supporting staff in this area and we launched a number of healthcare initiatives such as mindfulness, yoga and relaxation techniques which have been very successful.

Health and Wellbeing measures though are also impacted by environment, culture and relationships with managers and work colleagues. Consequently, in 2019, we aim to improve the health and wellbeing of staff through a comprehensive Health and Wellbeing Improvement Plan that includes:

- Creating a safe environment
- Appraisal and personal development (capitalising on the Trusts new learning platform Learn Now)
- Team and management development
- Building on a culture of safety (including Human Factors);
- Care for the Carers (supporting frontline staff with the emotional demands of their roles).

This programme recognises that health and wellbeing is a complex issue and one heavily influenced by the immediate environment in which they work – hence the areas concerned with appraisal, line manager development and team working.

In the 2018 staff survey, 13% of staff surveyed reported harassment or bullying by a manager, a 2% decrease, and 25% by another colleague, an increase of 1% since 2017. 41% of these staff stated that they reported the issue, compared to 40% in 2017. However, there has been in increase bullying and harassment grievances raised with HR from 10 in 2017 to 38 in 2018.

Data suggests some of the challenge lies in the capability of managers to have skilled and sometimes difficult conversations with their teams. Feedback from managers and staff has confirmed this. As part of the plan for 2018 a series of listening groups were held, presentations were delivered to managers to set out some key issues and to explore these issues from their perspective. This work was essential in developing and delivering

development interventions for managers in having diffcult conversations that will be incorporated into the Health and Wellbeing Improvement Plan.

HR Business Partners and the Organisational Development team will work closely with managers to implement the plan and they will be key in embedding the initiatives and developing the practice aligned to our Trust Values.

Workforce Race Equality Standard (WRES)[16]

The Trust completed its 2017/18 WRES submission in August 2018 and this was published on the Trust's website in autumn 2018 with an accompanying action plan.

For 2019, a greater focus has been placed on the WRES and on developing an action plan to support key targets. Whilst the data itself showed some improvement against some of the indicators when compared at a regional and national level, compared to the previous year some of the indicators had deteriorated slightly.

To this end, an action plan was delivered to focus specifically on those areas where results were not as the Trust expected, including:

- Investigation training for managers
- A simplified grievance and bullying and harassment policy
- Training mediators prior to a launch of the mediation service
- The continuation and expansion of listening groups for staff.

Our action plan is being continually reviewed and it is expected that the 2019 submission will be particularly representative given the increased return rate (59%) on the 2019 Staff Survey. Separate to the Trust's 2018 WRES plan, the Trust is setting up a BME network for staff with support from the central WRES team.

[16] 2019/20 NHS Standard Contract (Workforce Race Equality Standard)

Annex 1

Statement of directors' responsibilities in respect of the quality report

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

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

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2018/19 and supporting guidance, in the "detailed requirements for quality reports 2018/19"
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to March 2019
  - papers relating to quality reported to the Board over the period April 2018 to March 2019
  - feedback from commissioners
  - feedback from governors
  - feedback from local Healthwatch organisations
  - feedback from External Services Scrutiny Committee
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2018 national patient survey
  - the national staff survey published December 2018
  - the External Auditor's annual opinion of the Trust's control environment dated
  - CQC inspection report dated February 2019
- 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, and is subject to appropriate scrutiny and review the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

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Baroness (Sally) Morgan of Huyton
Chair

23 May 2019

.....

Robert J Bell
Chief Executive

23 May 2019

Annex 2

Statements from key stakeholders

Healthwatch Hillingdon's response to Royal Brompton and Harefield NHS Foundation Trust Quality Account 2018-19

Healthwatch Hillingdon wishes to thank the Royal Brompton and Harefield NHS Foundation Trust (the Trust) for the opportunity to comment on the Trust's Quality Accounts for the year 2018-19.

Healthwatch Hillingdon acknowledges that the Quality Account published by Royal Brompton and Harefield NHS Foundation Trust (the Trust) lies within the requirements framed by the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010 and the mandatory requirements set out by NHS Improvements for NHS foundation trusts.

Questioning the effectiveness of the Quality Accounts to reflect local quality, in a meaningful way for the public, is a position Healthwatch Hillingdon has taken since the inception of the Quality Accounts.

It is pleasing to see the number of achievements listed in part one of the report. In particular, the high percentage of patients who would recommend the services to family and friends. It is also pleasing to see the overall CQC ratings for the Trust following the re-inspection in 2018-19, confirming that improvements have been made since the 2016 inspection. The Trust is to be congratulated on this achievement, which could not be attained without the continued hard work and dedication of the workforce.

The glossary in 'Annex Three' is to be welcomed, as it allows the general public to better understand some of the terminology. Healthwatch Hillingdon's view is that the report could be a little less technical and enhanced with real examples of patient experience.

Should the Trust require any further information or clarification on the content of this response please contact Mr Turkay Mahmoud, Interim Chief Executive Officer.

Healthwatch Hillingdon
23 April 2019

Statement from Councillor Robert J. Freeman (Chairman, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea) on the Royal Brompton and Harefield NHS Foundation Trust's Quality Account 2018/19

We welcome the opportunity to respond to The Royal Brompton and Harefield NHS Foundation Trust's Quality Account for 2018/19.

We are proud of having The Royal Brompton Hospital based in the Borough. The Hospital has been a landmark in Chelsea since 1842.

We congratulate the Trust on the significant quality improvements made during the year 2018/19. These were reflected in the overall 'Good' Rating, with some areas of outstanding practice noted, from the Care Quality Commission in its report published February 2019. This achievement is particularly noteworthy as it took place against the background of the uncertainties that the Trust inevitably faced with the proposals to reconfigure cardiac and respiratory care across North West London.

We welcome the Trust's initiatives to reduce the times that patients wait from referral to treatment and to continue to improve the accuracy of the treatment data and information. We are disappointed that during 2018/19 four patients waited more than 52 weeks for their treatment. We welcome the Trust's commitment to learn from the investigations that followed these incidents.

We welcome the decision of the Governors to choose the mortality rate of Transcatheter Aortic Valve Implantation (TAVI) as a quality measure for the quality report but we would have welcomed as a further quality measure, information on the other TAVI serious procedure complications.

We welcome the Trust's Quality Priorities for 2019/20 particularly the identification and management of patients with sepsis and the strengthened commitment to Learning from Deaths including the purchase of a new mortality database.

We congratulate the Trust on its Quality Account and its achievements in 2018/19. We look forward to continuing to work with The Royal Brompton and Harefield NHS Foundation Trust in the coming year.

Councillor Robert J. Freeman
Chairman,
Adult Social Care and Health Scrutiny Committee, Royal
Borough of Kensington and Chelsea

ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

Consultation on the Trust's Quality Account - 2018/2019

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

The External Services Select Committee welcomes the opportunity to comment on the Trust's 2018/2019 Quality Account report and acknowledges the Trust's continued commitment to try to attend its meetings when requested.

It is pleasing to see that the Trust's staff survey achieved the highest response rate within specialist acute trusts in the country with 59% of staff (2,026 out of 3,450) returning their completed surveys. This high response rate will give the Trust confidence in the issues identified at an organisational and divisional level and justifies any action being taken locally at a departmental or unit level. Issues raised include 63% of staff reporting that the Trust does not take positive action on the health and wellbeing of staff and three out of ten staff felt that their line manager didn't take a positive interest in their health and wellbeing.

Health and wellbeing is a complex issue which is heavily influenced by the immediate environment in which staff work. By encouraging staff to speak up and by training a number of staff to provide an in house mediation service, there's been a significant increase in the number of bullying and harassment cases reported, the majority of which have been resolved through mediation. The Committee is pleased to see that 'Coaching for Bullies' training has also been made available. Although Freedom to Speak Up is embedded in the Trust's strategy and policies, arrangements need to be revised to ensure that all staff have easy access to speak with someone when they have concerns. The Committee notes that this learning has fed into the new Health and Wellbeing Improvement Plan. Members look forward to receiving updates on the implementation of the Plan in 2019/2020 which (it is hoped) will develop and maintain a supportive and developmental working environment.

Despite the measures that have been put in place to support staff and improve the patient experience, the number of staff who would recommend the Trust to friends or family needing care has reduced from 94.86% in 2017/2018 to 91% in 2018/2019. However, it is recognised that this is above the national average (89%). The percentage of inpatients that would recommend the Trust to friends or family needing care has also decreased slightly (95.68% in 2017/2018; 95.33% in 2018/2019) leaving it just below the national average (95.4%). Members look forward to seeing the results of any action taken by the Trust to improve this outcome.

Over the course of the last year, the Trust has established that its mortality database was not fit for purpose as it couldn't easily link to other related information such as incidents and complaints. As this is of concern to Members, they are pleased to note that funding has been approved to install a new database by the end of 2019/20 to enable cross referencing and the identification of common themes to help inform improvements to care. The Committee looks forward to receiving an update on how the learning has been applied.

The Committee is delighted that, following CQC reinspection of some services during 2018/2019, the Trust was awarded an overall rating of 'Good'. Particular achievements include Surgery being

rated as 'Outstanding' at Harefield Hospital and 'Good' ratings at Royal Brompton in relation to the Surgery and Critical Care services and the Safe, Responsive and Well-led domains.

Members are aware of changes recently introduced in relation to information governance measures whereby the previous self-assessment toolkit has been replaced with a requirement to submit evidence for 100 mandatory questions. Whilst information governance compliance is of huge importance, it seems as though the change in how this assessment is undertaken is now more onerous.

The Committee is disappointed to see that, against the *cancer - 62 day urgent GP referral to first definitive treatment target* (85%), the Trust has achieved 64% for the year (which is a significant reduction on the previous year's 74.84%). The Committee is reassured that further work is being undertaken by the Trust to help ensure that this target is met; for example, accurately recording dates for referral and treatment completion. However, it is also recognised that work towards meeting this target needs to be undertaken in partnership with referring hospitals, which can cause complications and delays. It would also be useful to include the number of patients in the report for context.

Members are aware that the Trust is committed to continuing to meet the national target of 92% of patients starting their treatment within 18 weeks. However, in 2018/19, four patients waited more than 52 weeks for their treatment to start. The Committee looks forward to seeing what action is taken to ensure that these targets are met during the current year.

A new national lung cancer diagnostic and treatment pathway is expected to be fully implemented by 2020. Although it is recognised that the Trust has been working towards achieving the treatment target of 24 days since 2016/17 and it is not yet compulsory, caution needs to be applied in celebrating too soon on achieving an average of 24 days 2018/19. Of course this is great in terms of service improvement and with regard to patients not having to wait longer than is necessary, but there is still a little way to go.

All wards have consistently achieved above 90% accuracy in the recording and calculating of NEWS scores, and this improvement was recognised by the CQC inspection team in 2018. As this target is already routinely being achieved, Members are surprised that the Trust has not set a more challenging target for NEWS2 in 2019/2020.

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 2018/19.

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08th May 2019

Royal Brompton Quality account

Statement from NHS England to Royal Brompton and Harefield foundation trust quality account 2018-2019

NHS England is happy to receive and comment on this year's quality report and see the progress that the trust has made.

Over the year NHS England has enjoyed working with the trust and would like to congratulate them on their improvements recognised through their CQC inspection in 2018. The improvements noted represent the trusts focus on continuous improvement and strong clinical leadership.

It has been encouraging to see an improvement this year in referral to treatment times for surgical procedures following the implementation of new scheduling programmes. We look forward to the further roll out of this programme, and a reduction in avoidable cancellations as a result.

The trust has been fully engaged in NHS England CQUIN schemes, whilst clinical teams have demonstrated proactivity and drive towards creating new systems, pathways and processes to improve patient care through those schemes. The palliative care team utilised the opportunity to work towards their goal of extending their services to patients with heart failure who currently attend the trust as outpatients.

The Trust has also worked closely this year with partners within the North West London Sustainability and Transformation Partnerships, working towards improving health and services for the local population.

Significant improvements within the year have included 5 steps to safer surgery initiatives to improve safety, sepsis 6 compliance and implementation of NEWS2. While the trust has made significant improvements within theatres, we hope that this remains a continued quality priority for the trust. The Trust have made efforts to maintain good infection control processes, thus no concerns regarding infection rates during the year have been noted.

There has been transparent reporting of incidents within the year and NHS England feels the Trust works hard to continuously identify areas for improvement. It has been particularly encouraging to see the trust review and action outcomes of national benchmarking audits.

NHSE is keen that all our providers meet constitutional standards including 62-day cancer waits, reduced cancellations and a reduction in 52-week breaches. We look forward to continuing to

work with the Trust to achieve these, leading to continuous improvements in quality of service provision and patient care.

M.A. Cummins

Marie Cummins
Deputy Director of Nursing and Quality (Interim)
Specialised Commissioning (London Region)
On behalf of NHS England

Statement from our Council of Governors

Governors have a key role in ensuring that the voice of our patients, members and local community is at the heart of the trust's decision making. This includes, where appropriate, getting involved in the quality improvement work undertaken at the Trust.

The Trust's Council of Governors has 21 positions, of whom 17 are elected from the public, patient and staff constituencies.

One of the responsibilities of the Council of Governors is to choose the local quality indicator to be included in the Trust's Annual Quality report and to be audited by the Trust's external auditors, Deloitte LLP. Because of the cutting edge cardiac surgery undertaken at the Trust, the local quality indicator that we selected was mortality associated with the TAVI (transcatheter aortic valve replacement) procedures undertaken at the Trust.

The Council of Governors has received and reviewed the Annual Quality Report and, on behalf of the Council of Governors, I am confident that the report is an accurate reflection of the quality of services provided at the Trust. In determining this, I have utilised knowledge gained from quality walk-rounds undertaken by Governors with Trust Directors and from the knowledge gained from attending internal and external workshops attended by Governors.

The Annual General Meeting of the Council of Governors will be held on 17th July 2019. We will consider the report provided by Deloitte LLP on the Trust's Annual Quality Report at this this meeting.

George Doughty

Lead Governor

Annex Three

Glossary

A	
AKI	Acute Kidney Injury.
Aortic stenosis	Aortic stenosis is one of the most common and most serious valve disease problems in the heart. It is a narrowing of the aortic valve opening.
B	
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.
Care Quality Commission (CQC)	**The independent regulator of health and social care in England.** www.cqc.org.uk
Clinical audit	*A quality improvement process that seeks to improve patient care and outcomes by* **measuring** *the* **quality** *of care and services against agreed* **standards** *and* **making improvements** *where necessary.*
Clostridium difficile infection	A type of infection that can be fatal. There is a national indicator to measure the number of *C. difficile* infections which occur in hospital.
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.
D	
Darwin	Our productivity programme focused on helping us to ensure that we make best use of the resources available to us.
Department of Health (DH)	The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk
Duty of Candour (DoC)	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and

	treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
DATIX	Datix is an information system used by the Trust to enable incident reports to be submitted from clinical and non-clinical areas, greatly improving rates of reporting & promoting ownership of risk. The system utilises an online incident reporting form that has been designed in consultation with the Trust so that it is simple to use and suitable for both clinical and non-clinical incident reporting. Incidents can be submitted by anyone in your organisation with access to a computer.
E	
Eighteen (18) week wait	A national target to ensure that no patient waits more than 18 weeks from GP referral to treatment. It is designed to improve patients' experience of the NHS, delivering quality care without unnecessary delays.
Elective operation/procedure	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.
External Services 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.
F	
Foundation Trust	NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Royal Brompton & Harefield became a Foundation Trust on 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/
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.
K	
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.
M	
Multidisciplinary team meeting (MDT)	A meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients.
Multi-resistant staphylococcus aureus (MRSA)	A type of infection that can be fatal. There is a national indicator to measure the number of MRSA infections that occurs in hospitals.
MHRA	The **M**edicines and **H**ealthcare products **R**egulatory **A**gency regulates medicines, medical devices and blood components for transfusion in the UK.
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.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death (NCEPOD). NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. http://www.ncepod.org.uk/
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.
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.
R	
Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge.
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.
Standard contract	The annual contract between commissioners and the Trust. The contract supports the NHS Operating Framework.
T	
TAVI	Transcatheter aortic valve implantation (**TAVI**) is a non-surgical alternative to open heart surgery. **TAVI** is carried out in a cardiac catheterisation laboratory, also known as a catheter lab, and normally takes one to two hours to complete.