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A

External Services Scrutiny Committee

Councillors on the Committee

Mary O'Connor, Deputy Mayor of Hillingdon (Chairman)
Michael White (Vice-Chairman)
Phoday Jarjussey, Labour Lead - External Services
Judy Kelly
Peter Kemp

Date: **TUESDAY, 26 APRIL 2011**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 3 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

Agenda

PART I - MEMBERS, PUBLIC AND PRESS

1 Apologies for absence and to report the presence of any substitute Members

2 Declarations of Interest in matters coming before this meeting

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4 Exclusion of Press and Public

To confirm that all items marked Part 1 will be considered in public and that any items marked Part 2 will be considered in private

5 Performance Review of the Local NHS Trusts 13 - 110

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PART II - PRIVATE, MEMBERS ONLY

7 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

30 March 2011

HILLINGDON
LONDON

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Mary O'Connor (Chairman), Phoday Jarjussey, Judy Kelly, Dominic Gilham and Shirley Harper-ONeill **Witnesses Present**: CI Alison Dollery – Metropolitan Police Service Colin Gribble – London Fire Brigade David Brough – Chairman, Hillingdon Community Trust Christine Little – Director, Hillingdon Community Trust Carole Jones - Chair of Strong and Active Communities Partnership Keith Bullen - Chief Operating Officer, NHS Hillingdon Professor Ian Campbell - University of Brunel Ted Hill - Hillingdon Association of Voluntary Services (HAVS) Mike Gettleson - Hillingdon Inter Faith Network Lorraine Collins - Uxbridge College **LBH Officers Present**: Kevin Byrne, Fiona Gibbs, Dr Ellis Friedman (in part), Nikki Stubbs and Nav Johal **Also Present**: Malcolm Ellis – Standards Committee Vice-Chairman **Public Present:** 1	
34.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies were received from Councillors Peter Kemp and Michael White. Councillors Dominic Gilham and Shirley Harper-O'Neill were present as substitutes.	**Action by**
35.	**MINUTES OF THE PREVIOUS MEETING - 23 FEBRUARY 2011** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 23 February 2011 be agreed as a correct record.**	**Action by**
36.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**	**Action by**

37.	**COMMUNITY COHESION: BUILDING STRONG, COHESIVE AND ACTIVE COMMUNITIES IN HILLINGDON** *(Agenda Item 5)* The External Services Scrutiny Committee last considered the issue of community cohesion at its meeting on 9 June 2010. Representatives from the various organisations present had been asked to provide a summary report on 'building strong, cohesive and active communities in Hillingdon'. <u>LBH – Partnerships & Community Engagement</u> Ms Fiona Gibbs, Stronger Communities Manager, explained how community cohesion had become increasing important in the Borough. There were issues in relation to migration, depravation and inequalities amongst communities. Other challenges which needed to be taken into consideration included extremist views, terrorism and far right views. The positive factors that cohesion brought to the community were discussed. Community cohesion was widely used to describe a state of harmony or tolerance between people from different backgrounds living within a community. This was linked to the concept of social capital and the idea that, if we knew our neighbours and contributed to community activity, then we were more likely to look out for each other, increase cohesion and minimise cost of dependency on institutional care. Ms Gibbs advised that the challenges to cohesion included tackling issues such as local inequalities, rapidly changing communities and mistrust and misunderstanding. Factors such as hate crime, anti-social behaviour and gangs also needed to be considered as well as perceptions of groups such as the Somali community in Hayes. It was important for communities to have good relations and feel a sense of belonging and pride about where they lived so that they looked out for their neighbours. This could help to ensure a maximised individual and community potential. Ms Gibbs advised that, through partnership working, there had been increased participation in community activities, reduced isolation, increased satisfaction of services, increased aspirations, reduced community tension and an increased sense of belonging. This work had been carried out through the promotion of community engagement. The Strong and Active Communities Partnership goals included: - Capacity building - National and international links - Strengthening partnership working - Developing models of best practice - Promoting respect and understanding between communities - Community engagement The Partnership had identified key priorities to move forward in 2011 and continue to develop a strong and active community in Hillingdon. <u>Strong and Active Communities Partnership</u>	**Action by**

Ms Carole Jones, Chairman of the Partnership, updated Members on the successful outcomes throughout the year for Strong and Active Communities Partnership. Some key achievements in the year included the work undertaken with schools. Schools had a duty to promote community cohesion and, as such, had established a community cohesion partnership, developed a practitioners group and gained financial support to appoint a development worker.

The Partnership was working on developing a portfolio of models of best practice to share.

The National College (formerly NCSL) was looking to develop community champions and recognition of best practice. The Partnership also had been working with Buckinghamshire New University on its new Institute for Diversity Research, Inclusivity, Communities and Society (IDRICS. IDRICS had been set up to reflect the organisational recognition of the importance of inclusivity, celebration of diversity and community engagement in all aspects of University's work.

Work within the community had included Week of Peace, Week of Faith and engagement work with schools which included Big Fest and Hayes Carnival (which involved the wider community). The Women in the Community group had also enabled women to become more confident and gain employment. Leisure facilities in the Borough had been improved and included the opening of two new leisure centres in Hayes and Uxbridge.

The main focus of the Partnership's work had been targeted at the Peabody Estate in Yeading, West Drayton, Yiewsley and Hayes – specifically areas in the south of the Borough. The organisation was working to strengthen partnership working across the community.

Ms Jones updated Members on the Partnership's priorities for 2011. These included targeting local area partnership working and addressing issues in those identified localities. For example, work could be undertaken to: reduce health inequalities and promote health equalities; promote the positives of local people; look at opportunities for bringing people together; promote a sense of belonging; and promote sense of well-being.

Other priorities involved promoting and increasing residents' involvement in leisure and cultural activities across the Borough. This included work through Hillingdon Inter Faith Network (HIFN), schools, families, communities and community partnerships and other Local Strategic Partnership (LSP) theme groups.

Ms Jones added that the core functions of the group needed to be maintained. This included the following:

- Monitoring of community tensions and local issues, working with partners to respond accordingly and appropriately.
- Reviewing intelligence and information to develop further understanding of our communities and their needs, carrying out research where necessary.

- Ensuring dissemination and sharing of intelligence and information with partners and monitoring how services were responding to meet those identified needs.

Metropolitan Police Service

Chief Inspector Alison Dollery, Metropolitan Police Service (MPS), spoke to Committee about the positive things that the MPS in Hillingdon had done. Good work had been carried out by the Safer Neighbourhood Team (SNT) and schools team also, as well as Cadets, and Metropolitan Special Constables (MSC) and the Police Community Safety Team.

Work had been undertaken with Hayes Town Partnership with regard to the Somali community in Hayes. Work had also been done to identify on a potential gang prevention strategy and with vulnerable victims of crime.

The priorities for the next 6-12 months were discussed. There were still a lot of things to do in the future, for example, in relation to 'gangs' of young people who got into trouble with the police. The MPS was looking into preventing those young people becoming part of a gang. It was anticipated that there would need to be a lot of partnership work undertaken with these young people over the next 6-12 months. Chief Inspector Dollery stated that the majority of young people were not trouble makers or part of a gang and she did not want all young people labelled in the same way.

The MPS worked with all communities in the Borough, providing additional support for repeat or vulnerable victims. It would target those communities that were difficult to communicate with.

Work with young people has started and would be strategically based. Schools in the Borough were working together with the Police schools team to target difficult groups of young people and to provide an education programme for the Borough. This programme linked public safety and crime prevention and encouraged communities to support each other.

The MPS would be financially challenged next year and this would have an impact on how the service would be provided. The expectations of the community would remain the same so the challenge for the future was to empower the public and teach them to manage their own issues. It was noted that at a time when the service was tighter with finances it was a time to build relationships with other organisations to work in partnership.

University of Brunel

Professor Ian Campbell, University of Brunel, explained that the emphasis at Brunel was the internal community and how to encourage students to help in the community. The number of student and staff volunteers had continued to increase.

The university had 15,000 students and the Brunel Volunteer Scheme had been extremely successful in getting students and staff to

volunteer. Professor Campbell envisaged this expanding further. A number of activities were organised each year on campus to bring the community on site and show residents what the University did. The feedback received from the community had been positive towards staff and students.

The University had set up a public engagement service which demonstrated that conversations were happening. Around 250 people had attended 6 lectures which were themed around topical areas. The main topic this year was 'Answering the Biggest Questions of our Age'.

The over 50's group on campus was extremely successful. This had over 160 members and contributed towards an increase in the activity levels within the community.

The University provided a large range of sports facilities that were used by the community. A recent Olympics day was held and included themes around cultures. Over 100 primary school children had attended this event.

There had been significant work undertaken over the last 5 years to break down barriers between students and the rest of the local community. The University's aim for the next year was to: look at how it could interact more effectively with schools; work more closely with the community partners; and develop the volunteering further to encourage more students and staff to work within the community.

<u>Uxbridge College</u>
Ms Lorraine Collins, Uxbridge College, explained that the students attending the College tended to be local people. They were local before they joined the College and remained in the community after they had finished their courses. The Hayes campus of the College was known as the 'community' campus.

Uxbridge College comprised 3 communities: staff, students and external. Within the student community, there were two distinctions: the young people and the older age group. The College had more adult students than 16-18 year olds. Part of the College's role for the older students was to support them back into work.

The College aimed to try and encourage young people to be outspoken and develop as a person rather than just go to college to get qualifications. The focus was on a whole person and the generation. The College had been involved in events such as 'One World' and 'Big Fest'.

There were challenges for the future to consider. As there was less money, the College had the opportunity to think about things differently in order to provide the service. There were also changes around people who wanted to learn English as a 2nd language and barriers that were being faced in terms of the funding for this. Ms Collins was uncertain about how many would be eligible for the Government grant for this in the future. This was important, especially in the South of the Borough, and in particular in Hayes. The College did not want to

disengage the community so would find ways to meet this challenge.

Hillingdon Association of Voluntary Services (HAVS)
Mr Ted Hill, HAVS, stated that, according to the UK Social Exclusion task force, social inclusion was linked to community cohesion. The work of HAVS was directly linked to this.

Mr Hill stated that the sector locally was very robust and flexible and it had the capacity to deliver results. HAVS was determined to move things forward at a good pace. The organisation was working with the voluntary sector and the following year would prove to be a challenge with the financial difficulties that would need to be faced.

There had been some notable successes for HAVS in the last year: it had met its Local Area Agreement stretch targets; a lot of volunteers had signed up; there was now an online version of the HAVS newsletter, which would help to reduce costs; a very successful equality conference had been held in March; it was winner of the Brunel University Business School Workplace Employer 2009/10; and HAVS had also been reaccredited with Investors in People.

A new interactive website had been launched (Hillingdon Connected - www.hillingdonconnected.org.uk) which further improved communications. HAVS, in conjunction with Nick Hurd MP, had also developed new partnership arrangements with the national charity, Pilotlight. Work was being undertaken in partnership with the Hillingdon Inter Faith Network as part of the Week of Peace.

The organisation had clear plans for the future but it needed to find different ways to deliver due to the financial constraints.

PCT / Public Health
Mr Keith Bullen, Hillingdon PCT, spoke about the chairmanship and membership of groups in Hillingdon and promoting healthcare. The Wellbeing Centre that had opened in Boots in Uxbridge was identified as an example of the good work being done. Work that needed to be undertaken included the development of work programmes, initiatives to improve housing, mental health and wellbeing and health promotion.

The Health Promotions involved going out into the community and providing the service to the Borough. It was anticipated that this would continue into the following year. There had been a year on year improvement in the community in terms of promoting health care.

Key work also included smoking cessation and tobacco control with targeted work with ethnic minorities. Hillingdon was one of the best places in London for immunisation. This issue had been targeted in the last two years and the benefits could be seen throughout the Borough. The learning from the emergency planning work associated with swine flu had also been very beneficial.

The future challenges were discussed. There would be major organisational change which would bring more in-Borough control. The same financial challenges faced by other organisations would also be

faced by the PCT which meant that smarter working was required. More services would be put into a community setting and there would be a big push in the next two years to make improvements. Mr Bullen stated that better collaboration was needed to move this forward, even for the partnership within health. He went on to advise that the PCT was investing and developing in the area and would soon be asking GPs in the area what they required.

It was agreed that the work of the Joint Director for Public Health had been vital since he had been appointed.

Hillingdon Community Trust (HCT)

Mr David Brough, Hillingdon Community Trust, spoke about the projects the Trust had funded over the last year. This organisation had not suffered cuts in its funding as it was still guaranteed to receive £1million per year from BAA Heathrow Limited. Bids for this funding had been received by HCT, in 6 funding rounds per year and there was increasing demand for funding

HCT's overall strategies were discussed. Mr Brough questioned what community cohesion was and stated that a clearer understanding of what was meant was needed. He suggested that the concept was about more than race and ethnicity - it included the perception of travellers and gangs, and bridging the gap between the young and the old. It was noted that there was a north / south divide in the Borough.

Mr Brough suggested that redefinition was required for what was meant by community cohesion and what the aim was. He also suggested that organisations needed to ask themselves if the people in the Borough knew what they did, and what work had been done around community cohesion. It was noted that most people in the Borough would not know about the achievements organisations present. It was agreed that communication and the perception of how they were getting messages across to the ordinary resident were vital.

Mr Brough spoke about Yeading School House and how it was a supreme example of a project of people mixing across the community.

Difficult decisions would be required in relation to priorities for the next year. HCT would need to consider where the hot spots were, and if it was doing enough to meet the demands in these hot spots.

It was noted that the Somali community had been stereotyped and it was important that the Borough address this matter. There were also issues within the Harmondsworth and Sipson community regarding the third runway at Heathrow Airport. Consideration would need to be given to how the community could be rebuilt given that the uncertainty of the third runway had not gone away.

Mr Brough suggested that the Council's overall planning core strategy and social inclusion policy needed to give more prominence to community cohesion. It was stated that community cohesion was not the same as social inclusion.

Ms Christine Little stated that since it started in 2003, the HCT had looked at ways to target financial resources. It now looked at particular issues in the area and focused more on community cohesion. The organisation looked at how it could bring together people of different ages and backgrounds.

When analysis had been carried out of those projects the HCT had funded, it had seen lots of improvements. It had provided funding for projects such as the Hillingdon Inter Faith Schools programme, Minet's One World, Kickz and Yeading Schools.

There was a huge degree of passion in schools to get people involved. A large number of successful projects were based around schools. The Trust believed that projects that engaged young people and their parents were key to improving community cohesion. Schools were able to reach out to a large number of people and enabled groups of people to come together for activities and bring the same groups of people together over a period of time.

The Trust believed that a long term future challenge would be the reductions in public expenditure and funding from other sources. The 'Big Society' was unlikely to be able to replace the reductions as it would take time to develop in disadvantaged communities.

It was noted that community cohesion was a shifting target and this needed to be considered when looking at where resources where implemented. Physical activity and sports were important, including the different types of physical activity offered, e.g., bhangra, yoga, etc. It was noted that sometimes small amounts of money made huge changes to the community.

It was noted that lottery funding had been secured through the London Health Commission for a number of small projects in the 20 most deprived areas in London. A DVD of this work had been produced and copies would be sought for Mr Bullen, Dr Friedman and Ms Little.

<u>London Fire Service</u>
Mr Colin Gribble, London Fire Brigade, explained that many things had changed in the Fire Brigade over the last few years. The Brigade had carried out more activities than in the past and the role of a fire fighter was very different than it had been previously. The Brigade was now getting involved in an increasing number of differing projects.

The Brigade needed to make £60million of savings in the next 3 years. It was difficult to know what the impact of this would be. £1million of the available funding was used for trainers across London to improve the training offered. This £1 million pound was secured specifically for the LIFE project to fund trainers to facilitate the event. This should ensure that officers were secured for the task more effectively and was hence an improvement.

Projects in the last year included:

- Projects in schools: The Schools Officers' core role was to deliver interactive educational workshops on fire safety to

children in primary school years 2 and 5 across London.

- We're in Safe Hands (WISH): This scheme supported London Fire Brigade's Home Fire Safety Visit initiative.
- Junior Citizen (JC): These events were a multi-agency, interactive schemes based on anti-crime messages, citizenship and safety. These events ran very smoothly and the next one was planned for March 2012.
- The Juvenile firesetters intervention scheme: This was designed to address firesetting behaviour among children and young people. Trained advisors were available to meet with the child or young person and their parents.
- The London Fire Brigade was helping to reduce anti-social behaviour by leading the way through the LIFE (Local Intervention Fire Education) programme: a scheme aimed at addressing the problems of young people who deliberately set fires, and their anti-social behaviour.
- School presentations at secondary schools on fire safety which had received very favourable feedback.
- Work was being done with Hillingdon's Road Safety Forum to reduce road traffic injuries amongst young people.

It was noted that Hillingdon Borough came top of the 33 London Boroughs in the 2009/10 End of Year report. The Borough had met 11 of the 12 categories. The only area where the Brigade did not meet its target was with regard to the response time for persons shut in lift - there was however a 35% improvement in this area. At the end of February 2011, Hillingdon was top of the statistics table in London and it was hoped that the Borough would lead the table for the second year running at the end of the year. Members congratulated the officers for this achievement so far.

<u>Hillingdon Inter Faith Network (HIFN)</u>

Mr Mike Gettleson, Hillingdon Inter Faith Network, spoke about the aim of the Network - to promote religious harmony. It was acting as a contact for a link to networking with the faith communities in Hillingdon. HIFN was now recognised as the vehicle for many statutory and voluntary leads in engaging with communities across the whole Borough.

HIFN wanted to get to know and understand other faith groups across the Borough. The work it was doing in Hillingdon was to bring faith groups together for the greater good. Mr Gettleson stated that it was crucial to understand other faiths in order to reduce the animosity amongst other faiths.

HIFN started in April 2007. Hillingdon was a diverse Borough which covered many religions and it was noted that it included over 100 active faith groups. There were more than 900 community activities taking place for these faiths including those for elderly and the young.

The organisation was proud of its website which contained a large database and catalogue of what went on in the 100's of faith buildings/activities in the Borough. The database could be searched online. The importance of visibility was discussed, to show that was

happening.

Mr Gettleson mentioned that, during the Week of Peace which promoted community cohesion, around 300 people had taken part in the peace walk. During the Week of Faith in November 2010, there were daily programmes of activities. The success of this programme meant the 'week' had been extended to 10 days. Mixing faiths and having open prayer meetings with different faiths coming together had also been very successful.

Although the organisation did not receive Local Authority funding, the Council did provide support and meeting rooms which were very important. The buildings in the Borough were important for the faith groups as they were vital for holding faith meetings and events. HIFN received grants from outside bodies which enabled it to run projects and network meetings.

HIFN worked with young people and had continued its faith in schools programme. Next week, facilitators from different faith backgrounds would be sent to Minet School to talk to different groups of children about their perspective of their own faith. HIFN promoted themselves during elections campaign and invited candidates of 3 MPs to come and talk.

Members commended the organisations present on the work they had undertaken in the last year and noted the good news stories. Members agreed that excellent facilities should be provided around the clock and that continuous improvement was needed.

Members acknowledged comments regarding the North / South divide in the Borough and it was noted that the mortality rate in the South of the Borough was 7 years lower than in the North. Identifying needs and meeting the needs of those that were hard to reach was important.

Members discussed the term 'communities' and felt that the term 'community' was better when discussing community cohesion rather than 'communities'. They stated that the Borough was one community and that the term 'communities' could build boundaries.

Members discussed how the younger generation were taught to be outspoken and think for themselves and it was agreed that drama helped them to gain confidence. It was noted that the North of the Borough was very rich in art and drama venues, whereas the South of the Borough was not. As not everyone wanted to do sports, it was suggested that the arts could be of interest to a lot of young people. Ms Collins advised that there was a theatre in Uxbridge College and suggested that consideration be given to opening up this venue to be used for the community arts as part of the community cohesion work. Officers agreed that expanding opportunities to get involved in the arts in the South of the Borough was something that they would progress.

Members discussed what activities would be scheduled in the run up to the London Olympic Games and the Royal Wedding. It was noted that

	Hillingdon Borough was the London borough with the most street parties for the Royal Wedding. Members spoke about literacy and how parents reading or talking to children from 0 – 2 years would make a huge difference to their lives as they grew up. Members thanked the organisations present for their work over the last year and their presentations to the Committee. **RESOLVED: That:** **1. the reports and presentations be noted;** **2. Democratic Services arrange for copies of the London Health Commission DVD to be sent to Mr Bullen, Dr Friedman and Ms Little;** **3. Ms Gibbs consider how the to rephrase 'The Strong and Active Communities Partnership' so that it was clearer that the Borough was one community;** **4. Ms Collins discuss with the other organisations present how arts and drama could be expanded in the South of the Borough;** **5. Ms Collins look at how the use of the theatre in Uxbridge College could be expanded to involve more of the community; and** **6. the organisations present be thanked for the work they had completed over the last year and their continued effort for the following year, particularly in light of future financial constraints.**	
38.	**CHILDREN'S SELF HARM WORKING GROUP - DRAFT FINAL REPORT** *(Agenda Item 6)* Councillor Shirley Harper-O'Neill, Chairman of the Children's Self Harm Working Group, introduced the Working Group's draft final report on children's self harm. Councillor Harper-O'Neill advised that the Working Group meetings had been attended by various witnesses from different organisations and their input at the sessions had been invaluable. Members had found the selfharm.co.uk launch at Channel 4 very interesting and the work undertaken by children who had experience of self harming had been very emotional. Members agreed that improvements were needed around communication and the provision of information for those that needed it: this included teachers, carers, social workers, the children themselves and parents. The report proposed recommendations to build and improve on the work that the Council already did for children that self harmed and their families. Members asked that more statistics from the scoping report be included in the final report to show the scale of the problem for children. **RESOLVED: That, subject to the proposed addition, the report of the Children's Self Harm Working Group be agreed and submitted to Cabinet for consideration at its meeting on 14 April 2011.**	**Action by**

39.	**WORK PROGRAMME** *(Agenda Item 7)* **RESOLVED: That the report and work programme be noted**	**Action by**
	The meeting, which commenced at 5.00 pm, closed at 7.45 pm.	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nav Johal - 01895 250692. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

PERFORMANCE REVIEW OF THE LOCAL NHS TRUSTS

Officer Contact	Nav Johal and Nikki Stubbs, Central Services
Papers with report	Appendix A - Royal Brompton & Harefield NHS Foundation Trust Quality Account Report Appendix B - The Hillingdon Hospital NHS Foundation Trust Quality Account Report

REASON FOR ITEM

To enable the Committee to submit comments to the Care Quality Commission (CQC) on the performance of local NHS Trusts and to comment on the Trusts' Quality Accounts.

OPTIONS AVAILABLE TO THE COMMITTEE

1. Members question the Trusts on their Quality Account reports for 2010/11
2. Members use information from their work this year to question the Trusts on issues measured by the CQC
3. Members decide whether to use this information to submit a commentary to the CQC

INFORMATION

Introduction/background

CQC Assessment

1. The Care Quality Commission (CQC) is the regulator for health, adult social care and mental health services. The organisation helps to ensure that residents get better care by:
    I. driving improvements across health and adult social care
    II. putting people first and championing their rights
    III. acting swiftly to remedy bad practice

2. The CQC is committed to gathering and using knowledge and expertise and working with others, particularly with people who use services and their representatives. In June 2009, the CQC launched Voices into Action which is a plan for involving and consulting individuals, groups and organisations so that they have an impact on decisions made.

3. The CQC expects the services it regulates to demonstrate that they involve people and respond to what people tell them. Providers have told the CQC that engaging with people can benefit all aspects of care, including how services are planned, organised and provided, how services are used, the outcomes of care, and wider benefits for those who are involved, for their staff, as well as for the public. The public, including people who use services and carers have said that effective involvement can give them a voice in services, recognise their right to be heard, and can increase their understanding, trust and confidence in services and their knowledge about their local services, and lead to improvements in their health and wellbeing.

4. Local authorities are being encouraged to send evidence to the CQC about the quality of local NHS services to help inform decisions about providers' compliance with the core standards assessment (previously known as the Annual Health Check). Unlike the Annual Health Check, Councils can now send evidence to the CQC on an ad hoc basis. The assessment now covers adult social care as well as health and mental health services.

5. From April 2010, new essential standards of quality and safety were introduced gradually across all health and adult social care services. Providers of health and adult social care are registered with the CQC if they meet essential standards and are constantly monitored by the CQC to ensure that they comply with new legislation.

6. Under the Health and Social Care Act 2008, NHS Trusts were the first providers that were incorporated into the new system which started on 1 April 2010. Providers of adult social care and independent health care started in October 2010. Primary dental care providers must be registered by the Care Quality Commission from 1 April 2011 - this includes NHS and private dentists, and those who work in both sectors. GPs must be registered by April 2012.

7. Any feedback received from the External Services Scrutiny Committee will help the CQC decide whether the health services provided within the Borough meet the essential standards of quality and safety.

8. The CQC will use a judgement framework to help make judgements about compliance and to promote consistency. The framework explains how a decision should be reached by considering evidence about compliance. It focuses on 16 of the 28 regulations and associated outcomes that most directly relate to the quality and safety of care. The framework is split into four stages:
    i. Determining whether there is enough evidence to make a judgement.
    ii. Checking whether the evidence demonstrates compliance or whether there are concerns about the provider's compliance with the regulations.
    iii. If concerns are found at stage ii, making a judgement about the impact on people using services and the likelihood of the impact occurring.
    iv. Validating the judgement.

9. A copy of the *Summary of regulations, outcomes and judgement framework* document has been attached at Appendix A. The 16 core quality and safety standards included in this document that are relevant to this Committee are Outcomes 1-2, 4-14, 16-17 and 21. These are summarised as:

Section	**Outcome**	**Regulation***	**Title**
Information and involvement	1	17	Respecting and involving people who use services
	2	18	Consent to care and treatment
Personalised care, treatment and support	4	9	Care and welfare of people who use services
	5	14	Meeting nutritional needs
	6	24	Cooperating with other providers
Safeguarding and safety	7	11	Safeguarding people who use services from abuse
	8	12	Cleanliness and infection control
	9	13	Management of medicines

Section	Outcome	Regulation*	Title
	10	15	Safety and suitability of premises
	11	16	Safety, availability and suitability of equipment
Suitability of staffing	12	21	Requirements relating to workers
	13	22	Staffing
	14	23	Supporting workers
Quality management	16	10	Assessing and monitoring the quality of service provision
	17	19	Complaints
	21	20	Records
Suitability of management	N/A		

* Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009

10. The Committee is tasked with submitting evidence that demonstrates compliance or non-compliance with these outcomes. This evidence can be submitted online or to the CQC Area Manager and could potentially look at:
    - what matters most to the people in your community?
    - examples of good practice, as well as areas that should be improved.
    - recent experiences of care and whether these are common among the people using a service or in a community.
    - notes from meetings or visits to a service, the results of a local survey, or a set of personal stories from individuals with dates and supporting documents.

Quality Accounts

11. The Department of Health's *High Quality Care for All* (June 2008) set the vision for quality to be at the heart of everything the NHS does, and defined quality as centered around three domains: patient safety, clinical effectiveness and patient experience. *High Quality Care for All* proposed that all providers of NHS healthcare services should produce a Quality Account: an annual report to the public about the quality of services delivered. The Health Act 2009 placed this requirement onto a statutory footing.

12. Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. The details surrounding the form and content of Quality Accounts were designed over a year long period in partnership between the Department of Health, Monitor, the Care Quality Commission and NHS East of England. This involved a wide range of people from the NHS, patient organisations and the public, representatives of professional organisations and of the independent and voluntary sector.

13. For the first year of Quality Accounts (2009/2010), providers were exempt from reporting on any primary care or community healthcare services. This year, the community healthcare service exemption has been removed. In this second year of Quality Accounts, providers will report on activities in the financial year 2010/2011 and publish their Quality Accounts by the end of June 2011.

14. Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the overview and scrutiny committee (OSC) in the local authority area in which the provider has a registered office and invite comments prior to publication. This gives

OSCs the opportunity to review the information contained in the report and provide a statement of no more than 1,000 words indicating whether they believe that the report is a fair reflection of the healthcare services provided (this limit was 500 words in 2009/2010 to allow for those OSCs and LINks that was to submit a joint statement). Scrutiny Committee's can also comment on the following areas:

- whether the Quality Account is representative
- whether it gives a comprehensive coverage of the provider's services
- whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Accounts.

15. The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report for publication. Providers are legally obliged to publish this statement as part of their Quality Account.

16. Providers must send their Quality Account to the appropriate OSC by 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account ready for review by its stakeholders.

17. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer and encourage then to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

18. It should be noted that Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

19. Where possible, draft copies of the Trusts' Quality Accounts have been appended to this report for consideration.

<u>Dental Service Provision in Harefield</u>

20. It has been previously noted by Members of the Committee that Dr Robert Melhuish will soon be retiring and closing his dental practice in Harefield. Members have requested that representatives from NHS Hillingdon and the Local Dental Committee be invited to attend this meeting to update them on what action is being undertaken to ensure that the dental needs of the residents of Harefield are measured. Members are also seeking assurances of what action will be taken if it is established that the needs of these residents will not be met by current provisions within the area.

Witnesses

21. Senior officers from each Trust will attending and will be able to explain the likely contents of their Trust's draft report. Representatives have been invited from the following organisations:

- Care Quality Commission (CQC)
- NHS Hillingdon
- The Hillingdon Hospital NHS Foundation Trust

- Central & North West London NHS Foundation Trust
- Royal Brompton & Harefield NHS Foundation Trust
- London Ambulance Service
- Local Dental Committee

22. Members of the Social Services, Health and Housing Policy Overview Committee have also been invited to attend this meeting.

SUGGESTED SCRUTINY ACTIVITY

23. Members review the evidence collected during the year and, following further questioning of the witnesses, decide whether to submit commentaries to the CQC.

BACKGROUND INFORMATION

None.

SUGGESTED KEY QUESTIONS/LINES OF ENQUIRY

All

1. What factors have led to the non-achievement of targets? What has been done to address failed targets?

2. What is latest financial position of the PCT and the Trusts? What is the forecast for the financial year end?

3. What initiatives have been implemented during the course of the last year? What had been the impact of these initiatives? What has been the feedback from patients on these initiatives?

4. What plans are there for Trusts to improve their facilities in Hillingdon?

5. How do the Trusts ensure that learning and innovation continues and is filtered through the organisation?

The Hillingdon Hospital NHS Foundation Trust

6. In the recent annual staff survey undertaken by THH, it is noted that 81% of staff were satisfied with the quality of work and patient care that they delivered (compared to a national average of 70%). How does this compare to the percentage of patients that are happy with the care that they receive?

NHS Hillingdon

7. How much does the PCT currently spend on the provision of public health services in the Borough (including the commissioning of public health services)?

8. How is the PCT proposing to tackle health inequalities in the Borough? What investment will be made on this, and on what services? What action is being taken to ensure that work to tackle health inequalities continues after the PCT has gone?

9. What impact has the creation of the cluster had on services in the Borough?

10. What action is being taken to ensure that the dental needs of residents in Harefield will be met following the closure of the local dental surgery?

Royal Brompton & Harefield NHS Foundation Trust

11. The Safe and Sustainable consultation includes options which would see the withdrawal of children's congenital heart surgery from RBH. If this were to go ahead, what impact would it have on the services that the FT provides?

Central & North West London NHS Foundation Trust

12. Following the realisation of the vertical integration of provider services on 1 February 2011, have any challenges have been identified? If so, what action has been taken to address them?

London Ambulance Service (LAS)

13. Has the Service managed to transport all stroke patients to the nearest HASU within 30 minutes since the introduction of the new care pathway? What have the challenges been (if any)?

14. Given that the has advised that it expects to make 890 job cuts over the next five years in an attempt to reduce costs and realise savings of £53m, what impact is expected on the service delivery in the Borough?

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Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality Account 2010-11

Please note: This is a DRAFT report. All data included in this report is accurate, but for some indicators, data is not yet available for the later months of this financial year.

Contents

Part 1: Chief Executive Statement

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

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

- Service Excellence
- Organisational Excellence
- Productivity and investment

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

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

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

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

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

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

BOB BELL
Chief Executive Royal Brompton & Harefield NHS Foundation Trust

Part 2: Priorities for Improvement

Introduction

The Trust is required to choose between 3 and 5 priorities for improvement in relation to quality each year. These priorities must encompass the key areas of patient safety, clinical effectiveness and patient experience.

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

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

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

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

Patient Safety:

- Accuracy of medication prescribing
- **Availability of patient notes for appointments and hospital stays**
- Use of national guidelines e.g. NICE
- **Treatment options discussed by group of relevant specialists**
- Accurate training records of nursing staff

Patient Experience

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

Patient Outcomes

- **Care of patients who have a cardiac arrest (heart attack) whilst in hospital**
- Minimising unnecessary delays for patients on day of discharge

- Planning the care of diabetic patients undergoing surgery
- Maximising nutrition for paediatric patients
- Use of patient reported outcome measures (PROMS tool)

Out of Intensive Care Cardiac arrests

Patient Outcomes – decrease the number of Out of Intensive Care Unit (ICU) Cardiac Arrests

Rationale

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

The Trust carried out a survey on priority areas for quality improvement asking patients, staff, public, FT members and Governors to vote for their priority topics.

Definitions

PAR Score – **P**atient **A**t **R**isk score. Patients are scored depending on key observations such as blood pressure, pulse rate, respiratory, temperature etc. A patient with a high score may be deteriorating and should be referred for further review.

Quality Standards

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

Improvement Plan

Quarter 1: Baseline agreed for all 3 quality standards;
Quarter 2: Some improvements achieved to the standards comparing to the previous quarter;
Quarter 3: Some improvements achieved to the standards comparing to the previous quarter;
Quarter 4: Achieve quality standard targets in all 3 areas

End of Life Care

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

Rationale

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

Nationally, the DH published the End of Life Care Strategy, implementation of which is an attempt to create a joined up service, encourage healthcare practitioners to adopt robust and tested procedures to ensure effective end of life care and to ensure that, wherever possible, peoples' wishes as to the care they receive at the end of life are respected.

This is a regional CQUIN measure for all Trusts within NHS London. The Trust carried out a survey on priority areas for quality improvement asking patients, staff, public, FT members and Governors to vote for their priority topics. This topic was identified as a priority.

Definitions

End of life: last 48 hours of life for expected deaths
Expected death: an anticipated patient death caused by a known medical condition or illness
Advanced care plan: a plan in place for how the patient will be cared for
Liverpool care pathway: a care pathway specifically for patients who are dying

Quality Standards

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

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

Improvement Plan

Quarter 1: Data collection started, baseline and trajectory for improvements has been agreed - 100% of payments; incomplete achievement of the quarter goals due to the fault of the Trust - 80% of payments; incomplete achievement of the objectives due to delays by commissioners- 100% of payments.

Quarter 2: Evidence of data collection - 100% of payments.

Quarter 3: Achieving 90%-100% of the agreed trajectory of improvements - 100% of payments; achieving 80-94% of agreed trajectory for improvements - 85% of payments; achieving 70-79% of agreed trajectory for improvements - 75% of payments.

Quarter 4: Achieving 90-100% of the agreed trajectory of improvements - 100% of payments; achieving 80-94% of agreed trajectory for improvements - 85% of payments; achieving 70-79% of agreed trajectory for improvements - 75% of payments.

Availability of patient records

Patient Safety – ensuring patient records are always available for outpatient clinics

Rationale

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

The Trust carried out a survey on priority areas for quality improvement asking patients, staff, public, FT members and Governors to vote for their priority topics. Availability of patient records was selected as one of the topics.

Definitions

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.

Quality Standards

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

Improvement Plan

Quarter 1: Baseline has been established: % of paper patient records are available at the start of the outpatient clinic.
Quarter 2: Some improvement comparing to the baseline or achieving the Q4 target - 100% of payments.
Quarter 3: Some further improvement comparing to the previous quarter or achieving the Q4 target - 100% of payments.
Quarter 4: Fully achieving the target of 95% of paper patient records are available at the start of the outpatient clinic - 100% of payments; achieving the figure of 85% of records availability - 85% of payments; achieving 75% of records availability - 75% of payments.

Discussion of Treatment Plans at a Multi-Disciplinary Team (MDT) Meeting for Elective Patients Undergoing Surgery

Patient Safety – ensuring elective patients have their treatment plans discussed and agreed in an MDT meeting prior to surgery

Rationale

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

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

Definitions

Multi-disciplinary team meeting (MDT): a meeting involving health-care professionals with different areas of expertise to discuss and plan the care and treatment of specific patients

Quality Standards

To be agreed. The standards are to be finalised and will be included in the final report.

Improvement Plan

To be agreed based on quality standards once finalised.

CQUIN Payment Framework 2011/12

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

Goal Number	Goal Name	Description of Goal	Goal Weighting *
1	VTE prevention	Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)	**15.00%**
2	Patient experience- personal needs	Improve responsiveness to personal needs of patients	**15.00%**
3	Pressure Ulcers	Reduction of grade 2 and 3 pressure ulcers	**10.00%**
		Evidence in achieving grade 4 ulcer prevention and reduction trajectory	**10.00%**
4	Falls	Reduce the total number of falls according to the agreed trajectory	**10.00%**
		Reduce the number of falls resulting in "harm" according to the agreed trajectory	**10.00%**
5	End of Life Care	Improving end of life care for people and achieving the quality standards.	**15.00%**
6	Availability of patient records in outpatient clinics	Improving availability of patient records in outpatient clinics	**15.00%**

* as a % of the CQUIN scheme available

VTE Prevention

To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE).

Rationale

VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated in 2005 there were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team.

Quality Standards

% of all adult NHS inpatients who had a VTE risk assessment on admission to hospital using the locally adapted VTE risk assessment tool which includes the clinical criteria of the national tool, and was agreed for use in 2010/11

Improvement Plan

At the end of each quarter the following percentage of payment will be received based on achievement:
100%-90% compliance- 100% of payments
80%-90% compliance- 85% of payments
70%-80% compliance- 75% of payments

Patient Experience – Personal Needs

The indicator incorporates questions from the NHS inpatient survey which are known to be important to patients and where past data indicates significant room for improvement across England.

Rationale

Adult inpatient survey, from the CQC nationally coordinated patient survey programme. The survey is conducted annually between October and January for patients who had an inpatient episode between July and August.

Quality Standards

The indicator is a composite, calculated from 5 survey questions. The aim is to maintain performance and score in the top 20% of Trusts assessed. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients".
The elements are:
1) Involvement in decisions about treatment/care,
2) Hospital staff being available to talk about worries/concerns,
3) Privacy when discussing condition/treatment,
4) Being informed about side effects of medication,
5) Being informed who to contact if worried about condition after leaving hospital.

Improvement Plan

Assessed at 2011/12 year end only:
Maintenance of top 20% performance for all 5 questions - 100% of payment
Maintenance of top 20% performance for 3-4 out of 5 questions - 85% of payment
Maintenance of top 20% performance for 1 – 2 out of 5 questions - 75% of payment

Pressure Ulcers

Safe care, including a reduction in pressure ulcers, is one of the DH's Quality, Innovation, Productivity and Prevention (QIPP) workstreams. It is also included within the recent DH patient safety campaign 'Safety Express'.

Rationale

It was estimated in 2004 that the NHS in the UK spent £1.4 - £2.1bn treating pressure ulcers. These figures are a conservative estimate. Ninety percent of this cost is nursing time. Evidence suggests that between 4 and 10% of patients admitted to UK district hospitals develop a pressure ulcer. In 2008/9 there were just over 51,000 pressure ulcers coded in HES in England. Community figures are more difficult to obtain but it has been estimated that 20% of people in nursing and residential homes may be affected and up to 30% of the general population. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions e.g. diabetes. The presence has been associated with an increased risk of secondary infection and a two to four fold increase of death in older people in intensive care units.

Quality Standards

1) To prevent the development and deterioration of newly acquired grade 2, 3 and 4 pressure ulcers.
2) Use of agreed reporting method. If a patient arrives into the Royal Brompton or Harefield with a pressure ulcer, this must be recorded as "zero" and action taken to encourage the referring organisation to investigate action/root cause analysis. A summary root cause analysis must be conducted in accordance with the national criteria for each developed pressure ulcer after 72 hours of stay.
3) Engagement with all levels of organisation and relevant personnel in the local economy as appropriate.

Improvement Plan

Indicator for grade 2 and 3 pressure ulcers:

Quarter 1: set baseline, agree on pressure ulcers definitions and appropriate evidence or engagement with the local health economy, referring trusts and within the organisation. If only some of the criteria are met due to delays from the Trust- 80% of payment received.
Quarters 2-4: 4% reduction if the incidence is above the national average (unless it reached the national average - then 100%) - 85% of payment received; 3-4% reduction if the incidence is above the national average (unless it reached the national average then 100%) - 80% of payment received.

Indicator for grade 4 pressure ulcers:
Quarter 1: set baseline, agree on pressure ulcers definitions and appropriate evidence or engagement with the local health economy, referring trusts and within the organisation. If only some of the criteria are met due to delays from the Trust- 80% of payment received.
Quarter 2: Maximum 3 new grade 4 pressure ulcers - 100% of payment; 4 new grade 4 pressure ulcers - 80% of payment.
Quarter 3: Maximum 2 new grade 4 pressure ulcers - 100%; 3 new grade 4 pressure ulcers - 80% of payment.
Quarter 4: No new grade 4 pressure ulcers - 100% of payment; 1 new grade 4 pressure ulcer - 80% of payment; 2 new grade 4 pressure ulcers - 70% of payment.

Falls

To reduce the total number of falls and to reduce the severity by reducing the number of falls resulting in 'harm'. 'Harm' is defined as scoring 2 or above in the NPSA severity level table for falls. This includes categories of minor, moderate, major and catastrophic harm.

Rationale

Safe care, including a reduction in falls, is one of the DH's QIPP workstreams. It is also included within the recent DH patient safety campaign 'Safety Express'. The NPSA (2007) reports rates of falls in acute hospitals as 4.8 per 1000 bed days per month and in community settings as a rte of 8.4 (range 5.0-12.2) falls per 1000 bed days in regular reporting organisations. A regular reporting organisation is one that reports >100 incidents per month.

Each year 35% of over 65s experience one or more falls. Approx 45% of people over 80 who live in the community falls each year with 10-25% sustaining a serious injury.

The CQUIN aims to set a discipline for recording all falls as common practice so that providers can more accurately reduce the total number of falls and those which cause harm.

Definition of community setting to include - patients own home, community based beds, foot health services, community therapists, nursing homes eligible for CQUIN.

Quality Standards

1) To prevent the development and deterioration of newly acquired grade 2, 3 and 4 pressure ulcers.

2) Use of agreed reporting method. If a patient arrives into the Royal Brompton or Harefield with a pressure ulcer, this must be recorded as "zero" and action taken to encourage the referring organisation to investigate action/root cause analysis. A summary root cause analysis must be conducted in accordance with the national criteria for each developed pressure ulcer after 72 hours of stay.
3) Engagement with all levels of organisation and relevant personnel in the local economy as appropriate.

Improvement Plan
Indicator for total number of falls:
Quarter 1- Baseline agreed, falls definitions and the evidence required are specified and agreed; If only some of the criteria are met due to delays from the Trust - 80% of payment received.
Quarters 2-4: If the baseline is above the national average of 4.8 per 1000 bed days (or other more recent NPSA national average as agreed at Q1), 5% reduction of falls comparing to the previous quarter until it reaches the national average - 100% of payment received. If the baseline is above the national average of 4.8 (or other more recent NPSA national average as agreed at Q1) per 1000 of bed days, 2% reduction - 80% of payment received. Maintaining the current performance - 70% of payment received.

Indicator for falls resulting in harm:
Quarter 1- Baseline agreed, falls definitions and the evidence required are specified and agreed; If only some of the criteria are met due to delays from the Trust - 80% of payment received.
Quarters 2-4: If the baseline for falls resulting in "harm" is above the national average per 1000 of bed days, 5% reduction of falls resulting in "harm" comparing to the previous quarter until it reaches the national average - 100% of payment received.
If the baseline for falls resulting in "harm" is above the national average per 1000 of bed days, 2% reduction of falls resulting in "harm" comparing to the previous quarter until it reaches the national average - 80% of payment received.
Maintaining the current performance comparing to the previous quarter - 70% of payment received (unless it had already reached the national average - 100% of payment received).
If there is a significant adverse movement in any quarter after the national average level has been achieved, bringing the rates again above the national average - no payment received. For avoidance of doubt if despite adverse movement the figures remained below national average - 100% of payment received.

Part 3: Review of Quality Performance

Introduction

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

At the time of registration, the Trust notified CQC of some issues in respect of compliance with the essential standard relating to safety and suitability of premises in connection with the Fire Code. In response CQC noted a 'moderate' concern regarding the safety and suitability of premises standard. During 2010 – 2011, the Trust has undertaken work to ensure full compliance with the Fire Code and full compliance was achieved on 31st July 2010. CQC have since confirmed satisfaction with the Trust declaration of full compliance with the essential standard relating to safety and suitability of premises.

Please note: the paragraphs below in green are mandatory for inclusion and will be completed for the final report. We are awaiting clarification from the DOH in relation to some definitions.

During 2010/11 the Royal Brompton and Harefield NHS Foundation Trust provided and/ or sub-contracted [insert number] NHS services.

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

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

The Trust reviews the NHS services it provides to assess the quality of care via many different approaches including patient and staff surveys, participation in national and local audits and service improvement projects. Since 2007 the Trust has carried out a programme of patient safety "walkrounds" which consists of a senior member of the Quality & Safety team and an executive director visiting a patient area (such as wards, x-ray, theatres and catheter labs) to discuss any patient safety issues they have and to address these. These are carried out on a quarterly basis where the executive director is linked to the same area for a period of 12 months. The programme is constantly evolving and recent changes include recording the results from all walkrounds on the Trust's Datix system to enable production of

a single report for all areas, Trust Governors have begun attending the walkrounds, and extending the programme to include patient support areas such as laboratory medicine.

Compliance Framework

The Trust is required to make quarterly returns to Monitor detailing compliance with the terms of its Authorisation in relation to all targets, and Care Quality Commission registration requirements as set out in the Compliance Framework. The table below shows compliance at the end of quarter 3 2010/11.

Figures will be updated to end of quarter 4 in final report. This will show absolute numbers in the status column.

Governance Rating	Score 0.0	Status – Green

	Threshold	Weighting	Status
Targets – Weighted 1.0 (national requirements)			
Clostridium difficile - year on year reduction to comply with the trajectory for the year agreed with Kensington & Chelsea PCT	Achievement of Trajectory for reduction	1.0	Met
MRSA – maintaining the annual number of MRSA bloodstream infections at 5 or less (baseline year 2003/04) as agreed with commissioners	Achievement of Trajectory for reduction	1.0	Met
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	94%	1.0	Met
Maximum two month wait from referral to treatment for all cancers*	79%	1.0	Met
Maximum two month wait from consultant upgrade to treatment for all cancers*	79%	1.0	Met
Targets – Weighted 0.5			
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	0.5	Met
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Met
Screening all elective in-patients for MRSA	-	0.5	Met
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	-	0.5	Met
Care Quality Commission Registration			
Moderate CQC Concerns regarding the safety of healthcare provision		1.0	None
Major CQC Concerns regarding the safety of healthcare provision		2.0	None
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) or as subsequently amended with the CQC's agreement		4.0	None

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

Quality and Risk Profile (QRP)

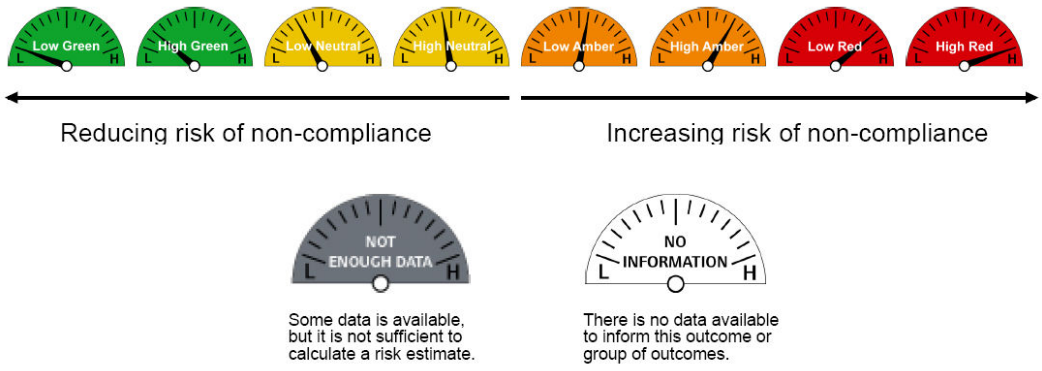
From 1 October 2010, all health and adult social care providers are legally responsible for making sure they meet essential standards of quality and safety and must be licensed with Care Quality Commission (CQC).

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

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

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

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

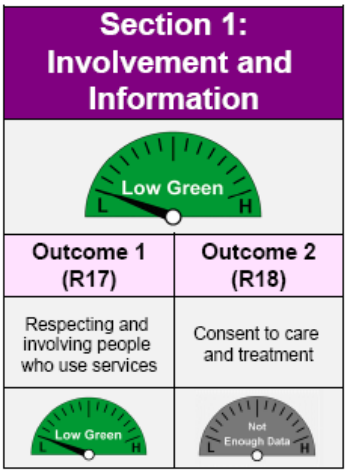


The essential standards

The results below are extracted from the QRP for March 2011. The Trust scored between low green and high neutral for all 5 essential standards.

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

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



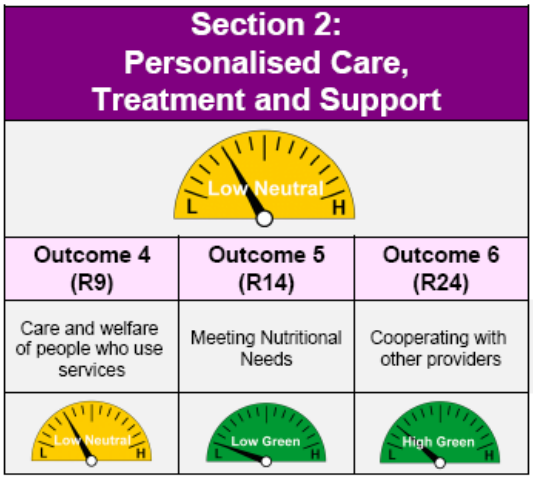
Scores range from low green to high red

Low green is the best possible score

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

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

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



Scores range from low green to high red

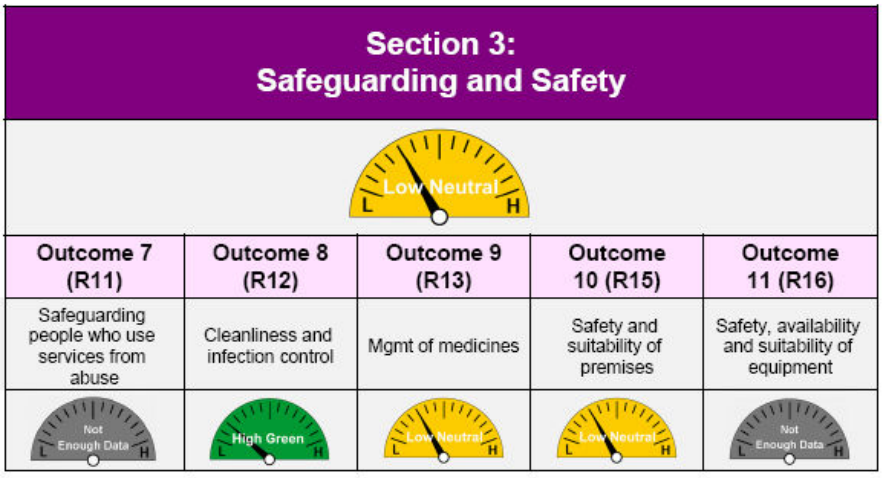
Low neutral is a better than average score

Low green is the best possible score

High green is the second best possible score

Standard 3: You can expect to be safe

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



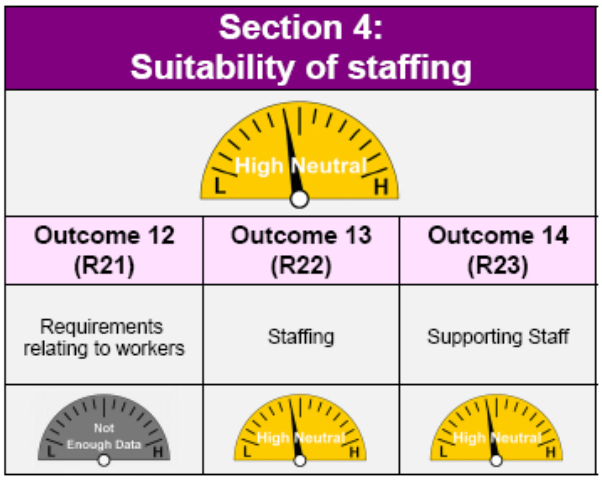
Scores range from low green to high red

Low neutral is a better than average score

High green is the second best possible score

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

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



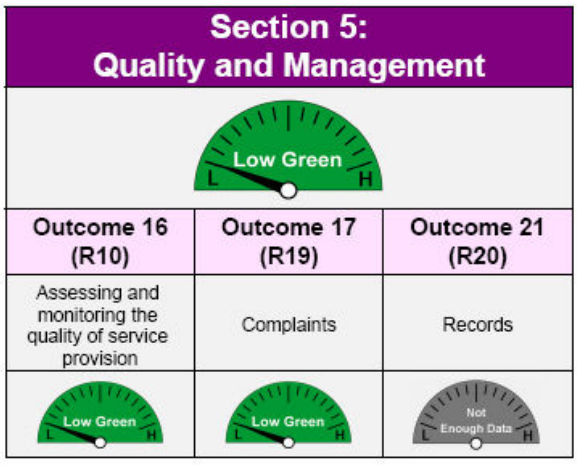
Scores range from low green to high red

High neutral is a better than average score

There are only two indicators relating to requirements relating to workers, which his why Outcome 12 is scored as 'Not enough data'.
The Trust scored 'much better than expected' for one indicator.

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

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



Scores range from low green to high red

Low green is the best possible score

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

Commissioning for Quality and Innovation (CQUIN) 2010-11

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

The Trust has achieved 100% of CQUIN payment at Q3 2010/11, the outcome for Q4 is currently awaited and will be available in time for the final draft of the Quality Account.

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

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

1. National CQUIN Indicators				
Goal	Target	Baseline	Achievement by end Q3	CQUIN met? (Q1- Q3)
Improve VTE Prevention	National Target 90%	73.3% (Q2 Actual)	82.8%	✓
Responsiveness to Patient needs	Top 20% of trusts	Annual Target based on 2010 Survey	Annual Target based on 2010 Survey	✓
2. Regional (London) CQUIN Indicators				
Discharge on agreed date	Q2 – 60%, Q3 – 70%, Q4 – 80%	55.9% (Q1 Actual)	79%	✓
Information in Discharge Letters	60% across all divisions	30% (Q1 Actual)	91%	✓
Outpatient letters sent within 5 days	70% across all divisions	20%	56%	✓
Global Trigger Tool	10 sets of notes audited per fortnight	10 sets of notes audited per fortnight	10 sets of notes audited per fortnight	✓
3. Local CQUIN Indicators				
CABG SSI	6.3 per 100 operations	Baseline Value: 7.8 per 100 operations	5.84 per 100 operations	✓
Valve SSI	To be agreed – National baseline	To be agreed	0 per 100 operations	✓

	not released yet			
Safeguarding Children Level 3 Training	80% Trained by Q4	8%	96%	✓
Pressure Ulcers	Improvement in reporting compliance	83%	93%	✓

As mentioned above, for the CQUIN scheme 2010/11 the Trust agreed 10 goals with its commissioners which were linked to the contractual income. The CQUIN measures in total equate to 1.5% of the income (£180 million) therefore if all the goals are achieved this would equate to £2.7 million of income for the Trust. These measures were a mix of nationally mandated, regionally suggested and locally developed indicators.

Five of the indicators and achievement of the goals are detailed in the Review of Priorities for Quality 2010/11 section of Part 3 as they had been identified as priority topics: discharge on agreed date, information in discharge letters, safeguarding children training, surgical site infection following CABG and cardiac valve procedures.

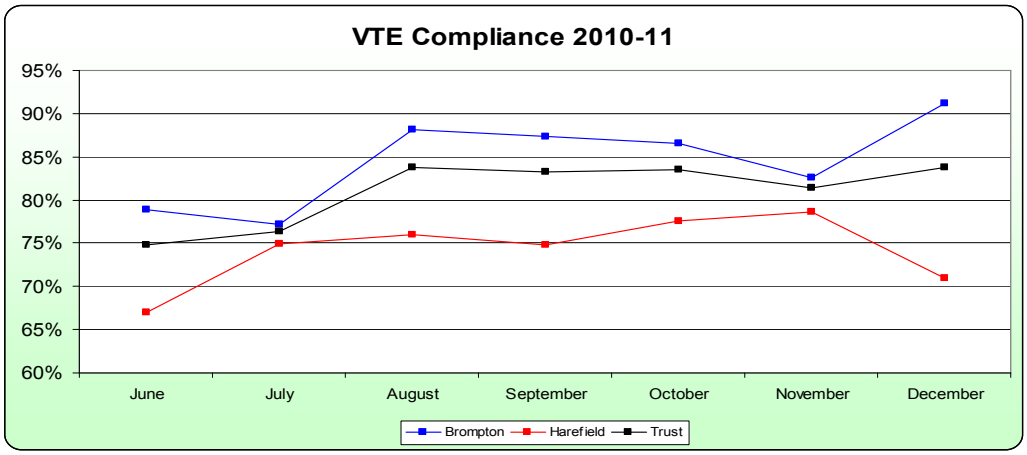
Improve venous thromboembolism (VTE) prevention

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

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

The percentage of VTE assessments completed in Q3 is 82.8% which means achievement against the baseline of 73.3% however it is still short of the Q4 target of 90%. December has shown the highest performance to date of 91.2% at Brompton. This has been achieved through regular ward rounds and logging of assessments by the Trust lead. This will be implemented in Harefield during Q4 in order to achieve the 90% target across both sites. (paragraph & chart to be updated for final report).

VTE compliance since reporting began in June 2010



Improve patient experience as per adult inpatient survey

Responsiveness to patient needs is measured through the NHS inpatient survey once a year. The survey is based on a sample of consecutively discharged inpatients who attended our Trust in June 2010 (see section 5 for more information on the inpatient and outpatient survey results).

This indicator is calculated from 5 survey questions known to be important to patients and where past data indicates room for improvement:

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

The target, agreed with commissioners, is to remain within the top 20% trusts nationally for each of the five questions in order to receive 100% payment. Maintenance of top performance for 3-4 questions will result in 85% payment and 1-2 questions will mean 75% payment.

Achievement of the CQUIN is based upon the Care Quality Commission report which will be published in April 2011. The patient surveys are conducted by Picker Institute Europe who benchmark our results with 75 other trusts, which is approximately 50% of trusts nationally. The results are then forwarded to the Care Quality Commission who benchmark our results with 100% of trusts nationally.

The scores in the table below show the Trust scores for 2009, preliminary results for 2010 from Picker and in comparison to the Picker average. It demonstrates that on all five questions the Trust scores significantly

better than average and against three questions the Trust has either made an improvement or remained at the same score.

Trust inpatient survey scores 2009 and 2010

Improving responsiveness to personal needs of patients (CQUIN)			
			Lower scores are better
	2009	**2010**	**Average**
Care: wanted to be more involved in decisions	34 %	36 %	46 %
Care: could not always find staff member with whom to discuss concerns	49 %	45 %	57 %
Care: not always enough privacy when discussing condition or treatment	20 %	20 %	28 %
Discharge: not fully told side-effects of medications	42 %	40 %	46 %
Discharge: not told who to contact if worried	11 %	14 %	21 %

The target, agreed with commissioners, is to remain within the top 20 nationally for each of the five questions in order to receive 100% payment. Maintenance of top performance for 3-4 of the questions will result in 85% payment and for 1-2 questions will provide us with 75% payment.

Although we are in the top 20% of trusts and this predicts a positive outcome, this is subject to change when our results are compared with 100% of trusts. This will be known when the CQC report is published in April.

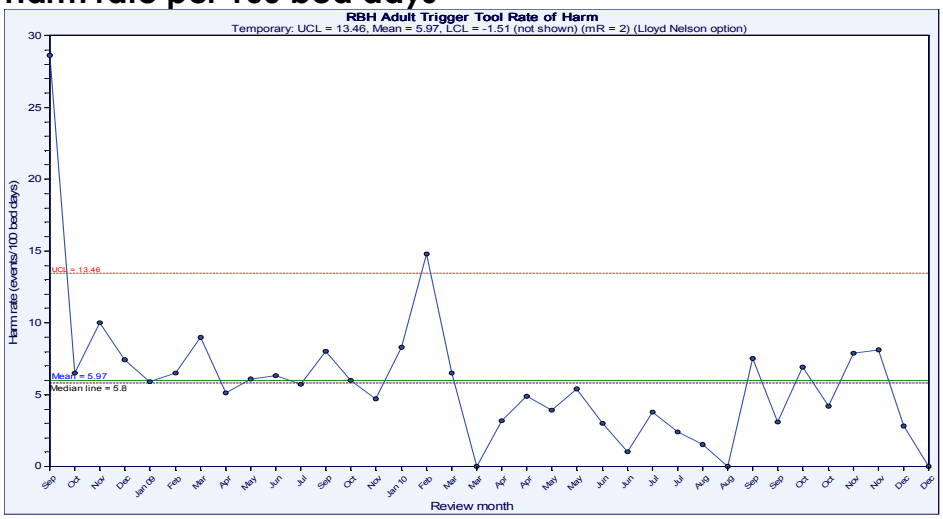
Implement the IHI global trigger tool (GTT)
The GTT was developed by the Institute for Health Improvement in the US to improve patient safety through a systematic approach that proactively identifies key triggers and enables focussed intervention that over time reduce the incidence of hospital acquired events that result in actual injury or harm.

The IHI GTT was adapted for use in the UK as the adult trigger tool (ATT) which was introduced at RBH in August 2008. To date, 360 patients have been reviewed over a period of 36 reviews.

The indicator requires implementation of the ATT with 10 patient admissions to be reviewed every fortnight using the ATT over a minimum of 6 consecutive months. At each review 10 sets of patient notes are reviewed using the trigger tool to measure how many triggers are present in that episode of care and how many events have occurred as a consequence. Each event is then given a harm rating. Notes are reviewed retrospectively at approximately 3 months in arrears in order to ensure notes can be accessed.

The chart below shows the harm rate per 100 bed days for the 36 reviews carried out to date. The chart shows the harm rate has fluctuated around the median since the first review with two peaks in Sep 08 and Feb 10. In quarter one 2010/11 the harm rate remained below the median for all reviews however since the end of quarter two the rate has increased and has returned to fluctuating around the median which is currently at 5.8 events /100 bed days. Quarter 4 figures will be included in the final report.

Harm rate per 100 bed days



In response to the findings a number of initiatives have been commenced. A group was established to implement NICE guidance No 50 'Acutely ill patients in Hospital' and we now have a track and trigger system for the deteriorating patient in place which is monitored monthly and currently demonstrates >90% compliance across the trust. Secondly both sites have multidisciplinary groups looking at peri-operative bleeding and returns to theatre which have reviewed current practice and are making recommendations for improvements in practice and which report to the Governance and Quality Committee. Thirdly a cross site group looking at Wound Infection Prevention, chaired by the Director of the Heart division has been implementing a number of changes to practice to reduce Surgical Site Infection rates with the current rate being comparable to the national rate (as reported by the HPA) and below the CQUIN indicator rate. Wound infections in first time CABG and valve patients are monitored monthly as is compliance with the SSI prevention care bundle. The latter has demonstrated the need to improve control of blood sugar in diabetic patients in the peri-operative period and work on this has commenced.

Future Plans

The Trigger tool was introduced on the Harefield site in September with the reviews being carried out by a new consultant intensivist and a pathologist. The UK version of Paediatric Trigger Tool is also being piloted on the Brompton site. The Trigger Tool was developed as a generic tool for acute care facilities. Its specific application to specialist organisations has not been fully assessed.

Increase effectiveness of outpatient care planning

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

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

The indicator requires a minimum of 20% of letters sent within 5 days with the target rising to 70% in the last quarter. Data is collected at a divisional level through medical secretaries undertaking individual audits which are then collated via the Assistant General Managers.

In quarter 3 an audit across the trust found 56% of letters were sent within 5 days. This is above the baseline of 20% but slightly below the quarter 4 target of 70%. Quarter 4 figures will be included in the final report.

Preventing pressure ulcers

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

This indicator measures the monitoring and prevention of pressure ulcers. During 2010/11 the emphasis was on implementing the system for reporting pressure ulcers and improving compliance with reporting.

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

The table below shows that with new management emphasis being placed upon weekly pressure ulcer incidence reporting compliance by nursing management, the reporting on both sites has shown a significant improvement.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admitted with ulcers	14	13	16	10	5	10	12	16	9
Hospital acquired ulcers	18	22	17	19	19	21	31	32	18
Ulcer reporting compliance	**82%**	**85%**	**82%**	**91%**	**89%**	**96%**	**85%**	**97%**	**97%**

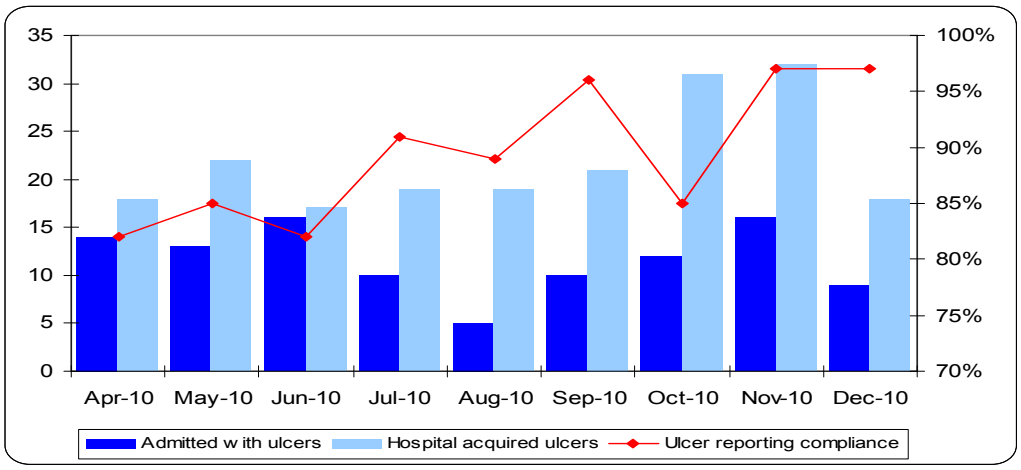
Q3 has shown an improvement in reporting compliance across the trust, rising from 83% in Q1 to 92% in Q2 and 93% in Q3.

With the increase in reporting compliance there has been a corresponding increase in reported hospital acquired pressure ulcers. Across the Trust in total the hospital acquired pressure ulcers showed an increase of approximately 33% in Q3. The proportion of Grade 1 pressure ulcers to Grade 2 and above however has remained consistent with Q2 at a ratio of 75%: 25%.

Quarter 4 figures will be included in the final report.

The chart below demonstrates the relationship between reporting compliance and reported pressure ulcers.

Pressure ulcer reporting



Intensive Care Unit patients require high levels of critical care nursing and therefore it is essential that the Trust Pressure Ulcer Prevention and Management Guidelines for Very High/High Risk Patients are fully understood and adhered to at all time. These are available within the ITU and HDU areas and can be accessed via the Trust intranet site. In Q3, higher levels of temporary staff have been employed to provide nursing care, and there is a need to increase the amount of time for induction to ensure comprehension of, adherence to and implementation of these specific guidelines.

Patients in intensive care were shown to have a higher incidence of nasal bridge sores when receiving nasal ventilation. In response to this the Trust has produced specific guidance and progress will be reported in the final report.

Data for quarter 4 will be included in the final version of the report.

Current actions in progress

- The implementation of 8 Tissue Viability Champions at Harefield ITU is complete. Benefits of the program are expected to show during Q4.
- The trial introduction and audit of "Anchor Fast" Oral Endotracheal Tube Fastener in ITU Harefield occurred during Q3. This device relieves the pressure of the tube from the lips, corners of the mouth and surrounding tissue. It also eliminates the need for re-taping. Audit data has demonstrated that the use of this

product in practice has reduced hospital acquired oral pressure ulcers.

- The P.U.M.P (Pressure Ulcer Management Process) Tool was formally launched in February 2011 in Harefield ITU. This tool incorporates the Waterlow Risk Assessment Score, NICE Pressure Ulcer Management Guidelines (2005) and RBH and Harefield NHS Foundation Trust Pressure Ulcer Prevention and Management Guidelines for Very High/High Risk Patients (2010). It also gives a measure for dependency and substantiates the use of specialist pressure relieving devices.
- "Aderma" pressure relieving gel pads continue to be the first line management of pressure ulcer prevention and management for very high/high risk patient category patients in accordance with trust guidelines.
- IntelliVue Clinical Information Portfolio (ICIP)-computerised documentation has been configured to capture data about pressure relieving care and prompts the user to initiate appropriate management strategy.

Participation in clinical audits

During 2010/11, 18 national clinical audits and 3 national confidential enquiries covered NHS services that the Royal Brompton and Harefield NHS Foundation Trust provides.

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

The table below shows the national clinical audits and national confidential enquiries that the Royal Brompton and Harefield NHS Foundation Trust was eligible to participate in during 2010/11, including actual participation rates:

National Clinical Audit[1]	Did trust participate?	Participation rate[2]
Lung Cancer (LUCADA)	✓	100%
Adult Cardiac Interventions	✓	100%
Adult Cardiac Surgery	✓	100%
Cardiac Rhythm Management	✓	100%
Heart failure	✓	100%
Myocardial Ischaemia (MINAP)	✓	100%
Congenital Heart Disease (children and adults)	✓	100%
Paediatric Intensive Care Audit (PICANet)	✓	100%
Endocarditis	✓	100%
Familial Hypercholesterolaemia	✓	100%
Major Complications of Airway Management in the UK	✓	100%
National Audit of Pulmonary Hypertension	✓	100%
National Cardiac Arrest Audit†	x	n/a
National Comparative Audit of Blood Transfusion	✓	100%
SCTS Adult Thoracic Surgery	✓	100%
UK Cystic Fibrosis Registry	✓	100%
UKT Cardiothoracic Transplant	✓	100%
Trans-aortic valve implantation (TAVI)	✓	100%

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

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

National Confidential Enquiry[1]	Did trust participate?	Participation rate[2]
Surgery in Children	✓	100%
Peri-operative Care	✓	100%
Cardiac Arrest Procedures	✓	100%

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

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

† **Please note:** there is a significant financial cost associated with participation in this national audit, which is why the Trust has not participated

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

National clinical audits

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

Local clinical audits

Patient Identification

Audit showed that the way porters identified patients did not always follow the policy, and that they were often expected to remember verbal instructions of where to take patients. Over the last year, the porters have all attended specific training and have started to use a form to record the key information they need, which acts as a reminder and checklist.

Re-audit has shown significant improvement both in understanding the procedure to correctly identify patients and in carrying this out.

PAR Score

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

Bleeding following cardiac surgery

Following a trend noted in the monthly monitoring of outcomes, a trustwide project was initiated on both sites to better understand the reasons for post-operative bleeding and to identify best practice for managing it and preventing it.

This has resulted in a reduction in the rate of re-operation for bleeding to below the national average.

Continuous Positive Airway Pressure (CPAP) therapy for patients with sleep apnoea

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

Participation in Research

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

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

Participation in clinical research
The number of patients receiving NHS services provided or sub-contracted by Royal Brompton and Harefield NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 1,425.

In addition a further 1,127 patients consented to donate their tissue for retention within the Trust's ethically approved Research BioBank. This tissue will be used in future research within the conditions governing the BioBank's ethical approval.

These patients were recruited to one or more of 219 clinical research studies ongoing in respiratory and cardiovascular disease during 2010/11, approved by a research ethics committee. These studies involved a total of 178 clinical staff.

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

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

Foundation Trust's commitment to testing and offering to its patients the latest and most promising treatments.

Data Quality

NHS Number and General Medical Practice Code Validity

Royal Brompton and Harefield NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

At 1st March 2011

	Admitted NHS patients	National rate	NHS Out-patients	National rate
% of patients with a valid NHS number	95.3%	98.3%	97.8%	99.0%
% of patients with a valid GP Practice code	98.4%	99.8%	98.2%	99.6%

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

- To implement the PAS data quality manual which was developed this year, which sets out the framework for managing data quality on the PAS system, with impact on Payment by Results and SUS data.
- To raise the profile of data quality with Information Asset Owners & Administrators (IOA, IAA). Identify with the IAA areas of weakness & coordinate the development of local /system specific data quality manuals, thus creating frameworks to ensure data quality.

Information Governance Toolkit attainment levels

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

Clinical coding error rate

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

The last Payment by Results clinical coding audit during 2009/2010 by audit commission was carried out 15th to 18th March 2010. As the Trust's

Clinical Coding performance is excellent compared to the previous year it was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

The clinical coding manager who is a Connecting for Health registered auditor carries out regular internal audits. The manager will submit an IG audit report for CfH registration before the end of financial year.

The outcome of the coding audit are as follows:
Primary Diagnosis - 94%
Secondary Diagnosis - 98%
Primary Procedure - 96%
Secondary Procedure - 97%

Review of Priorities for Quality 2010-11

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

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

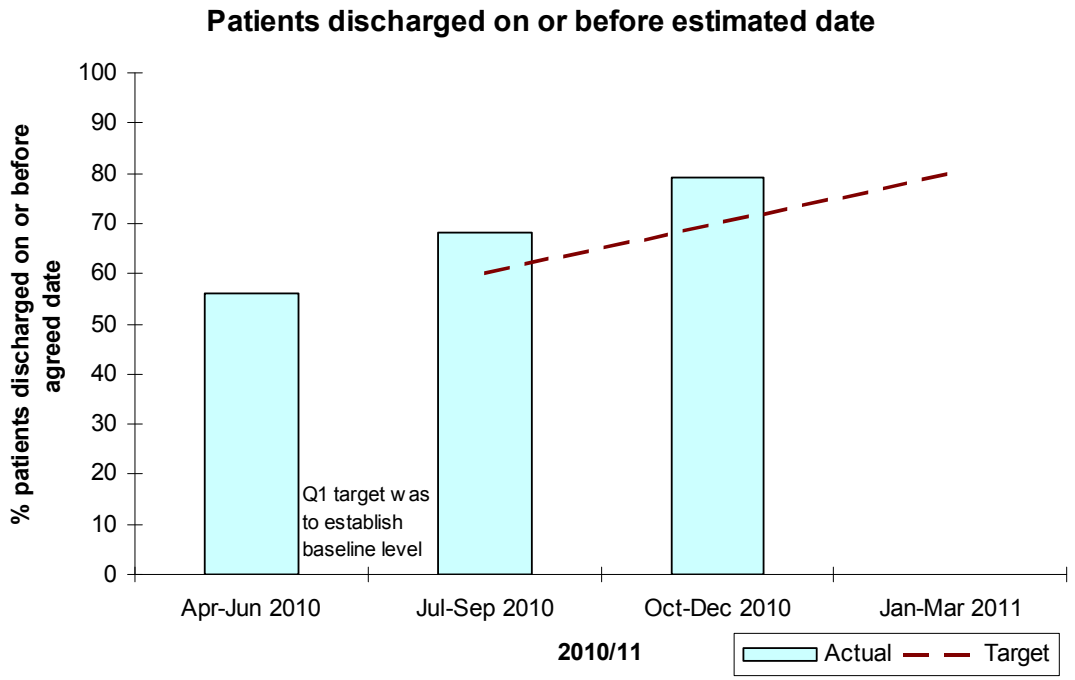
- Patient Experience – making the discharge process easier for patients
- Clinical Effectiveness – providing more training for staff in safeguarding children
- Patient Safety – ensuring the incidence of surgical site infection is reduced

Patient Experience

Discharge on agreed date

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

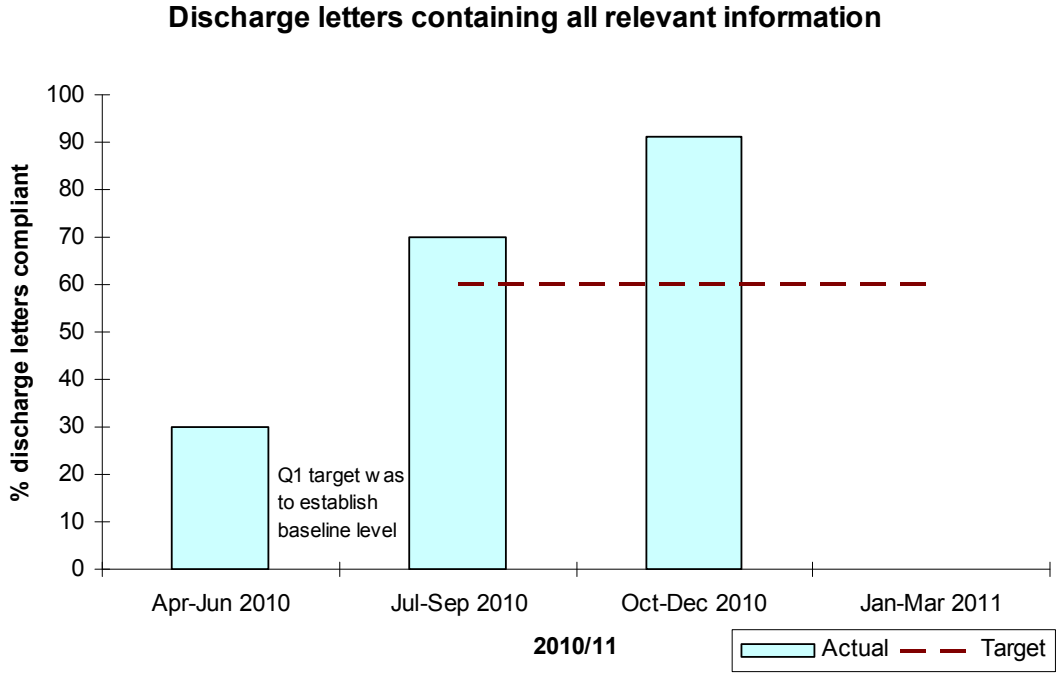
The chart below shows how the Trust has been performing against this target and demonstrates that there has been a steady increase in the number of patients being discharged on or before their agreed date. In the first quarter of the year the baseline was set from which the targets were set for each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



Information in discharge letters

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

The chart below shows how the Trust has performed in 2010/11 on including additional information in inpatient discharge summaries. This data is based on sample audits carried out each quarter (total summaries audited by end of Q3 was 172). In the first quarter the baseline was established from which the target was set for the rest of the year. As the chart shows the target has been exceeded in the subsequent quarters of the year however we do not as yet have figures for Q4. These will be included in the 2nd draft. The inclusion of additional information in the discharge summary should provide a comprehensive source of information for both the patient and their GP on the admission at the Trust.



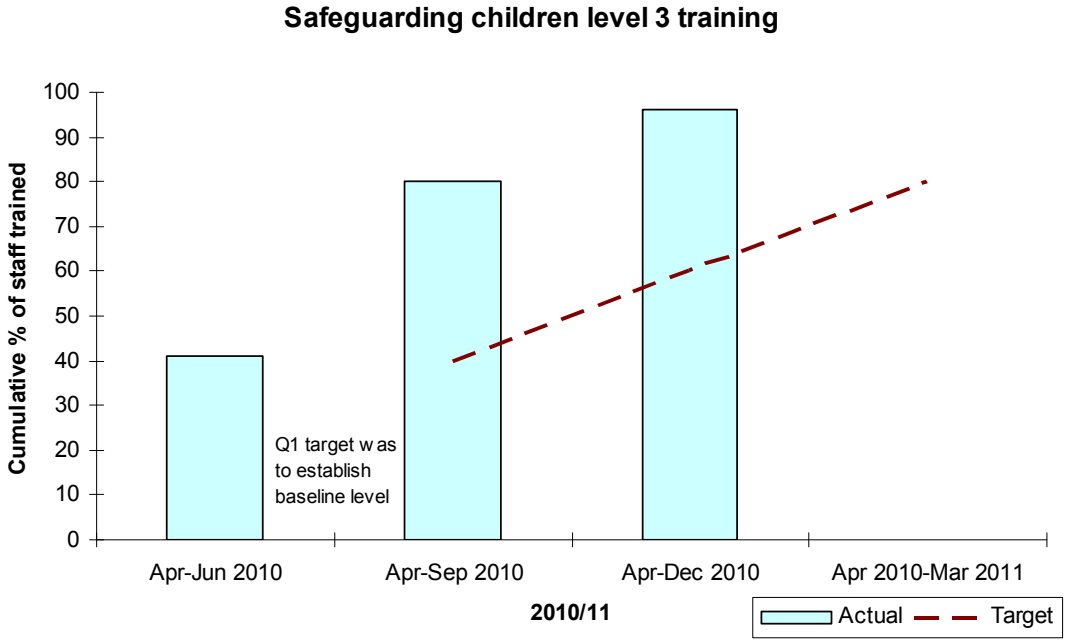
Clinical Effectiveness

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

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

The trust has also been working to ensure all relevant staff undertake the correct level of training. In early 2010 the Trust reviewed safeguarding children training and established which staff groups needed training at level 1, 2 or 3. Level 3 is the most comprehensive training and is required by all staff who work predominantly with children, young people and their parents. In response to this level 3 courses were commissioned from the start of February 2010 to ensure eligible staff received level 3 training by the end of 2010/11.

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

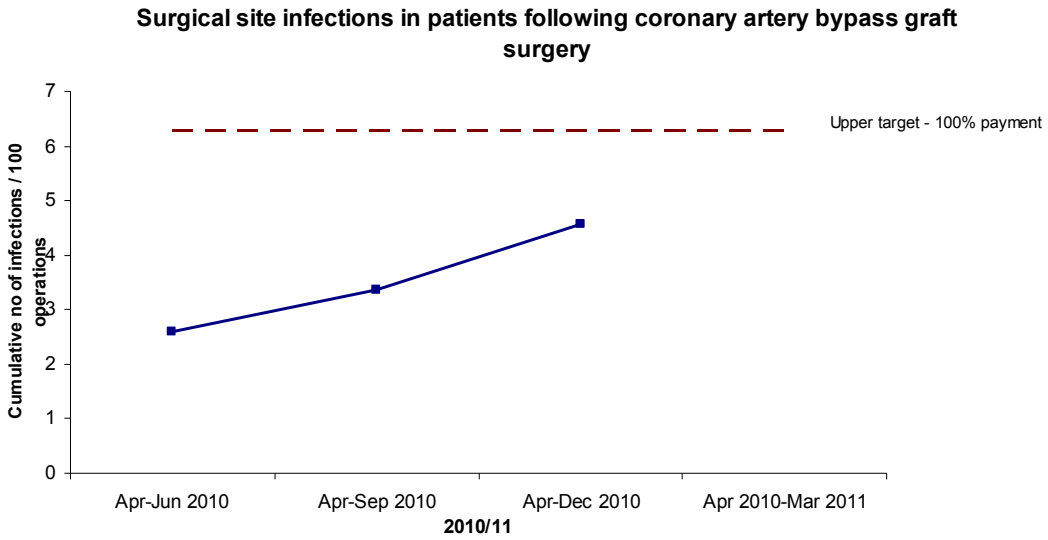

Safeguarding children level 3 training
Cumulative % of staff trained
100
90
80
70
60
50
40
30
20
10
0
Q1 target was to establish baseline level
Apr-Jun 2010
Apr-Sep 2010
Apr-Dec 2010
Apr 2010-Mar 2011
2010/11
Actual
Target

Patient Safety

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

Reduce surgical site infections for coronary artery bypass grafts (CABG)
The Trust routinely collects surgical data on patients undergoing cardiac procedures. This includes data from the Infection Control team who have been collecting and reporting infection data on patients undergoing CABG since 2000 which is reported within the Trust and also to the Health Protection Agency (HPA).

As part of the commissioning for quality and innovation scheme (CQUIN) the Trust has agreed set targets with our commissioners for reducing the number of infections experienced by patients following CABG procedure. As part of the CQUIN scheme the targets set were linked to financial payments where the number of infections is reflected in the percentage of payment received. The chart below shows the Trust's cumulative number of infections over 2010/11. The chart demonstrates that the number of infections at the Trust at the end of quarter 3 2010/11 for patients undergoing CABG was 4.58 / 100 operations. This level of infection is below the upper target set however the figures will be updated with quarter 4 levels in the final report.

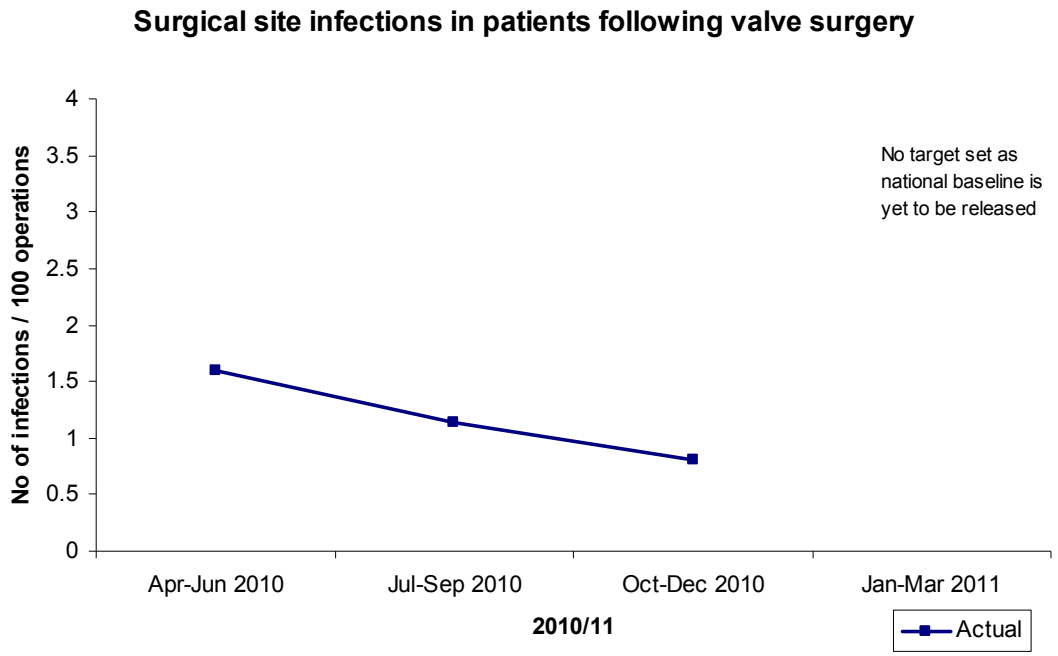


The Trust has been working hard to reduce surgical site infections and has introduced various new practices which have contributed to this. There is a new option for harvesting the vein required for patients undergoing CABG. The vein is harvested endoscopically therefore reducing the infection risk and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

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

Reduce surgical site infections for cardiac valve procedures

The Trust routinely collects surgical data on patients undergoing cardiac valve procedures. The Infection Control team have carried out surveillance of patients undergoing valve procedures since April 2009. The chart below shows there has been a reduction in the number of infections / 100 operations over the first 3 quarters of 2010/11. No target was set for this indicator as the national baseline has yet to be released, however, it was agreed to aim to reduce the rate or maintain the level if performance was good by year end. The data will be updated to include quarter 4 figures in the final report.



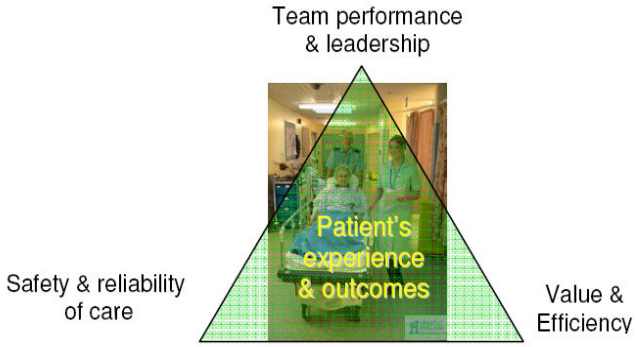
Other Quality Improvement Projects in 2010/11

The Productive Operating Theatre and Catheter Lab Utilisation programme

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

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

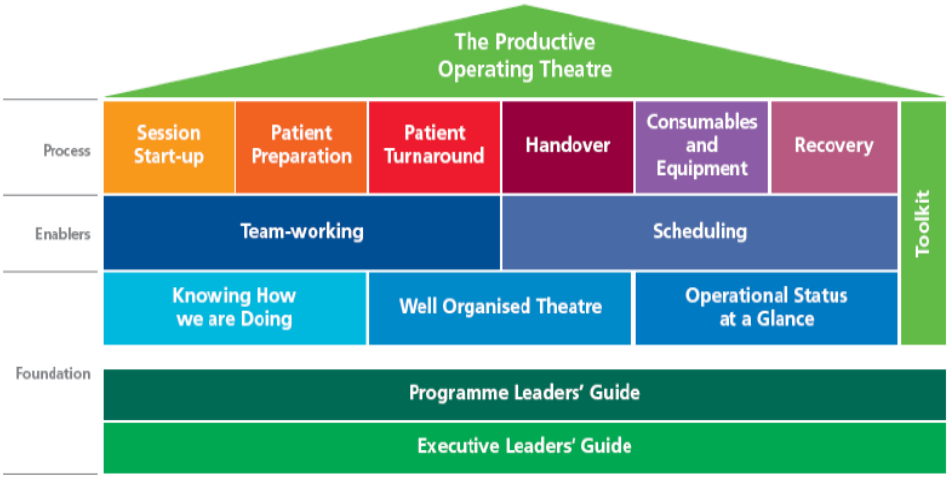
- Increase the **safety and reliability of care** through reducing errors and incidents of harm
- Improve **team-working** and performance, staff morale and leadership
- Add value and improve **efficiency**



The programme utilises lean methodology and effective team-working principles to create the 'perfect operating list' and environment. It is aligned to the principles and methodology outlined in the national quality, innovation, productivity and prevention (QIPP) agenda and addresses some key issues outlined in Professor Darzi's *High Quality Care for All.*

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

T-POT structure



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

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

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

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

Patient Survey results

In 2009 the Trust participated in both the national inpatient and outpatient surveys. The inpatient survey is carried out on an annual basis with the outpatient survey being carried out every two years. The surveys are administered by the Picker Institute on behalf of the Trust with a report published by the Care Quality Commission (CQC) where the Trust is benchmarked against all English NHS Trusts. The sample size is approximately 850 patients for each survey; the questions are nationally set and can not be amended by the Trust.

Inpatient Survey
The Trust had a 61% response rate in comparison to the national average of 52%. The feedback from patients is very encouraging and the Trust rated in the best performing 20% of Trusts within the survey for 76.6% (49/64) of the questions. These included questions on cleanliness of the hospital, having confidence in the nurses and doctors, the hospital food, privacy, respect and dignity, and overall rating of the hospital.
The Trust was rated in the worst performing 20% of Trusts for only one question: where patients received a copy of correspondence between the hospital and their GP, was it written in a way patients could understand. The NHS Plan states that *'letters between clinicians about an individual patient's care will be copied to the patient as of right'*. The Trust policy states that the letters written by clinicians about patients are then copied to them therefore the information in the letter is written for a clinician and may at times be difficult for a patient to understand. However this is in addition to many other ways patients receive information about their care e.g. patient information leaflets.

Outpatient Survey
The Trust had a 58% response rate in comparison to the national average of 53%. The Trust again performed well in this survey and was rated in the best performing 20% of Trusts within the survey for 55% (22/40) of the questions. These included questions on choice of appointment times, communication with and confidence in the doctor, information provided, privacy and overall satisfaction.
The Trust was rated in the worst performing 20% for four areas: told how long to wait, why you had to wait, explanation of need for a test and how to find out about test results. In response to waiting times, the Trust has recognised that good communication is key and have implemented several actions including informing patients of known delays when arriving in outpatients and of unexpected delays in clinic and regularly updating electronic waiting time boards.
In response to patients undergoing tests, the issues have been discussed at local staff meetings to raise awareness amongst staff the importance of explaining the test required and how the patient can find out about their results.

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

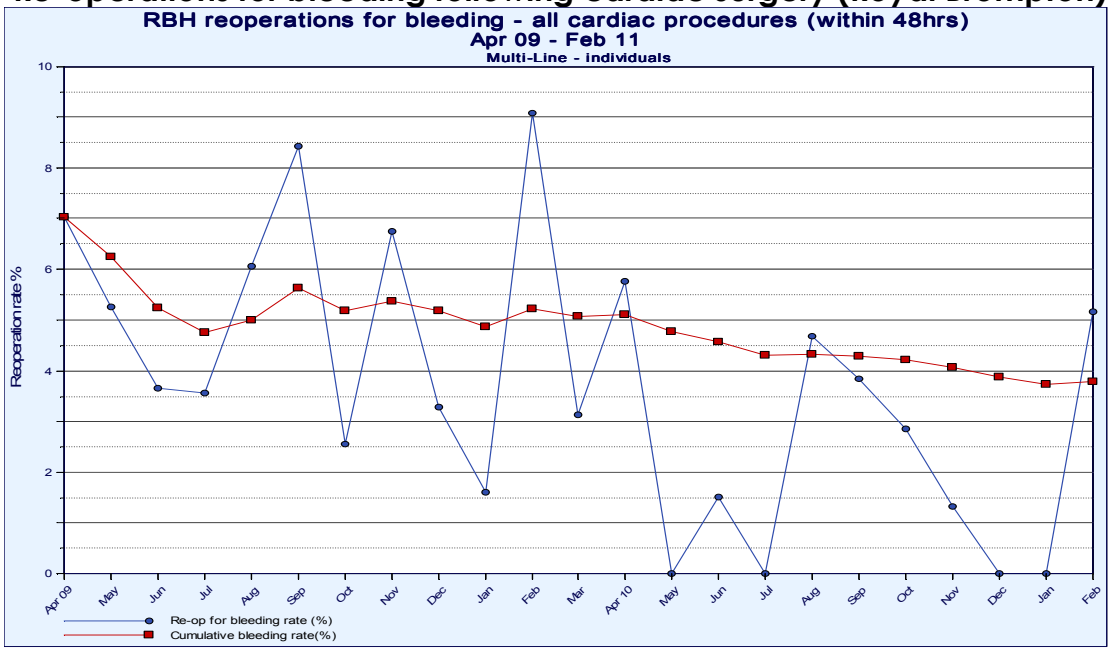
Reducing Re-operations for Bleeding following Cardiac Surgery

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

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

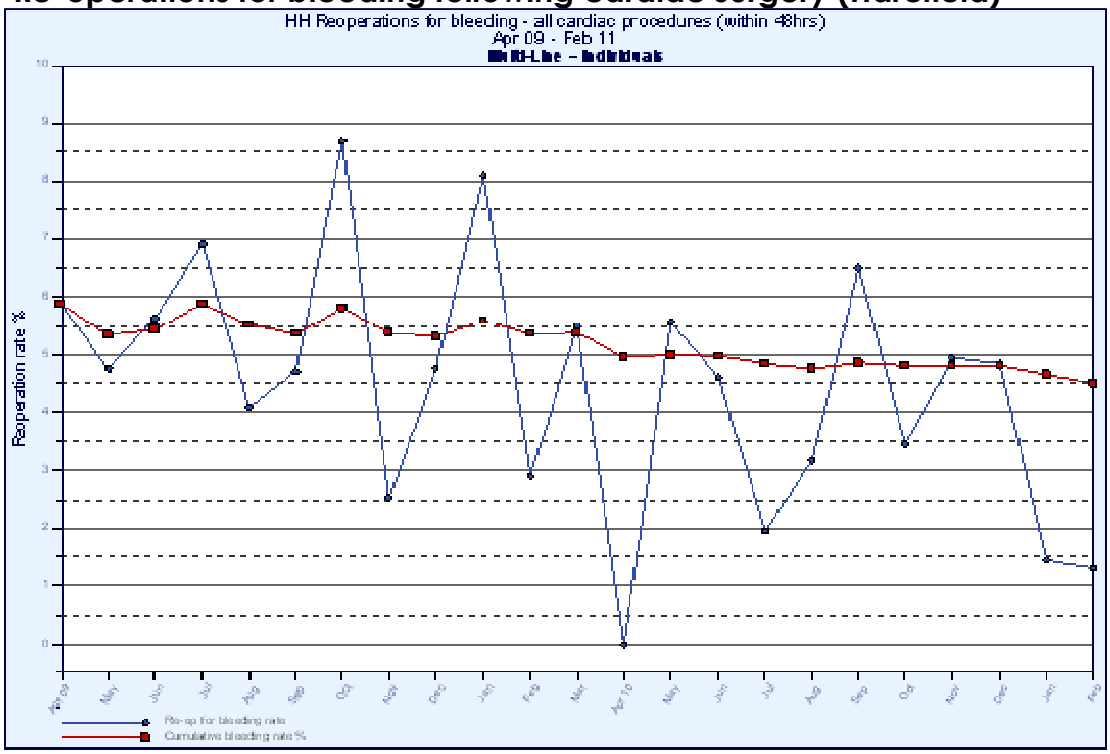
The rate of patients returning to theatre for a re-operation at RBH has reduced by 56.9% in the first three quarters of 2010/11 when compared to 2009/10. The chart below shows the re-operation rate by month and cumulatively since April 2009. For example, in the first three quarters of 2010/11 no patients undergoing mitral valve surgery have returned to theatre for bleeding within 48 hours of the procedure.

Re-operations for bleeding following cardiac surgery (Royal Brompton)



The chart below shows the re-operation rate by month and cumulatively since April 2009 at HH. The chart demonstrates that the cumulative rate of patients returning to theatre for re-operation for bleeding has consistently decreased since April 2009 with the rate in the first three quarters of 2010/11 having decreased by 26.2% when compared to 2009/10. Data for both sites will be updated to include quarter 4 figures in the final report.

Re-operations for bleeding following cardiac surgery (Harefield)



Part 4: Involvement in Quality Account 2010-11

Who is involved in creating the Quality Account 2010-11?

Choice of Priorities for Quality

Each year, the Trust is required to choose 3 to 5 areas to focus on for quality improvement in the Trust. This year, we wanted to ensure we reflected the priorities of a wider range of staff, patients, carers and members of the public.

Therefore, a shortlist of possible quality projects was identified, which reflected a mix of patient safety, clinical effectiveness and patient experience. The list included topics specifically suggested by both the Kensington and Chelsea LINks and the Hillingdon LINks, and by the Trust's Governors.

This shortlist was then made available on the intranet and internet for 1 month and everyone was encouraged to vote for their preferred topics.

Review of Draft Quality Account

The Local Involvement Networks, Oversight and Scrutiny Committees and our local commissioners have been offered the opportunity to comment on the draft copy of the Quality Account, and hence offer some valuable feedback regarding it's content, and in particular it's accessibility for members of the public, which can be incorporated into the final version.

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

Statements from Local Involvement networks, Overview and Scrutiny Committees and Primary Care Trusts

Kensington and Chelsea LINks

Hillingdon LINks

Kensington and Chelsea Oversight and Scrutiny Committee

Hillingdon Oversight and Scrutiny Committee

North West London Commissioning Partnership

Glossary

The final draft will have a glossary included. Please let us know if there are any specific words or phrases you would like included.

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The Hillingdon Hospitals NHS
NHS Foundation Trust

Improving your local hospitals – our report to you (*main title*)

(take in pictures of ward activity at both hospitals)

Annual Quality Account 2010-2011
Fifth Draft (v9) (*subtitle)*

To be re drafted when the document is complete

CONTENTS

To be re drafted when the document is complete

About this report

Local people want hospitals that are safe and efficient and that care for them as individuals. This is exactly what we, the Trust Board, want for our two hospitals – Hillingdon and Mount Vernon.

This report is an innovation in the NHS. For the first time all hospitals are publishing information about the work they are doing to improve the quality of the service they provide.

We have divided the report into three sections. First we look forward and outline our priorities for improvement over the next year. We look at seven priorities and examine whether they fit our three quality principles: safety, clinical effectiveness and the patient's experience, and what we are doing in each case to improve.

Then we look back on last year and report on what our priorities were then and what we did about them. Finally we examine our services against those provided by other hospital Trusts so that you can see how we compare on quality.

I hope you find this report readable and interesting. I would be very grateful for any feedback on style or content. Please write to me at the email address below.

Yours sincerely

David McVittie,
Chief Executive
david.mcvittie@thh.nhs.uk

To include comment from recent staff survey re – positive comments on patient quality of care

1 page summary to be added when document is complete which can be used for easy distribution to the public

PART 2. Looking forward - our priorities for 2011/2012

Every year we engage all of our stakeholders to review our services and agree a clinical quality strategy. All of the service reviews and developments in the hospital which result from this strategy have since October 2010 been subject to a formal quality impact assessment tool. Furthermore, progress of all these developments are monitored at the bimonthly Hospital Quality Improvement, Productivity and Prevention (QIPP) group, which has as its membership all the relevant stakeholders. Key indicators identified as part of this clinical quality strategy will be added to an already wide range of indicators relating to the three domains of quality, clinically effective care, safety and patient experience that are currently monitored monthly at Trust Board level.

For the purposes of this section, we have focused on the seven priorities that make up part of our clinical quality strategy. These have emerged from what our patients have told us, and the ideas of our staff as well as those of a range of friendly organisations and stakeholders.

To ensure that we monitor and deliver on our objectives, in addition to the QIPP group and the Trust Board monitoring of key indicators, there will be monitoring of all other measurable indicators by the Hospital Clinical Quality and Standards Committee (a sub-committee of the Trust Board which meets bimonthly), with a quarterly report to the Trust Board.

PRIORITY 1: Enhanced Recovery Programme

Why is this one of our priorities?
The aim of the Enhanced Recovery Program is to enable all patients undergoing an operation to recover safer and sooner from their surgery, and have an improved overall experience. The program is designed so that there is detailed pre-operative assessment and planning, including patient education, so that the patient has clear expectations as to what is going to happen at each stage of their pathway. During recovery certain milestones are set, including mobilisation, eating and therapy input and the patient is asked to record their journey in a diary. Data gathered nationally shows that patients who undergo the enhanced recovery program pathway get better quicker, are better able to control their pain and recovery, are more informed, and are able to leave hospital sooner.

The hospital was pioneering in offering this type of treatment for Trauma and Orthopaedic patients and the method has now been taken up nationally by the Department of Health for roll out to other types of surgery at other hospitals. We have been offered the opportunity to become one of the hospitals (chosen by the Department of Health) to participate in the enhanced recovery programme roll out. Clinicians in two of our specialties expressed an interest in taking part in this work so we will now be offering the enhanced recovery program to patients undergoing elective bowel surgery and hysterectomies.

Below is a selection of quotes from our patients who have already had their surgery as part of the Enhanced Recovery Program:

"I thought I would have more pain and take longer to recover but I'm back to nearly normal after just 3 weeks – I put it all down to what happened before and after the operation. Because of all the information I had beforehand, I knew what to expect and I felt encouraged to move around."

"I felt prepared because I was told what to expect."

"It was very good to hear that I could go home in 2 or 3 days. I am 72 years of age and remember when patients had to stay in much longer. This is an amazing advance in technology."

"Great care was taken to prepare me for the operation and this no doubt contributed enormously to my feelings of ease and confidence"

"I even had a chicken sandwich the 1st day after my operation. This was my best day yet".

Our aims for 2011/12 are:

- Embed the Enhanced Recovery Program for patients undergoing selected Gynaecology and Bowel Surgery procedures.
- Bowel Surgery patients;
    - Reduce the average Length of Stay from baseline (Jan-June 09) of 13 nights (national average 10.9) to an average of 9 nights.
    - Have no increase in re-admissions from the baseline rate (Jan-June 09) of 16.2%

- Gynaecology Hysterectomy patients:
    - No Increase in the Mean Length of Stay; baseline (Jan-Jun 09) 3.6 nights (national average 4.3), success factor is to remain at 3.5 nights average length of stay.
    - No Increase in the Median Length of Stay; baseline (Jan-June 09), 3 nights (national average 4), success factor is to remain at 3 nights average.
    - Reduction in Readmission rate from baseline (Jan-June 09) of 9.09% to less than 6%

- Improve the patient experience for patients, using experience based design techniques to gather data regarding patient's feelings and outcomes throughout their pathway. This will include some telephone interviews before and after the procedure, as well as each patient being asked to complete a diary throughout their journey to capture how they feel at different stages. This information will be fedback to the clinical teams at their enhanced recovery team meetings and will directly influence how the program is developed.
- Fully report and record pathway data onto the national Enhanced Recovery Database, which is held by the Department of Health, so that our progress can be tracked and we can compare ourselves against the best from across the country.
- Participate in shared learning and networking events to inform practice locally and nationally.

PRIORITY 2: Development of Clinical pathways for dementia and diabetes

Why is this one of our priorities?

We believe that redesigning pathways for patients with long term conditions ensures that patients receive the best possible care in the most appropriate place. Effective pathways ensure better co-ordination and continuity of care and reduce duplication of services thereby ensuring efficiency.

<u>Dementia Cinical Pathway</u>
In 2010 the Borough of Hillingdon committed to review the pathways for patients with dementia. It is estimated that the growth of dementia cases in Hillingdon between 2005 and 2021 will be between 14% and 22%. It is recognised that these patients often stay longer in hospital and have worse outcomes.

A Borough wide dementia working group has been formed with representation from acute, community, mental health, social care and voluntary organisations. This group has reviewed the current patient pathways for this group of patients and suggested improvements.

How are we doing so far?

- We have identified 21 senior clinical staff from areas all around the hospital to be "Dementia Champions". All these staff have attended a bespoke training course focusing on improving the care of the patient with dementia in the acute hospital setting. These staff will deliver local training and ensure that good quality care is delivered in clinical areas.

- All new staff now attend dementia awareness training as part of the New Starter Programme when they commence employment at the Trust.
- Clinical and project leads have been identified and a hospital dementia working group has been formed.
- A local dementia assessment protocol has been approved and is now in use.

Our aims for 2011/12
In the coming year we aim to:

- Ensure our workforce have the appropriate skills and training to deliver high quality care to this patient group.
- To demonstrate through local re-audit that more inpatients are being appropriately assessed for cognitive impairment.
- Implement the action plan written by the Trust following the participation in the National Dementia Audit. This includes:
    - Reducing the number of in-hospital transfers for patients with dementia
    - Writing and launching a protocol to help staff manage challenging behaviour in people with dementia
    - Introducing a standardised multidisciplinary assessment tool.

The progress will be monitored by the Borough and Hospital Dementia Group.

<u>Diabetes Clinical Pathway</u>
Diabetes nationally is increasing at an alarming rate. Late detection and poor diabetes management increases the risk of preventable complications.

The Hospital works with the Hillingdon Diabetic Network Board which has the role of setting and monitoring goals, and overseeing diabetes-related service developments in the Borough of Hillingdon, with the aim of improving high quality and safe care for people with Diabetes in the most appropriate location, whether that be in the community or in hospital.

How are we doing so far?

- Key clinical staff have attended the DAFNE training course to allow them to deliver the structured education programme.
- Diabetic patients are being routinely followed up post discharge from hospital to monitor their progress.
- A multidisciplinary foot clinic has been set up with input from the Orthopaedic and General Surgeons, Wound Care Specialist Nurses and Diabetes Consultants.

Our aims for 2011/12 are

- To offer structured DAFNE (Dose Adjustment for Normal Eating) education to high risk patients with Type 1 Diabetes.
- To reduce diabetic emergency re-admissions from 9.5% to 3.4% for 14 day readmissions and from 12% to 7.4% for 28 day readmissions.
- To reduce the number of patients being admitted with Diabetic Ketoacidosis and hypoglycaemia.

Progress will be monitored by the Hillingdon Diabetic Network Board and the Medicine Divisional Board.

PRIORITY 3: The Leaving Hospital Project – Improving the patient's discharge experience

Why is this one of our priorities?
There needs to be a focus within the trust on trying to improve the discharge process to ensure safe and effective transfer out of the hospital for patients, whether they are being discharged to their home or on to continuing care services in the community.

Whilst improvements have been made in some areas, data from the national in-patient survey 2008/09 actually shows deterioration in performance in nine of the questions relating to discharge, with improvements only demonstrated in two areas. Patient Survey Data to be added.

Feedback from our community colleagues, and collected by the local LINKS, highlights further issues with the safe transfer of patients for continuation of care and effective communication with all parties (patients, carers, community teams) relating to discharge out of hospital.

It is clear that a co-ordinated and concerted effort is now needed to ensure that real and sustainable improvements are made regarding every aspect of every patients discharge from our hospitals. A dedicated high level project board, including patient representatives, will be established to create a co-ordinated and concerted effort to improve the experience of the discharge process.

Our aims for 2011/12 are:

- Establish the Leaving Hospital Project; set up the steering group, assign roles and communicate across the organisation.
- Agree and create a set of metrics to enable measurement of success and track if changes being made result in an improvement. These metrics will include;
    - Time and day of Discharge; in January 2011 an average 17% of patients were discharged by 12 noon
    - Length of Stay; in January 2011 average 4 days
    - Readmission rates; in January 2011 9.5%.of patients were readmitted within 28 days of their discharge.

  These metrics will be agreed by the steering group, and targets for improvement set against each of them. Progress will be monitored at the monthly steering group.
- Rewrite and embed the Hospital Discharge Policy, to include clear roles and responsibilities for all of those involved in the Discharge process.
- Hold a series of workshops with stakeholders, internally and externally, and make immediate changes to processes based on what is being said.
- Carry out a detailed analysis on Length of Stay; benchmark against best practice and make changes to pathways to improve performance.
- Introduce a system of Real Time Bed Management across the whole hospital, so that our beds can be managed more efficiently and effectively.

PRIORITY 4: The First Contact Project – Improving the outpatient experience

Why is this one of our priorities?

This two year project, which started in 2009, will continue in 2011/12. The project was established as a direct result of feedback received from patients about the difficulties they experienced when trying to contact the hospital and when visiting the hospital for out patient appointments. The aims of the project are to improve the way we book appointments, to improve the customer care skills of our staff and improve the overall experience of visiting our outpatient departments.

How are we doing so far?
The results of what we achieved during 2010-11 can be seen in Part 3 of this document

What are our aims for 2011/2012?
The main areas where work will be focused in 2011/12 will be:

- Using intelligence gathered from patient focus groups to improve the outpatient department environment and experience – quotes from current surveys to be inserted
- Embedding excellent customer care standards in the booking centre and outpatient areas.
- Installing a call management system in the booking centre and outpatient areas to provide a better experience when patients are trying to contact these locations. This system will also provide a functionality to remind patients of their pending appointments.
- Moving the location where appointments get booked in the hospital to the booking centre, whose staff have the expertise to deal with queries and provide an efficient service.
- The changes above will be measured for impact by reviewing data from;

    - Out-Patient Experience Surveys, current data to be inserted
    - Numbers of Complaints. Currently there are on average 25-30 complaints and 100 plus expressions of concern noted about the booking centre and outpatients per month.
    - Did Not Attend (DNA) Rates; In January 2011 10.9% of patients did not attend their out patient appointment without previously cancelling.

We are hoping to see significant improvements in each of these areas as a result of the work of the project. Progress against these metrics are monitored by the project group.

PRIORITY 5: Communication – Seeing the Person in the Patient

Why is this one of our priorities?
We recognise that people are at their most vulnerable when they are unwell. We want patients to know that they matter and feel respected and involved in decisions about their care and treatment. This means understanding that our patients are individuals with their own unique needs and wishes; in short 'seeing the person in the patient'. However, our patients have told us that we do not always succeed in ensuring that they feel cared for. This means communicating in a way that is easily understood and involving them in decision making. In our most recent inpatient experience survey our patients have described how it feels for them when we get this right

'*when staff had time to stop and chat it made me feel like they cared and I wasn't just another on a conveyer belt'*
'staff were very caring, understanding my special needs'

Our patients have also told us how to improve their experiences:

'a bit more information about what is happening during the admission process'
'communication between hospital staff and patients'

What are our aims for 2011/12?

- In 2010 our staff were involved in reviewing and refreshing our existing culture and values and developing a more explicit framework of expected behaviours. The framework known as PRIDE (Professional, Respect, Inspire, Deliver, Equity) will be launched early in 2011; seeing the person in the patient is integral to the framework. The refreshed values will be introduced to new employees during their induction programme and will be promoted continuously through the annual Personal Development Review. This will ensure that the values are kept 'live' and that staff commit to their personal responsibility in providing excellent patient care. Clear examples of how to make the written words a practical reality will be communicated to all staff.
- Traditionally nursing shift handover takes place in an office away from the bedside. During 2011 we will be implementing a protocol for a bedside nursing ward round. This will promote a patient centred approach to care, and encouraging patient/carer involvement

- We will continue to work closely with our local carers association, jointly developing and implementing guidance that will shape how we work in partnership with carers to ensure the best outcomes for patients.

We will monitor our patients experience through analysing the results of our inpatient surveys, reviewing complaints and concerns raised through our Patient Advisory Liaison Service (PALS) alongside other feedback. During 2011 our new real time patient experience surveys 'Your Views Count' will be launched. We will identify questions within this survey that are directly related to our patients experiences of communication and involvement in care. Our new system will enable us to monitor improvements in these questions in real time week by week.

PRIORITY 6: Maternity

Why is this one of our priorities?
Maternity is one of the Trust's key large volume services and particularly one where choice options for expectant mothers on where to deliver are explicitly available and communicated by a variety of means. We are committed to continually improving quality and birth experience for women and extending the choice options available.

How are we doing so far?
- During 2010 Hillingdon launched its Midwifery Led Pathway – this promotes normal natural childbirth for women where this is the best and most attractive option, but within an integrated unit so that medical help can be urgently accessed if needed.
- A new co located second operating theatre was commissioned in July 2010, improving safety when there are simultaneous obstetric emergencies taking place.
- A new birthing pool was installed in the summer of 2010, improving birthing choice.
- New leadership and an improvement programme have made a tangible difference to mother's experience on our post natal ward. This change took place in late 2010 and has made a significant positive impact as evidenced by personal feedback, the recent patient surveys and reduction in complaints.
- Recently we have reviewed our Maternity Early Warning Chart, which helps to identify a woman who is becoming more unwell so that her care can be quickly escalated. This has been complemented by a comprehensive training programme which has been reviewed by the Care Quality Commission on an unannounced visit and they were very pleased with the content
- The reduction in post partum haemorrhage rate has been maintained at 53 (current target <96)
- Early Access to Maternity – (12+6 target current trajectory 90%) **–** Hillingdon's performance fluctuates around 80% however we meet the target for ALL women who are referred to us before they reached 10 + 6 weeks gestation. We are working closely with public health to promote the health advantages of earlier assessment in pregnancy.
- Caesarean Section Rate – (target 24%) – this too has been a challenge to meet and benchmarking with other organisations indicate this across the sector. Average in month performance is 26 – 27%.

What are our aims for 2011/12?
- To set measurable goals for improvement since the launch of our Midwifery Led Pathway in 2010. In terms of immediate measurables we have already seen a marked reduction in CTGs and an increase in water births. Other metrics include an improvement in the patient experience, via the survey, and an increase in the number of non obstetric deliveries.
- We have participated in a Pan London review of maternity staffing levels and have increased our midwifery staffing establishment. This means that we have improved our staffing ratios from 1 midwife to 34 women (1:34) to 1 midwife to 32 women (1:32) and are making excellent progress in reaching our goal of 1:30.

- The aim in 2011/12 is also to increase the number of women accessing home birth. This has already grown over the past 2 years to 2% but we hope that more women can be supported to take up this option in the coming year and we aim to reach 5% in the next financial year.
- Currently all women have a named midwife from booking up to the point of delivery. During 2011/12, as part of our community midwifery reconfiguration, we aim to improve this and have midwives working in small teams of 3 or 4. In this way women can become familiar with a named group of midwives so that they can be sure to have a known named midwife with them right through to and including delivery.

Priority 7: CQUINs

How are we doing so far?
The results of what we achieved with our 2010-11 CQUINs can be seen in Part 3 of this document

What are our aims for 2011/12?
To be added when finalised

PART 3. Looking back – what we said we would do last year, 2010/2011

(Take in two/three relevant case studies in this section with patient quotes)

This section looks at key metrics in a dashboard format, and using narrative text some specific areas that were identified as quality objectives in our last Quality Accounts in 2010.

Priority 1. Commissioning for Quality and Innovation (CQUINs) framework

CQUIN is a scheme to encourage NHS Trusts to improve quality and patient safety by setting targets and rewarding achievement of those targets financially. These targets are set with local, regional and national bodies.

Targets for 2010/11	What we did
Assess patients for risk of venous thromboembolism (VTE) on admission to hospital.	Target 45% in quarter 2 – achieved 45.4% Target 80% in quarter 3 – achieved 63.0% Target 90% in quarter 4 – achieved 65.5%
Improve patient experience as judged by the national survey	Target on key questions 69.3% satisfaction, our local survey carried out every month achieved 75.2% satisfaction.
Use a clinical experience assessment tool (Global Trigger Tool) to identify areas for improving patient safety and quality of care	50 sets of notes assessed where patients died, using the Global Trigger Tool.
Achieve a faster and better recovery programme for patients following surgery.	Targets agreed with the PCT, will be measured in the final quarter of the year.
Improve the quality of discharge summaries sent to GPs	It has been agreed that an audit will be carried out but details have not been confirmed
Increase the proportion of discharges before midday and at weekends	Targets agreed for trauma & orthopaedics and gastroenterology
Improve care planning for outpatient care	Method of measuring still to be agreed
Implement the Healthcare for London dementia service guide	Patient pathway and lead clinician have been agreed, staff training has taken place, targets for patient assessments have been met.
Reduce the number of emergency readmissions for patients with COPD, diabetes and heart failure with 14 day readmissions reduced by 10% and 28 day readmissions by 5%.	Achieved for 14 day readmissions for COPD but readmissions at 28 days have increased as have readmissions for diabetes and heart failure patients.
For patients with fractured neck of femur by the end of the year 70% to receive osteoporosis medication, 100% to have a standardised anaesthetic assessment prior to surgery, 100% to have type of fracture recorded.	Interim targets for the first three quarters have been achieved.

Developing the clinical pathways detailed in Part 2 will help reduce readmission for chronic conditions such as diabetes in 2011/2
Need some text to address VTE performance.
Need to get fourth quarter data for fractured neck of femur

Priority 2. The Patient Safety First Campaign

We said:

We would improve the escalation of the patient at risk of becoming acutely unwell using an established scoring system (PAR score). We also said that we would reduce harm from insulin and a blood thinning drug, warfarin. In surgery, we said we would improve on a package of measures known to reduce the risk of surgical infection, implement and audit the WHO safe site surgery checklist, and measure the rate of all surgery-related infections.

We did:

Identifying the patient at risk

- We have implemented a Maternity Early Warning System (MEWS) and are piloting a Paediatric Early Warning System (PEWS).
- The number of ward cardiac arrest calls has reduced from 203 in 2009-10 to 183 in 2010-11.

Reducing harm from insulin

- We have combined the blood glucose monitoring and insulin prescription chart as per National Patient Safety Agency (NPSA) recommendations.
- We have incorporated an e-learning insulin module as part of new doctors induction and rolled out a programme of education for nurses.
- We have just started to pilot a Hypo Box as a standard way of treating low blood sugar levels.

Reducing harm from warfarin

- We have incorporated the NPSA e-modules as part of new doctors induction,
- A referral form to the anticoagulant nurses for all patients commencing warfarin which highlights good practice has been developed, and the good prescribing guidelines are on the intranet.
- The ward pharmacists have a greater policing role for prescriptions relating to blood thinning medicines.
- We have defined triggers for both insulin and warfarin errors which will allow us to monitor the rates of errors related to these agents, which we expect to see reduce in the coming years.

Reducing harm from surgery

- We have implemented and audited the adapted WHO safe site surgery checklist, and compliance is at 92%.
- We have extended surgery-related infection monitoring to gynaecology and other orthopaedic procedures. However, collating data with GPs where patients may also go in case of post-operative infections makes the monitoring of all infections difficult.

Priority 3. The First Contact Project – Improving the Outpatient's Experience

We said:

We would improve booking appointments, improve the customer care skills of our staff and improve the overall experience of visiting our outpatient departments.

We did:

- Standardised all new and follow up appointment letters, reducing the number of different letters being sent to patients and improving their content
- Streamlined processes in the booking centre and installed all new computers to speed up work
- Redesigned the appointment booking process to reduce the number of steps, speed up the process and reduce the margin for error or delay
- Created an email address so that patients have an alternative to telephone to contact the booking centre
- Provided further training for booking centre and outpatient staff in customer care and agreed customer care standards.

Priority 4. Improving the delivery of care – Measures of care

We said:

Measures of Care is a system to set and monitor standards of nursing care across a range of nursing indicators such as; pressure area care, patient falls and food and nutrition on our general wards.

We did:
We realised our main aim of achieving an overall compliance of greater than 90% for each standard. We have also reviewed all our indicators, taking into account the findings from the Care Quality Commission (CQC) Mid Staffordshire Report and the National Patient Association report "Patients not numbers... People not statistics…". As a result of this thorough review we have revised our indicators to include the following:

- Record Keeping
- Hydration and Fluid Balance
- Medicine Management

Specific Measures of Care indicators have also been rolled out to our children's and maternity wards. There has also been focussed work on both falls and pressure ulcer prevention. This has included:

- A review of the Slips, Trips and Falls Policy and Pressure Ulcer Prevention Policies to ensure they reflect national guidance/best practice and are easy for staff to follow.
- Audit and replacement of our mattresses to ensure that they provide the required level of support to enhance prevention of pressure ulcers
- Implementation of the SKINS bundle that aims to reduce avoidable pressure ulcers in NHS provided care. The SKINS bundle was piloted successfully on one ward and a plan has now been developed to roll it out to our other wards

Priority 5. Improving Care - the Emergency Care Pathway

We said:
Our aim in 2010/11 was to ensure that all patients receive good quality care in A&E, supported by community care when appropriate, and are treated with respect and dignity.

We did:

- A&E Consultants are now present for longer hours, seven days a week
- Paediatric Consultants work evening shift when patient numbers are known to be at their highest
- Additional twilight shifts have been introduced for Senior Grade Doctors to ensure patients are seen and assessed promptly
- Introduced a Rapid Access Consultant Triage system in Majors to ensure that patients receive pain relief quickly and diagnostic tests are ordered without delay
- An audit was carried out by the Deputy Director of Nursing and A & E Matron to see if there was a need to introduce the red peg initiative but they found it was not necessary as staff were not entering cubicles when patients were being treated
- Designed a local patient satisfaction survey
- Ensured that there is close liaison between the nursing staff and the A & E housekeeper at meal times so appropriate patients are offered food and drink. We also regularly update patients' dietary needs on the information screens
- Introduced a community antibiotic intravenous pathway for a limited number of conditions to negate the need for these patients to be admitted to hospital for treatment
- Regular meetings are now held with external organisations (including PCT, Urgent Care Centre, Community Health providers, Mental Health Trust and London Ambulance Service) to jointly work on improving emergency care pathways both in the Hospital and the Community.

We also did:

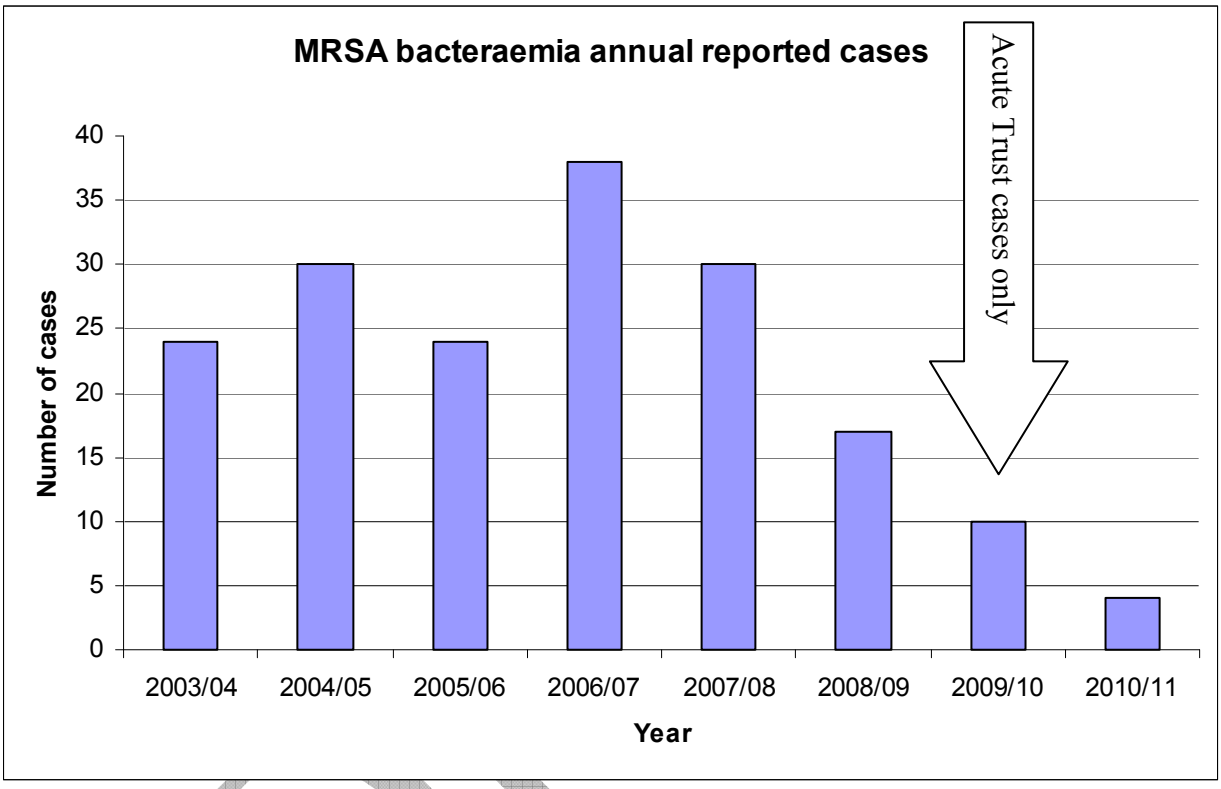
- Introduced a new investigation for patients with chest pain which allows rapid diagnosis and treatment
- Developed the skills of 4 Health Care Assistants to enable them to become Emergency Department Technicians. These staff are now competent to perform tasks such as taking blood, applying plasters and closing wounds

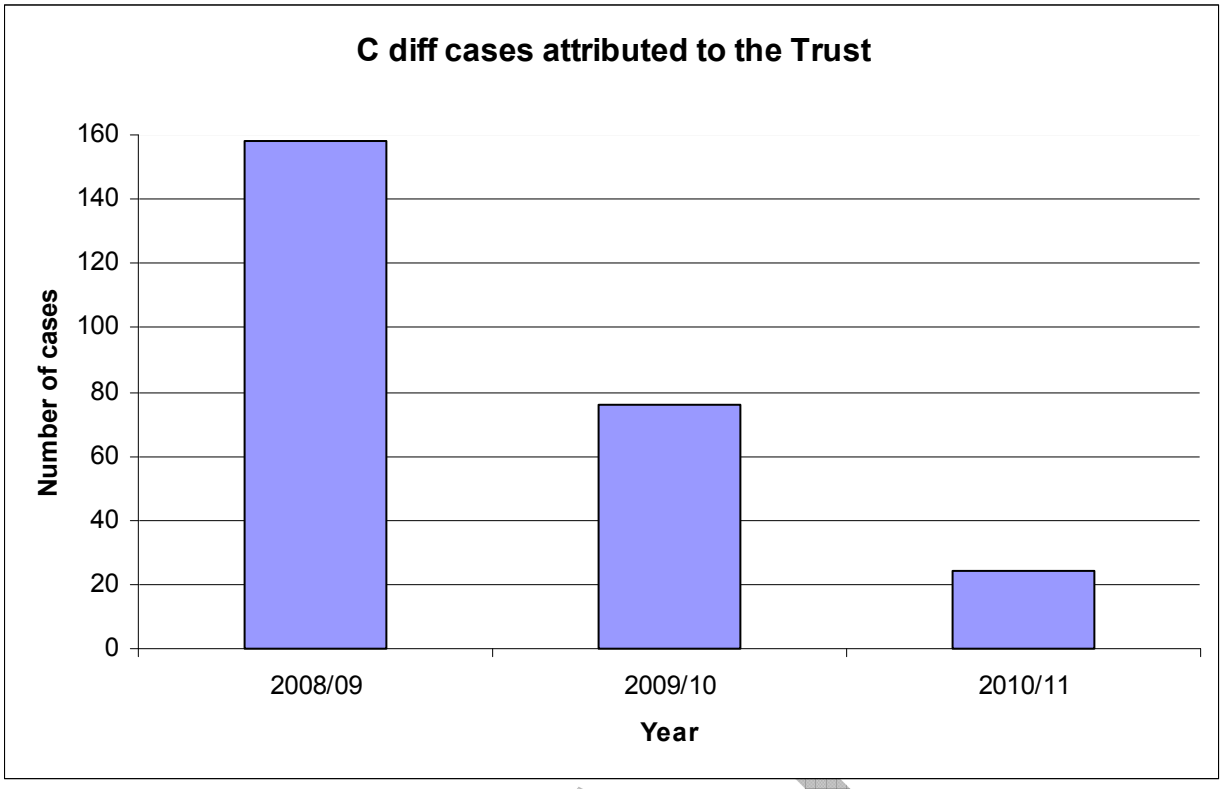
Priority 6. Improving Hospital Acquired Infection

We said:
We would reduce the number of cases of Clostridium difficile (C diff) to 78 for the year 2010/11, and the number of cases of MRSA to 4 for the same year.

We did:

The following graphs show that we have exceeded our targets





This has been achieved through:

- MRSA screening now for all emergency and routine patients
- Introduction of C Diff ward rounds
- Aseptic Non Touch Technique (ANTT) competency assessment across departments
- Close scrutiny of performance at Infection Control Committee and the Trust Board
- Root cause analysis for all Trust-attributed MRSA and C Diff cases
- Learning from close working with community colleagues
- Review of decontamination processes and services to ensure a more effective and efficient provision of service
- Improving antibiotic compliance from TBC to TBC

Our MRSA rate is lower the London average but still higher than the national average, and our C Diff rate is still higher than London and the national average. Further work will still continue to reduce our levels of infection.

Dashboard of other key quality measures

The Hillingdon Hospitals NHS Foundation Trust Performance

	Latest Data Available	Trust	How London Trusts perform	National average performance
In Hospital Standardised Mortality Ratio	Apr-Dec 2010 (Dr Foster)	88.9 (confidence limits of 81.3-97.1)	Not available	England average ratio is 100. >100 is worse, <100 is better
Readmissions to hospital within 28 days	Apr-Sept 2010 (Dr Foster)	101.0 (confidence limits of 96.6-105.5)	Not available	England average ratio is 100. >100 is worse, <100 is better
Non clinically justified single sex accommodation breach, rate per 1,000 finished constulant episodes	01/12/2010 (Dr Foster)	0	8	11
Cancer: Two week wait from GP referral to seeing a specialist (suspected cancer)/(breast symptoms)	2010/2011 Q2 (Dept of Health)	95.1%/94.7%	Not available	95%/94.2%
Cancer: 31 day maximum wait from diagnosis to first treatment		96.5%	Not available	>96%
Cancer: 31 day maximum wait from diagnosis to subsequent treatment, drug or surgery		100.0%	Not available	96.7%
Cancer: 62-day maximum wait from referral by GP/screening service/consultant upgrade to treatment		95.3%/100%/98.5	Not available	86.9%/93.6%/93.7%
Referral to treatment waiting times - admitted (95th percentile)	01/11/2010 (Dept of Health)	17.9 weeks	20.8 weeks	21.3 weeks
Referral to treatment waiting times - non admitted (95th percentile)	01/11/2010 (Dept of Health)	14 weeks	15.6 weeks	15.7 weeks
Percentage of patients treated within 28 days of having operation cancelled for non-clinical reasons	2010/2011 Q2	100.0%	99.0%	97.3%
Fractured neck of femur emergency patients in theatre within 36 hours	Apr 2009 - Mar 2010 (National Hip Fracture Database)	52.2%	59.8%	57.3%
Total time in A&E: 4 hours or less	Jan 2011 (Dept of Health)	97.6%	96.3%	95.9%
Percentage of patients treated within 28 days of having operation cancelled for non-clinical reasons	2010/2011 Q3 (Dept of Health)	100.0%	98.9%	96.9%
Percentage of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy	2010/2011 Q1 (Dept of Health)	82.10%	79.90%	85.20%
Stroke patients: Percentage of Patients that have spent at least 90% of their time on the stroke unit	Apr-Dec 2010 (Dept of Health)	95.70%	92.10%	74.6%
Stroke patients: Percentage of high risk TIA patients who are treated within 24 hours	Apr-Dec 2010 (Dept of Health)	100%	93.20%	64.1%

	2009/2010 Performance	2010/2011 Year-to-Feb Performance	2010/2011 Target
Inpatient Experience Programme (local survey results)	89.00%	88.00%	>=80%
Outpatient Experience Programme (local survey results)	79.00%	84.00%	>=80%
Maternity Experience Programme (local survey results)	75.00%	77.00%	>=80%
PEAT: independent assessment of cleanliness of hospital	Good	Good/Excellent	Good/Good
Percentage of complaints responded to within agreed timescale	87%	79%	90%

QA_metrics

Dashboard aim 11
National guidance[1] and best practice[2] demonstrates the outcomes and mortality rates of patients presenting with fractured neck of femurs (#NoF) are improved significantly through best practice pathways that deliver access to theatres within 36 hours of arrival in Accident and Emergency (A&E). As part of the Division of Surgery and Anaesthetics' surgical strategy a dedicated trauma unit, with all-day trauma operating, launched on 15 November 2010, since which time performance has improved from 51%to 62%.

To continue to improve performance and thus meet the 90% target in 2011/2012, as well as continuing other measures to improve quality of care, future areas of work will include:

- Real-time management of trauma patients via a visible monitor which has been installed and needs to be linked to the Trust's information systems.
- Reviewing and re-distributing junior doctor cover from within the week to support weekend operating.
- Improving pain relief within the first 30 minutes of arrival via 'Pain Block Training for A&E Physicians'. This is being led by anaesthetics and outcomes measured through an anaesthetic-led audit.
- Continuing to contribute to, and learn lessons from, the National Fracture neck of the femur audit, for example ensuring all patients receive medication for osteoporosis.

Need text to accompany Dashboard aims 19 and 21

[1] http://www.institute.nhs.uk/quality_and_value/high_volume_care/fractured_neck_of_femur_facts.html, accessed 16 March 2011
[2] http://www.fractures.com/pdf/BOA-BGS-Blue-Book.pdf, accessed 16 March 2011

APPENDIX

Information for our regulators

Our regulators need to understand how we are working to improve quality so the following two pages are specific messages they have asked us to provide:

Services

During 2010/2011 The Hillingdon Hospital NHS Trust provided medicine, surgery, clinical support services and women's and children's NHS services. The Hillingdon Hospital NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2010/2011 represents 100 per cent of the total income generated from the provision of NHS services by The Hillingdon Hospital NHS Trust for 2010/2011.

Audit

NATIONAL AUDITS
During 2010/11, 39 national clinical audits and 3 national confidential enquiries covered NHS services that The Hillingdon Hospital NHS Trust provides.

During that period, The Hillingdon Hospital NHS Trust participated in 72% of national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in
The national clinical audits and national confidential enquiries that The Hillingdon Hospital NHS Trust was eligible to participate in are as follows:

Perinatal Mortality (CEMACH)
Neonatal Intensive and special care (NNAP)
Paediatric Pneumonia (British Thoracic Society (BTS))
Paediatric Asthma (BTS)
Paediatric Fever (College of Emergency Medicine (CEM))
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)
Diabetes (RCPH National Paediatric Diabetes Audit)
Emergency Use of Oxygen (BTS)
Adult Community Acquired Pneumonia (BTS)
Non invasive ventilation (NIV) – adults (BTS)
Pleural procedures (BTS)
Cardiac Arrest (National Cardiac Arrest Audit)
Vital signs in majors (CEM)
Adult critical care (Case mix programme)
Diabetes (National Adult Diabetes Audit)
Heavy Menstrual Bleeding (RCOG National Audit of HMB)
Chronic Pain (National Pain Audit)
Ulcerative colitis & Crohn's Disease (National IBD Audit)
Parkinson's Disease (National Parkinson's Audit)
COPD (BTS/European Audit)
Adult Asthma (BTS)
Bronchiectasis (BTS)
Hip, knee and ankle replacements (National Joint Registry)
Elective Surgery (National PROMS Programme)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)
Carotid Interventions (Carotid Intervention Audit)
Familial Hypercholesterolaemia (National Clinical Audit of Mgt of FH)

Acute myocardial infarction & other ACS (MINAP)
Heart Failure (Heart Failure Audit)
Acute Stroke (SINAP)
Stroke Care (National Sentinel Stroke Audit)
Renal Colic (CEM)
Lung Cancer (National Lung Cancer Audit)
Bowel Cancer (National Bowel Cancer Audit Programme)
Hip fracture (National Hip Fracture Database)
Severe Trauma (Trauma Audit and Research Network)
Falls and non-hip fracture (National Falls and Bone Health Audit)
O Neg blood use (National Comparative Audit of Blood Transfusion)
Platelet use (National Comparative Audit of Blood Transfusion)

Participation Rates

The national clinical audits and national confidential enquiries that The Hillingdon Hospital NHS Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit	**Participation**	**%Cases submitted**
Peri and Neonatal		
Perinatal Mortality (CEMACH)	Yes	100%
Neonatal Intensive and special care (NNAP)	Yes	100%
Children		
Paediatric Pneumonia (British Thoracic Society (BTS))	Yes	93%
Paediatric Asthma (BTS)	Yes	100%
Paediatric Fever (CEM)	Yes	100%
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)	Trust registered to participate and organisational audit completed.	
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	98%
Acute Care		
Emergency Use of Oxygen (BTS)	No	N/A
Adult Community Acquired Pneumonia (BTS)	No	N/A
Non invasive ventilation (NIV)	No	N/A
Pleural procedures (BTS)	No	N/A
Cardiac Arrest (National Cardiac Arrest Audit)	No	N/A
Vital signs in majors (CEM)	Yes	100%
Adult critical care (case mix programme)	No	N/A
Long Term Conditions		
Diabetes (National Adult Diabetes Audit)	No	N/A
Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	Trust will be participating – data collection not yet started
Chronic Pain (National Pain Audit)	Yes	
Ulcerative colitis & Crohn's Disease (National IBD Audit)	Yes	Trust participating – data collection until Aug 2011
Parkinson's Disease (National Parkinson's Audit)	Yes	100%
COPD (BTS/European Audit)	No	N/A
Adult Asthma (BTS)	No	N/A
Bronchiectasis (BTS)	No	N/A

Elective Procedures		
Hip, knee and ankle replacements (National Joint Registry) (calendar year)	Yes	69%
Elective Surgery (National PROMS Programme)	Yes	Hip replacements: 233 Knee replacements: 328 Hernia: 182
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	66%
Carotid Interventions (Carotid Intervention Audit)	Yes	86%
Cardiovascular Disease		
Familial Hypercholesterolaemia (National Clinical Audit of Mgt of FH)	No	N/A
Acute myocardial infarction & other ACS (MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	Date for submission 5/5/11 – expect to submit close to 100%
Acute Stroke (SINAP)	Yes	100%
Stroke Care (National Sentinel Stroke Audit)	Yes	83%
Renal Disease		
Renal Colic (CEM)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit)	Yes	100%
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	expect to submit close to 100%
Severe Trauma (Trauma, Audit Research Network)	Yes	Tbc expected less than 100%
Falls and non-hip fracture (National Falls and Bone Health Audit)	Yes	75%
Blood Transfusion		
O Neg blood use (National Comparative Audit of Blood Transfusion)	Yes	100%
Platelet use(National Comparative Audit of Blood Transfusion)	Yes	83%

National Confidential Enquiry into Patient Outcome and Death		
Surgery in children	Yes	N/A - no appropriate patients
Peri-operative care	Yes	100%
Cardiac arrest	Yes	8 forms ?100% TBC
National Confidential Enquiry into Maternal and Child Health		
Head injury in children	Yes	To be confirmed
Perinatal Mortality 2010	Yes	100%

The reports of *20 (tbc)* national audits were reviewed by the provider in 2010/11 and THH intends to take the following actions to improve the quality of healthcare provided

Audit	**Actions**
Peri and Neonatal	
**Neonatal Intensive and special care (NNAP)	Awaiting information
Children	

Paediatric Asthma	Awaiting confirmation
Diabetes (RCPH National Paediatric Diabetes Audit)	Awaiting information
Long Term Conditions	
Severe and Moderate Asthma (CEM)	Awaiting information
Continence Care (National Audit of Continence Care)	For further review in 2011/12 – to undertake risk assessment on actions as part of Trust Clinical Audit Framework
Elective Procedures	
**Hip, knee and ankle replacements (NJR)	For further review in 2011/12
Elective Surgery (PROMS)	For further review in 2011/12
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Awaiting information
Carotid Interventions (Carotid Intervention Audit)	Awaiting information
Mental Health	
Dementia Care	- Reducing the number of in-hospital transfers for patients with dementia - Writing and launching a protocol to help staff manage challenging behaviour in people with dementia - Introducing a standardised multidisciplinary assessment tool - Introducing systems to ensure that all staff coming into contact with a patient with dementia are aware of their dementia and how it affects them
Cardiovascular Disease	
**Acute myocardial infarction & other ACS (MINAP)	Awaiting information
Heart Failure	Improvement made: 5 hrs of admin support is now provided to the Heart Failure Nurse to maintain participation rates for this audit
Cancer	
National Oesophago-gastric Cancer	For further review in 2011/12
**National Mastectomy and Breast Reconstruction Audit	Awaiting information
Trauma	
Fracture neck of femur audit (CEM)	Awaiting information
Hip fracture (NHFD)	To add, re: Trauma Theatre changes
Blood Transfusion	
Audit of red cells in neonates and children	Action plan development in progress
National Confidential Enquiry into Patient Outcome and Death	
Parenteral Nutrition: A mixed bag	Action plan in progress
Elective and Emergency Surgery in the Elderly: An age old problem	Action plan drafted
National Confidential Enquiry into Maternal and Child Health	
Obesity in Pregnancy	Awaiting information

**to confirm where reviewed

Local Audits

The reports of (figure to be confirmed) local audits were reviewed by the provider in 2010/11 and The Hillingdon Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided – details can be provided on request

Research

Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services provided The Hillingdon Hospital NHS Trust in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 96 studies.

Participation in clinical research demonstrates The Hillingdon Hospital NHS Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. The Hillingdon Hospital NHS Trust was involved in recruiting ,1301 patients into multi centre clinical research both NIHR non commercially funded and commercially funded studies, as a participating site. In 2010 -11 we had studies open and recruited patients into studies in the following areas; cancer, oncology, stroke, haematology, infection, several of the general medicine specialities, paediatrics and women's heath, and several surgical specialities.

The improvement in patient health outcomes in The Hillingdon Hospital NHS Trust demonstrates that a commitment to clinical research leads to better treatments for patients. There were eighty three clinical staff, across all disciplines participating in research approved by a research ethics committee at The Hillingdon Hospital NHS Trust during 2010- 2011. These staff participated in research covering twenty four of our medical specialties. Our Haematology Consultants have studies open across all their disease areas and as part of standard care offer patients the opportunity to participate in both treatment and genetic studies.

Our engagement with clinical research demonstrates The Hillingdon Hospital NHS Trust commitment to testing and offering the latest medical treatments and techniques. To demonstrate this commitment, from our NIHR activity based funding, we employ a full time research nurse and a full time clinical trials coordinator/data manager to support our clinicians undertaking NIHR portfolio adopted research. This enables our clinicians to offer their patients access to the latest medical treatments at the same time as being able to deliver high quality data to the study centres in a timely manner. This shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Goals Agreed with Commissioners (CQUINS)

A proportion of The Hillingdon Hospital NHS Trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between The Hillingdon Hospital NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request from The Financial Planning Department, The Furze, The Hillingdon Hospital, Pield Health Road, Uxbridge, Middlesex, UB8 3NN.

Care Quality Commission

The Trust was registered with the Care Quality Commission without conditions. In January 2011 the CQC paid an unannounced visit as part of their planned review of the Trust. The report issued from this visit stated full compliance for all the Essential Standards of Quality and Safety. The Care Quality Commission has not taken enforcement action against the Hillingdon Hospital NHS Trust during 2010/2011.

The Hillingdon Hospital NHS Trust submitted records during April to January 2010/2011 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 97.6 % for admitted patient care (TBC)
- 99.7 % for out patients care (TBC)
- 94.7 % for accident and emergency care (TBC)

The percentage records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

The Hillingdon Hospital NHS Trust Information Governance Assessment Report score overall score for 2010/2011 was 68 % (TBC) and was graded red .

The Hillingdon Hospital NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were ***(still in draft):***

- Primary diagnosis incorrect 10 **%** (TBC)
- Secondary diagnosis incorrect 7.3 % (TBC)
- Primary procedure incorrect 7.7 **%** (TBC)
- Secondary procedure incorrect 3.3 **%**(TBC)

ANNEXE

Lead Primary Care Trust Statement

500 words maximum – provided through consultation.

LinkS Statement

500 words maximum – provided through consultation.

Overview and Scrutiny Committee Statement

500 words maximum – provided through consultation.

The Hillingdon Hospital NHS Trust response to consultation

We have made the following changes to the document in response to comments from our LINKs group and OSC (to be completed)

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WORK PROGRAMME

Officer Contact	Nav Johal and Nikki Stubbs, Central Services
Papers with report	Appendix A: Work Programme 2010/2011

REASON FOR REPORT

To enable the Committee to track the progress of its work in accordance with good project management practice.

OPTIONS OPEN TO THE COMMITTEE

1. Note the proposed Work Programme.

2. To make suggestions for/amendments to future working practices and/or reviews.

INFORMATION

1. At its last meeting, the Committee agreed the attached Work Programme. Pale shading indicates completed meetings.

2. The Children's Self Harm Working Group has now concluded its review and the report would be considered by Cabinet on 14 April 2011.

SUGGESTED SCRUTINY ACTIVITY

1. Members note the Work Programme and make any amendments as appropriate.

2. Ensure Members are clear on the work coming before the Committee

BACKGROUND DOCUMENTS

None.

APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2010/11 WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
9 June 2010	**Community Cohesion Review** The review the achievements of the following organisations since April 2009 with regards to Community Cohesion: • Metropolitan Police • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services
16 June 2010	**LINk** To receive a report on the progress of LINk in the Borough since the last update received by the Committee in June 2009.
	Provider Services Detailed scrutiny of provider services, with particular reference to vertical integration and the proposed appointment of Central & North West London NHS Foundation Trust.
14 July 2010	**Safer Transport** To scrutinise the issue of safety with regards to transport in the Borough (Safer Neighbourhoods Team, Metropolitan Police Service and British Transport).
22 September 2010	**CANCELLED**
28 October 2010 - 4.30pm	**NHS & GPs** Performance updates and update on significant issues: • NHS • GPs

Meeting Date	Agenda Item
24 November 2010	**Provider Services** Review of effectiveness of provider services (with particular reference to end of life care, TB, children's speech and language therapy, physiotherapy and specialist community dentistry) and of the progress of the vertical integration: • CNWL • PCT • London Ambulance Service
11 January 2011 - 4pm	**Health White Paper** Review the implications and proposals contained within the Health White Paper published on 12 July 2010. Invitees would potentially include: • Dr Mitch Garsin (Chairman of Hillingdon LMC) • Dr Tony Grewal (Medical Director of the Londonwide LMCs) • the Chairman of Practice-Based Commissioning • GPs **London Ambulance Service** Update from Ambulance Service on Service Provision in the Borough
23 February 2011	**Crime & Disorder** • Metropolitan Police Service • Safer Neighbourhoods Team • Metropolitan Police Authority • PCT • London Fire Brigade • Probation Service • British Transport Police • Safer Transport Team
30 March 2011 – 5pm	**Community Cohesion Review** The review the achievements of the following organisations since June 2010 with regards to Community Cohesion: • Metropolitan Police Service • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services

Meeting Date	Agenda Item
26 April 2011	**Quality Accounts & CQC Evidence Gathering** • Hillingdon Primary Care Trust (PCT) • The Hillingdon Hospital NHS Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • Care Quality Commission (CQC) • Local Dental Committee

Themes	Future Work to be Undertaken
Health Inequalities Working Group Comprising Councillors: • John Hensley (Chairman) • Beulah East • Phoday Jarjussey • Judy Kelly • John Major • Carol Melvin • Mary O'Connor • Michael White	Detailed review of the impact of housing overcrowding on educational attainment and children's development. Working Group Meeting dates: • 3 August 2010 • 31 August 2010 • 22 September 2010 • 19 October 2010 Witnesses • To be agreed
Children's Self Harm Working Group Comprising Councillors: • Shirley Harper-O'Neill (Chairman) • Peter Curling • John Hensley • Phoday Jarjussey • Peter Kemp • Mary O'Connor	Detailed review of children's self harm. Working Group Meeting dates: • Wednesday 19 January 2011, 5pm in CR4a • Tuesday 8 February 2011, 5pm in CR6 • Wednesday 2 March 2011, 5pm in CR3 Witnesses • To be agreed