Appendix C

The Hillingdon Hospitals NHS
NHS Foundation Trust

Quality Report 2015/16

Putting Compassionate Care, Safety and Quality at the Heart of Everything we do

WORKING DRAFT – AWAITING SIGN OFF ON YEAR END POSITION ON INDICATORS

Appendix C

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About the Trust's Quality Report

What is the Quality Report?

The Quality Report is produced by NHS healthcare providers to inform the public about the quality of services they deliver. As a Trust we strive to achieve high quality care for our patients. The Quality Report provides an opportunity for us to demonstrate our commitment to quality improvement and show what progress we have made in 2015/16 against our quality priorities and national requirements. The Quality Report is a mandated document which is laid before Parliament before being made available on the NHS Choices website and our own website – (www.thh.nhs.uk).

What is included in the Quality Report?

The Quality Report is a statutory document that contains specific, mandatory statements and sections. There are also three categories mandated by the Department of Health (DH) that give us a framework in which to focus our quality improvement programme. These are patient safety, patient experience and clinical effectiveness. The Trust undertook extensive consultation in developing this report to ensure that the quality improvement priorities reflect those of our patients, our staff, our partners and the local community.

Part 2 of the report highlights the Trust's quality priorities and includes:

- The areas identified for improvement in 2015/16;
- How we performed against these improvement targets
- and what this means for our patients.

There is also a section in Part 2 on the quality priorities that have been identified for improvement projects in 2016/17.

A glossary is available at the back of the report which lists the abbreviations and terms in the document.

Executive summary

This Executive Summary provides a very brief overview of the information in this year's report.

The report provides a summary of performance during 2015/16 in relation to quality priorities and national requirements. Overall, the Trust has performed very well in 2015/16 across a wide range of quality indicators. Particular successes include:

- An improvement in our mortality rates with a reduction in the variability between weekdays and weekends
- A reduction of more than 30% for Clostridium difficile infections from last year's figures
- Cancer performance indicators demonstrating better than London and national averages
- Improved patient satisfaction as measured by the Friends and Family Test (FFT).
- An improved patient safety incident reporting rate and a 'good' rating in the '*Learning from Mistakes League'*

We have also performed well in other areas including increasing our uptake of statutory and mandatory training and achieving the requirements of the National Specifications for Cleaning across the Trust as part of our Care Quality Commission (CQC) improvement programme.

However 2015/16 has been a challenging year for the Trust. We have seen increased patient activity and throughput with 32 additional beds open. This has put pressure on our internal systems and has stretched our manpower resources during a very challenging staffing market nationally. It has therefore been difficult to realise some of the stretching quality targets that we set ourselves at the beginning of the year.

Some examples of our achievements and progress against the key priority areas are listed below:

Quality Priority	How did we do?
Priority 1: Ensuring the safety of vulnerable and older people	
Increase number of relevant staff receiving the enhanced Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) training.	We have achieved 81% against a target of >80%.
Establish an Equality and Diversity (E&D) steering group with representation from people with different disabilities.	An E&D steering group has been established and a task and finish group focussing specifically on physical and sensory disability is soon to be established.
Improve the engagement with people who have a disability by attending local groups for people with disabilities.	We have attended local disability groups and information from these has been provided on areas for improvement with regard to physical and sensory disability.
Priority 2: Improving the safety of medicines management	
Increase reporting of medicine errors - Medication Related Incidents as a % of all Patient Safety Incidents	Behind plan. We have achieved 9% against a target of >11%. However this is an improvement from 2014/15 performance of 7.8%.
Develop a pharmacy services patient questionnaire, establish a baseline, audit quarterly and realise improvement for 2015/16 on the baseline.	Achieved. We have achieved 85% satisfaction with the service against a target of 75%.
Priority 3: Improving Maternity Services	
10% reduction in complaints received on maternity triage service once this has moved to its new clinical environment.	We have seen an improvement in women's satisfaction of the service with approximately 30% fewer complaints received.
A very positive experience for women in the new birth centre monitored via the FFT.	We achieved 97% satisfaction against a target of >88%.
Maintain current numbers of Hillingdon Borough women choosing to continue to use the Hillingdon Hospital	All Hillingdon women have been able to access the service during 2015/16.
Priority 4: Improving Communication with our patients	
Improvement on communication and information provided to patients in A&E	Achieved. We continue to receive in the main very positive feedback about people's experience within our A&E department as monitored by the Friends and Family Test.
Discharge summaries from inpatient episodes will be completed within 24 hours - >80% target	We are behind plan at 57% compliance. 98.7% of discharge summaries are completed but further work is required to ensure this happens within a 24 hr timeframe.
Involved as much as you wanted to be:	Behind plan. Achieved 84% against a target of 89%.
Nurses - Clear answers to questions	Behind plan. Achieved 87% against a target of 90%
Doctors - Clear answers to questions	Behind plan. Achieved 86% against a target of 90%.

Some elements of improvement work in the key priority areas have not been realised and the clinical teams will continue to drive forward improvement during 2016/17 to ensure the

improvement targets are achieved. In addition the Trust will develop a refreshed improvement plan for 2016/17 based on the findings of the CQC inspection of October 2014 and outcomes of mock CQC inspections conducted by our staff during the year. Our ambition will be to achieve an 'outstanding' rating, with a minimum of good, at a future CQC inspection.

We have set out our quality priorities for 2016/17 and we aim to achieve the following:

NEWS – National Early Warning Scoring System

1.	Achieving NEWS compliance to support early escalation of the deteriorating patient
2.	Achieving improvement in relation to seven day working priorities
3.	Delivering compassionate care and improving communication
4.	Safer staffing – improved recruitment and retention to ensure delivery of safe care

The key indicators that we are aiming to achieve under these priorities are outlined in the main report.

During 2015/16 there has continued to be increased focus on measuring and monitoring the quality of our services and the care that is delivered to our patients and their families. The Trust's Clinical Quality Strategy supports this work and helps us to achieve our vision: 'To put compassionate care, safety and quality at the heart of everything we do'. In 2016 we will launch a new Quality Improvement Strategy which is intended to support the delivery of the Trust's overarching Strategic Plan. The strategy will clearly articulate our ambitious aims across the domains of patient safety, clinical effectiveness and patient experience. Our quality improvement work will be informed and supported by the learning from and collaboration with colleagues form across the North West London sector as part of the Imperial College Healthcare Partners Academic Health Science Network.

We have also been working closely with our partners in health and social care and key stakeholders to deliver improvements in the services delivered across North West London with regard to the Shaping a Healthier Future (SaHF) programme and the Whole Systems Integrated Care (WSIC) project supporting new care models to ensure an improved quality of person-centred care.

The mandated sections within this Quality Report include information on our participation in national audits and our research activity during 2015/16. In addition, information is provided on our registration as a healthcare provider with the Care Quality Commission (CQC) and the progress we have made in response to the findings of their inspection of October 2014 and their re-visit of May 2015.

This Quality Report and the priorities for 2016/17 are presented as a result of consultation and engagement with Foundation Trust members, our Governors, patients and the public, our staff, our local Healthwatch and our Commissioners.

Part 1: Statement from the Chief Executive

This Quality Report provides the Trust with an opportunity to demonstrate its commitment to delivering high quality care and outlines the improvements that have been made during 2015/16.

Nationally, the NHS has had a difficult year, and has struggled to meet key performance targets in the face of unprecedented levels of emergency demand. Locally, it has also been a challenging year for the Trust in continuing to drive forward key improvements in response to the findings of the CQC inspection of October 2014 alongside higher activity. Our staff have worked tirelessly to implement improvements alongside continuing to deliver high quality and safe care for patients.

The Trust has responded extremely well in the last year to the requirements outlined in the CQC report of January 2015. By May 2015 we were able to demonstrate significant improvements and the two Warning Notices, issued for Regulation 10 – Assessing and Monitoring the Quality of Service Providers and Regulation 12 – Cleanliness and Infection Control, were removed by the CQC. In addition, the 'inadequate' rating for the safety domain was upgraded to 'requires improvement'. I am pleased with the great progress that was made in a relatively short space of time; this was due to the commitment and dedication of our staff.

Many examples of good practice are highlighted within this report and I welcome the very positive feedback provided by patients and staff. Whilst it is important to acknowledge the challenges we have faced and where we have not been able to fully achieve the targets we have set, we must also remember that there is a great deal to celebrate and commend and our staff should feel proud of their effort and achievements.

The last year has seen the Trust perform well in many areas. This includes:

- The Referral to Treatment (18 weeks) waiting times performance standards were changed this year and the Trust continues to maintain its high performance against this standard
- Key cancer performance indicators are being well maintained for all the national waiting times standards, and performing better than the London and national average
- The Trust has measurably low patient mortality figures and these are in line with expected mortality performance for the Trust
- We received more than 25,000 responses to the Friends and Family test (FFT) during 2015 and 93% of patients said they were happy to recommend our services to their friends and family.
- Our score for staff engagement was 3.86 out of 5, an increase on our 2014 score but also above the national average. Overall, we scored above average in 18 areas with 10 of these being in the top 20% of all acute Trusts in England.

We have also continued to invest in our services, some exciting developments include:

- More than £3 million investment to improve and expand our children's services as part of the Shaping a Healthier Future programme. Improvements include delivering a new children's A&E, and four new beds on Peter Pan Ward.

- More than £1 million was invested in establishing a new Nuclear Medicine Facility housing the latest SPECT CT scanner. This enables nuclear and CT scans to be carried out at the same time reducing the need for multiple patient scans.

- The Trust created a £240k state-of-the-art simulation suite, featuring high-spec robotic model patients, ensuring staff can develop and improve their skills in a safe and supportive environment.

I am proud that we have also received national recognition for outstanding core skills compliance by the London Streamlining Programme (collaboration between HR for London, NHS Employers and Skills for Health). This recognises that we raised our mandatory training compliance levels to over 90% and maintained this over the last year.

The Trust rated green (compliant) throughout the year in all but one (A&E four-hour target) of Monitor's key performance targets. Overall demand for our emergency services has increased by 2.6% during 2015/16; this is in addition to a 9% growth in emergency attendances seen in 2014/15. The number of category 1 (blue light) ambulances attending the Trust has increased by 22.8% year to-date. This upward trend began in April 2014, over the intervening two year period blue light activity has increased by 53%.

The Trust has expanded and developed its maternity services to accommodate changes as a result of the closure of Ealing Maternity Services under the Shaping a Healthier Future (SaHF) agenda. We have responded effectively to the increase in demand resulting from the changes including the development of a midwifery-led unit and expansion of the maternity triage service and the community midwifery and specialist teams. We have also seen an increase in both obstetric and midwifery staffing numbers to support the expansion, including obstetric consultant cover and the appointment of a consultant midwife.

Currently the Women and Children's Division is planning the transition of the Paediatric services as part of the SaHF programme which is due to complete in June 2016.

In April 2015 we saw the launch of the Hillingdon's Whole Systems Integrated Care project (WSIC) - a comprehensive new care model coordinating care across all providers, centred around patients over 65 years old. The Trust has been a significant partner in developing and delivering the programme to date and will continue to work hard to ensure the model is further refined and rolled-out across the borough to benefit as many people as possible.

Substantial progress was made during 2015-16, and plans are in place to accelerate the programme during the coming year. A key milestone in this work was the establishment of an Accountable Care Partnership (ACP) involving all of the main care providers in Hillingdon.

In developing our quality priorities for 2016/17 we have made reference to our latest CQC report, national best practice and reviewed our current quality performance in line with local, regional and national performance. We have also consulted with a wide group of stakeholders, including our Governors, Commissioners, People in Partnership and our local Healthwatch. Our aim is to continue to focus on the essentials of care in order to continue to improve clinical outcomes and to ensure that our patients have a positive experience.

We remain, as always, grateful for the ongoing commitment and contribution of patients, staff, governors, members, commissioners and other stakeholders in supporting our quality improvement goals. We are working at a time of challenging financial constraints in the NHS and it has never been more important to focus on our patients' experience of their care and evidence of clinical effectiveness to improve quality continually.

I am clear that our hospitals have staff who are committed to the highest possible standards of care for our patients. I hope that this Quality Report confirms our commitment to you to achieve improvement in the quality of our services to patients and ensures that we always put our patients at the forefront of service development and improvement.

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

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

  The Trust's Board and management have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

Following these steps, to my knowledge, the information in the document is accurate.

Yours sincerely

Shane Degaris

Chief Executive
The Hillingdon Hospitals NHS Foundation Trust

Part 2 – Priorities for improvement and statements of assurance from the board

2.1 Review of Quality Priorities for Improvement

In this part of the report we tell you about the quality of our services and how we have performed in the areas identified for improvement in 2015/16. These areas are called our quality priorities and they fall into the three areas of quality as mandated by the Department of Health (DH): patient safety, patient experience and clinical effectiveness; we are required to have a minimum of one priority in each area.

Firstly, the information below provides an overview of some of our key quality achievements in 2015/16. These are important indicators for the public and our key stakeholders to provide assurance on the quality of care and services that are delivered at the Trust:

Key Quality Achievements in 2015/16

- An improvement in our mortality rates with regard to levelling weekend and weekday mortality rates compared to last year
- A reduction of more than 30% for Clostridium difficile infections from last year's figures
- Cancer performance indicators demonstrating better than London and national averages
- High patient satisfaction with 95.2% recommending an inpatient ward and 93.1% recommending our Accident and Emergency department as measured by the Friends and Family Test
- An improved patient safety incident reporting rate and a 'good' rating in the '*Learning from Mistakes League'* published by Monitor and the NHS Trust Development Authority in March 2016.

LOOKING BACK

Quality priorities for improvement 2015/16 – How did we do?

PRIORITY 1 Safeguarding - Ensuring the safety of vulnerable and older people

We said:

We wanted to work with social care and community colleagues on improving discharge management for vulnerable and older people. We said we wanted to identify improvements for people with disabilities and the frail elderly in hospital and for those people who may lack the capacity to consent or who lack advocacy.

This element of care was identified by our key stakeholders as requiring improvement and concerns were also referenced via our complaints service in the feedback we get from patients and their families/carers.

How did we do?

The specific goals that we set and the performance during 2015/16 are outlined below:

Quality Priority indicators	2015/16 performance
Establish a baseline on the number of referrals to the Independent Mental Capacity Advocacy (IMCA) service and realise an increase in these numbers.	We have been unable to establish a system with London Borough of Hillingdon (LBH), who deliver the service, to accurately capture the numbers referred to the IMCA service. Awareness of the service however has been raised across the Trust during training and in discussions with staff.
Establish a baseline on the number of referrals to the Disablement Association Hillingdon (DASH) service and realise an increase in these numbers.	We have been unable to access this information via the DASH service however the Trust regularly involves DASH in discussions and when designing and developing new services.
Further increase the number of staff receiving the enhanced MCA/Deprivation of Liberty Safeguards (DoLS) training - >80% for relevant staff.	Achieved 81% against a target of 80%.
Establish an Equality and Diversity steering group with representation from people with different disabilities.	An E&D steering group has been established and a task and finish group focussing specifically on physical and sensory disability is soon to be established.
Improve our facilities for those people with physical and sensory disabilities, such as increased number of hearing loops in use, improved signage and improved access to interpreting services, especially British Sign Language	A hearing loop system has been installed in more areas across the hospital; signage improved based on feedback; translation services reviewed.
Improve the engagement with people who have a disability by attending local groups for people with disabilities (DASH and the Hillingdon Disabled Tenants and Residents Group).	We have attended local disability groups and information from these has been provided on areas for improvement with regard to physical and sensory disability.

What does this mean for our patients?

These changes mean that our patients now experience a service which is more responsive to their specific needs, especially where patients are more vulnerable and may lack the capacity or the ability to advocate for themselves.

Although we have been unable to establish numbers of referrals to the IMCA service and therefore provide assurance on an increase in numbers accessing this service, awareness of the service has been raised in several ways. The importance of using an IMCA for patients without capacity is discussed within Safeguarding Adult training sessions and information about the referral process and forms are available on the safeguarding adults' intranet page for staff to access. The Head of Safeguarding has good links with the local IMCA service delivered by *POhWER* (advocacy agency) on behalf of the local authority.

The local IMCA liaises directly with wards and departments who have referred patients for the service. Their workload has significantly increased since the Deprivation of Liberty Safeguards (DoLS) Cheshire West judgement and the subsequent increase in DoLS referrals nationwide. The role of the IMCA is clearly stipulated within the Trust's Mental Capacity Act (MCA) and

DoLs policy. Contact details are also given for the Disablement Association Hillingdon (DASH) advocacy service for patients who need support and do have capacity to make decisions.

Moving forward the Trust will re-visit this area with LBH to explore the use of a database to capture information on referrals and to use a similar process that we do to obtain information on DoLS referrals.

One of the focus groups looking at physical and sensory disability and accessibility to our services took place at DASH and was attended by service users providing valuable feedback on the Trust services. This will support us taking forward our improvement plan around disability.

Following the 2015 PLACE (Patient Led Assessments of the Care Environment) inspections, the patient assessors identified that many patient/public reception areas did not have hearing induction loops. The hearing loop is a special type of sound system for use by people with hearing aids to enable them to hear more clearly. As a result the Facilities department arranged for the installation of sixteen new hearing loops across both hospital sites. The introduction of the hearing loop system both improves privacy, dignity and well-being under PLACE and meets the requirements of the Equality Act (2010) requiring organisations to make all reasonable adjustments to provide deaf or hard of hearing people with full access to services.

Signage had been improved across both sites to reflect feedback on new services, clinical department moves and much of the signage (particularly for toilets, entrances, exits, lifts) has been altered to 'black text on a yellow background' to support people with dementia. In addition the Trust now has a contract with One Stop Language Services for the provision of British Sign Language (BSL) for patients using our services.

Focus groups have been held with a group of service users who have either a sensory or physical disability. Representatives from the Hillingdon Disabled Tenants and Residents Group have been invited to be involved in the relocation of the outpatient pharmacy.

A new Disability Discrimination Act (DDA)/Equality Act survey for both hospital sites is to be commissioned in the forthcoming year. Once this survey has been carried out the key actions will be evaluated, risk assessed and prioritised for funding along with other legislation requirements.

PRIORITY 2

Improving the safety of medicines management and improve the experience of people requiring medicines in the inpatient and outpatient setting

We said:

The Trust is committed to ensuring that patients are able to continue to take their medicines safely after leaving the hospital. We highlighted that allowing patients to continue to take their medicines themselves (self-administration) whilst they are in hospital (where they are able to do so) is an important element of medicines adherence and compliance. Maintaining independence in this way means that there is a reduced risk of readmission to the hospital due to medicines-related reasons.

In addition we reported that the Trust is committed to optimise the safe use of medicines and central to this is to ensure that learning from most errors/near misses of no harm are applied to reduce the risk of errors/near misses occurring that may cause harm.

How did we do?

The specific goals that we set and the performance during 2015/16 are outlined below:

Quality Priority Indicators	2015/16 Performance
Pilot the use of the revised patient self-administration of medicines policy and roll out its implementation across the Trust.	This work remains in progress. The pilot was completed. Feedback from staff varied highlighting issues in process and or shortfall in facilities to safely implement the existing Self Administration Medicines (SAM) Policy. Therefore roll out has been delayed until the policy is revised. This work is due in April 2016.
Develop survey and receive qualitative feedback from staff and patients on self-administration of medicines (SAM) in hospital and demonstrate evidence of changes to the process based on this feedback.	This work is in progress. A structured survey was devised and has been completed. The information is being used to inform the revision of the SAM Policy as above.
Increase the reporting of medicines errors, via our incident reporting system, that constitute no/low harm incidents so that learning from these can avoid more harmful incidents from occurring. The Trust aim will be to improve on current performance to achieve the national average of 11%*.	This work remains in progress. We have achieved 9% against a target of >11%. This is an improvement from 2014/15 performance of 7.8%. A Medication Safety Officer has now been employed to lead this work to achieve our target during 2016/17.
Develop a pharmacy services patient questionnaire, establish a baseline, audit quarterly and realise improvement for 2015/16 on the baseline.	We have achieved 85% satisfaction with the service against a target of 75%.

What does this mean for our patients?

Improving the safety of medicines management in hospital is key to ensuring patient harm is reduced and that patients receive the medicines they are prescribed. Ensuring patients are empowered to take their own medicines whilst in hospital where this is appropriate will help adherence to medicines especially when the patient is being discharged home. The Self Administration of Medicines (SAM) policy will be published in April 2016 based on feedback we have received with roll out of self-administration of medicines thereafter across the Trust.

The work to ensure improved safety in relation to patients' medicines will continue in this forthcoming year with our new Medication Safety Officer leading this agenda and working with key clinical and management leads. Key actions will include improved training, establishing medicine safety champions, prescribing tips for doctors based on learning from prescribing errors and a drive to further increase medicine incidents reporting to aid learning and improvement.

PRIORITY 3 Improving Maternity Services

We said:

The Trust wanted to ensure that all of the women accessing our maternity services would have a positive experience in relation to their care and treatment. This was particularly important in relation to increasing the number of deliveries at Hillingdon from 4,100 to 5,000 babies. This

was due to the re-allocation of Ealing maternity services to other maternity units across North West London including Hillingdon as part of the Shaping a Healthier Future (SaHF) programme.

How did we do?

Key aims we want to achieve in relation to the women's experience:

Quality priority Indicator	2015/16 Performance
A 10 % reduction in the complaints received on the maternity triage service once this has moved to its new clinical environment	We have seen an improvement in women's satisfaction of the service with approximately 30% fewer complaints received.
A very positive experience for women in the new birth centre monitored via the Friends and Family Test – target of >/88% extremely likely/likely to recommend	We achieved 97% satisfaction against a target of >88%.
Very positive feedback from women on the new neonatal transitional care model - target of >88% extremely likely/likely to recommend via the FFT	We achieved 97% satisfaction against a target of >88%.
Maintain current numbers of Hillingdon Borough women choosing to continue to use the Hillingdon Hospital service, despite the increase in Ealing women accessing the maternity services at Hillingdon.	All Hillingdon women have been able to access the service during 2015/16.

What does this mean for our patients?

The substantial increase in activity as part of the transition of Ealing Maternity services has required in-depth planning and robust implementation to ensure a safe and effective service. This work has involved the implementation of new service models such as a midwifery-led birthing centre, ambulatory pathways, a new community team and a transitional care unit.

The Trust has wanted to ensure that all women accessing maternity services at Hillingdon whether they are from within or outside of the borough have a positive experience in relation to their care and treatment. We believe the changes we have implemented have improved the quality of care and choice for all women choosing to have their baby with us.

The service currently receives positive feedback through the Friends and Family Test (FFT) across all our services. The challenge so far has been the limited number of respondents from service users in the community following the delivery of their baby. A lot of work has been undertaken to increase the number of responses in order to obtain adequate feedback to help shape our services. Following this work there has been a steady increase in the number of respondents providing feedback. We have started displaying 'you said, we did' posters based on the feedback received from FFT, NHS Choices, verbal feedback and complaints. We will continue to encourage responses and act on feedback going forward. All complaints have an action plan, where concerns have been identified and learning from the investigations is shared with all staff groups to further improve the quality of the service.

PRIORITY 4 Improving Communication with our patients

We said:

We wanted to ensure that there is continuing focus on improving the patient experience and that services that are delivered are truly responsive to individual patient needs. Feedback from a variety of sources including our complaints service indicated that communication from the healthcare team to the patient and their family/carers, as a key patient experience element, still needed to improve.

How did we do?

The specific goals that we set and the performance during 2015/16 are outlined below:

Quality priority Indicator	2015/16 Performance
Improved communication from the A&E department:	
Quarterly audit of quality of A&E discharge summary, demonstrating improvement in standard of information provided.	The staff have been unable to complete the quarterly audit as planned however there has been discussion and progress within the department on further improvements required as a result of the previous audit undertaken earlier in 2015.
Improvement on communication and information provided to patients in A&E	We continue to receive very positive feedback via the FFT about the A&E service - 93.1% satisfaction YTD.
Copy of discharge summary provided to patients attending A&E department before they leave	Behind plan. Despite our best efforts this proves to be a very challenging standard to meet within the acuity of services. The patient's GP receives an electronic summary within 12 hrs of the patient's attendance.
Discharge summaries from inpatient episodes will be completed within 24 hours - >80% target	Behind plan. We have achieved 57% within 24 hrs. 98.7% of discharge summaries are finally completed but not within the 24 hrs.
Improvement in the results of the local quarterly patient experience survey in the following areas*:	
Involved as much as you wanted to be (Target - 89%)	Behind plan. Achieved 84%.
Nurses - Clear answers to questions (Target - 90%)	Behind plan. Achieved 87%.
Doctors - Clear answers to questions (Target - 90%)	Behind plan. Achieved 86%.
If waiting more than 20 mins, informed and updated of waiting times (Target - 80%)	Behind plan. We achieved 63.3% against a target of 80% with further improvements required for the Eye department and the Mount Vernon Treatment Centre.

*Based on data available July 2015 and March 2016 – 2000 responses

Within the A&E we continue to receive in the main very positive feedback about people's experience of using our services. We are mindful however that we need to increase the number of patients who provide this feedback and act upon it in a meaningful way. The new A&E nurse consultant is going to undertake some projects to improve communication and feedback from patients and carers in the first quarter of 2016/17.

Despite our best efforts in ensuring a discharge summary is provided to each patient that has attended A&E, and within 24 hours to their GP, this remains a very challenging standard to meet within the activity of the A&E service. Overall there has been a steady improvement and now 98.7% of patients leaving the Clinical Decisions Unit within the A&E department receive a copy of their discharge summary albeit not within 24 hours of discharge. Moving forward it has been agreed that each doctor is allocated 30 minutes at the end of their shift to ensure compliance with this standard.

With regard to waiting time in the Outpatient department we achieved 63.3% against the 80% target for patients being informed and updated about delays. There are two clinical areas that contribute significantly to this position which are the Eye department and the MVH Treatment centre. Some of the contributing factors that affect the results for these two areas include the environment of the eye department which is very restricted and fragmented. There are three separate waiting areas and as a result the patient's journey is complex. When a clinic delay is announced the patient may just have been moved to another area for clinical input and may miss the announcement. At the Mount Vernon Treatment centre we rely on the Savience system display to advise patients of delays. There are TV screens for patients to see this display which are positioned in two different areas however patients may miss this display depending on where they are sitting.

Actions moving forward include Mount Vernon Treatment Centre staff using a Tannoy system in addition to the displays via the Savience system. Staff in the eye department will be encouraged to inform patients at each step of their journey through the department.

The Trust participates in the annual national patient survey programme and in addition a number of local patient surveys have also been developed and implemented. The Friends and Family Test has also been fully rolled out to all patient areas. We aim to be a listening and learning organisation, in which concerns that are raised by patients are understood, shared and responded too. Listening to feedback enables our staff to gain a real insight into the patient's experience of care. Involving the patient as much as possible in their care supports an improved experience for patients and assists in maintaining their patient safety; effective communication is a key part of this.

Ensuring patients are involved and that they receive clear answers to questions by all healthcare professionals continues to be a key priority for the Trust as part of our patient experience improvement work. It is disappointing that we have been unable to improve our performance in the patient experience indicators that we identified for improvement in 2015/16. As a result we will be continuing to focus on these areas and aim to achieve an improvement in 2016/17 as part of Priority 3 – Delivering compassionate care and improving communication.

LOOKING FORWARD

Our Clinical Quality Strategy

During 2015/16 there has continued to be increased focus on measuring and monitoring the quality of our services and the care that is delivered to our patients and their families. The Trust's three-year Clinical Quality Strategy has supported this work and has helped us to achieve our vision '*To put compassionate care, safety and quality at the heart of everything we do'*. The strategy has provided a structure for ensuring strong clinical governance and ongoing improvement in the quality and safety of patient care. Key principles that support this are outlined within our strategy and include:

- Always putting the patient first
- Clearly understood fundamental standards of care and measures of compliance
- Openness, transparency and candour throughout our organisation
- Improved support for compassionate and committed nursing
- Strong and patient centred leadership
- Accurate, useful and relevant information.

During 2015/16 a clinical quality strategy action plan was developed and was reviewed on a quarterly basis at the Quality and Safety Committee (Board committee). Clinical divisions developed their own local quality actions plans based on the overarching Trust action plan. These formed part of their business plans and were used to monitor progress at their divisional performance reviews.

The clinical quality strategy also outlines the responsibilities of Trust staff and is supported by our culture and values framework, CARES (Communication, Attitude, Responsibility, Equity and Safety) which embraces a culture that empowers staff to report incidents and raise concerns about quality and patient safety in an open, blame-free working environment. This is supported by the statutory Duty of Candour and best practice guidance such as 'Freedom to Speak'.

In 2016 we will launch a new Quality Improvement Strategy which is intended to support the delivery of the Trust's overarching Strategic Plan. The strategy will clearly articulate our ambitious aims across the domains of patient safety, clinical effectiveness and patient experience. Our quality improvement work will be informed and supported by the learning from and collaboration with colleagues from across the North West London sector as part of the Imperial College Healthcare Partners Academic Health Science Network.

The concerns that the Care Quality Commission (CQC) raised in its planned inspection of October 2014 in relation to assessing and monitoring were viewed extremely seriously by the Board. An assessment of systems and processes that staff follow alongside reviewing and achieving key quality indicators and positive patient outcomes was conducted and informed key improvement work during 2015/16.

Our Sign up to Safety Campaign

Towards the latter part of 2014 the Trust signed up to the national patient safety campaign that was launched by the Secretary of State for Health. *'Sign up to Safety'* is a campaign to strengthen patient safety in the NHS. Its three year objective is to reduce avoidable harm by 50% and save 6,000 lives. In 2015/16 the Trust developed a detailed plan outlining the work we would take forward to reduce harm and save lives; this was aligned with the Trust's clinical quality strategy.

As part of this work the Trust has committed to: **listen** to patients, carers and staff, **learn** from what they say when things go wrong and take **action** to improve patients' safety. We want to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times. The five key *Sign up to Safety* campaign pledges are listed below:

- **Put safety first -** commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
- **Continually learn** - make organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

- **Honesty** - be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Collaborate** - take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- **Support** - help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

The Trust is continuing to drive forward this work – a steering group has been meeting regularly to review progress and key actions that have been completed include:

- A *Sign up to Safety* launch event held in June 2015 to raise awareness of the campaign with our staff and patients and to share the excellent patient safety improvement work that is already in progress
- A patient engagement event focusing on patient safety and the patient safety champion role held in October 2015
- A staff workshop held in November 2015 which focused on patient safety incident reporting and developing the role of the staff champion role for safety
- Staff safety culture survey and a patient engagement in safety survey
- Improvements in the key indicators highlighted as part of our patient safety priorities

These include:

- A 2% improvement in medication safety incident reporting during 2015/16 and the employment of a Medication Safety Officer to drive forward our improvement campaign
- There has been a small reduction in inpatient falls and hospital acquired pressure ulcers but we have not achieved the stretching targets that we set ourselves for the year
- Improvements in the care for people with dementia (outlined later in report)
- Improvement in staff awareness of malnutrition in hospital and completion of nutritional risk assessments with staff taking specific actions to address patients' needs. Introduction of nutritional link nurses with delivery of training and resource folders for the wards. In addition the Trust held a week long campaign during Nutrition and Hydration week to focus patients, visitors and staff on the importance of nutrition and hydration. Dietetic, speech therapy, nursing and catering teams worked closely together to organise events aiming to optimise inpatients' nutritional care, alongside educating staff, patients and visitors.

Quality priorities for improvement in 2016/17

In this section of the report, we tell you about the areas for improvement for the next year in relation to the quality of our services and how we intend to assess them. To develop these priorities, the Trust held an engagement exercise with key stakeholders (Foundation Trust members, HealthWatch, Governors, local voluntary organisations) on 24th November 2015. This event included a review of our current position against this year's priorities and a discussion on the quality priorities for the forthcoming year. Results from the discussions on the day show that some areas of improvement that we have focused on during 2015/16 still need further work which includes improving the experience of people requiring medicines in the inpatient and outpatient settings and ensuring the safety of vulnerable and older people, particularly in relation to discharge management and for those with disabilities.

It was recognised that this work will continue outside of the priorities identified in this year's Quality Report as there are key working groups that continue to focus on these improvement areas further. An outline of the key results from the consultation is included in the table below:

Quality Report 2015/16 Consultation

Respondent Category	Quality Priority Topic 2016/17
Patient Safety	
Staff Healthwatch Governors and FT members	• NEWS compliance – testing the knowledge and understanding of the staff • Improve recruitment and retain staff • Improved communication about medications and the needs of individual patients • Reduce patient harms, such as patient falls
Clinical Effectiveness	
Staff Healthwatch Governors and FT members	• Ensure integrated care systems and collaboration • Need to have electronic records • Care of the elderly not well co-ordinated and communication can be ineffective • Delayed discharges - prioritise patients for discharge • Processes for patients with mental health issues need improving
Patient Experience	
Staff Healthwatch Governors & FT members	• Improved communication and staff attitude, ensuring robust CARES programme - delivery of customer care training • Lack of positive response from staff to suggestions made by patients • All patients must receive individualised care – thorough assessment of needs • Sensitivity with giving information that is tailored to individual patients • Keeping people updated in A&E • There is no loop system for hard of hearing patients. Staff have to raise their voices and the environment can be noisy • Visual information often not suitable for people with eyesight problems. • Clinic organisation not good – too many cancellations • Patients waiting for TTAs. Better co-ordination with the Pharmacy department

In addition, the Trust triangulated data from several sources to identify themes and recurring trends. The Trust has also engaged with clinical and management staff via divisional governance board meetings and divisional reviews to establish priorities. During the last year there has continued to be active engagement with our local Healthwatch including its members on several of our Trust working groups. The Trust has also met with Healthwatch on a quarterly basis to review quality and patient safety data and the progress on the quality report priorities. This engagement has proved invaluable in being able to hear the feedback that Healthwatch receives from people with which it engages.

The Board has considered all of the suggestions put forward and the review of data and the priorities below have been recommended for inclusion in the Quality Report for 2016/17. These have been identified as falling under the three domains of safety, clinical effectiveness and patient experience as follows:

No.	Priority	Safety	Clinical Effectiveness	Patient Experience
1	Achieving NEWS compliance to support early escalation of the deteriorating patient	✓	✓	
2	Achieving improvement in relation to seven day working priorities	✓	✓	✓
3	Delivering compassionate care and improving communication			✓
4	Safer staffing – improved recruitment and retention to ensure delivery of safe care.	✓	✓	✓

PRIORITY 1

Achieving NEWS (National Early Warning Score) compliance to support early escalation of the deteriorating patient

Why is this one of our priorities?

Maintaining patient safety is a key priority for the Trust. The National Early Warning Score (NEWS) is a simple physiological scoring system that can be calculated at the patient's bedside, using agreed parameters which are measured in all patients who attend hospital. It alerts health care staff to abnormal physiological parameters and triggers an escalation of care and review of the patient. Clinical deterioration can occur at any stage of a patient's illness. There will be certain periods when a patient is more vulnerable to deterioration for example, the onset of illness, during surgical or medical interventions and during recovery from critical illness. Patients on general adult wards and emergency departments who are at risk of deteriorating may be identified before a serious adverse event by changes in their physiological observations. Timely interpretation and escalation of recognised deterioration is of crucial importance in minimising the likelihood of serious and adverse events including cardiac arrest and death.

NEWS audits conducted during 2015/16 have shown that staff are not fully compliant with our Trust NEWS policy with regard to fully documenting the evidence of escalation and the review of the acutely unwell patient. There needs to be increased training in this area and there also needs to be a better understanding of when it is appropriate to make physiological parameter changes dependent on the patient's condition. This was also a safety priority identified by our stakeholders at the Quality Report consultation event.

How are we doing so far?

Our NEWS compliance audit scores have not demonstrated significant improvement during this past year. In addition, patient safety incidents concerning NEWS compliance continue to be reported via our incident reporting system. There have also been two serious incidents reported that have been investigated using detailed Root Cause Analysis investigation by a multi-professional panel. Inadequate NEWS compliance has now been put onto the Trust's corporate risk register. Identifying improvement in NEWS compliance to support the care of the deteriorating patient as one of our quality priorities for this forthcoming year will assist in driving up performance in this area to ensure our patients are receiving safer care.

Our aims for 2016/17 are:

All aspects of the NEWS process and the outcome measures need to be addressed. This includes education to all healthcare professionals, policy review and continuing audit.

Key objectives:

- Review the NEWS education programme – this includes revisiting what is taught, how it is taught and by whom. Explicit learning outcomes to be made transparent and to ensure that evaluation of education reflects learning outcomes.
- Continue NEWS audits regarding completion of NEWS charts and also compliance with escalation policy via monthly 24 hour snapshot NEWS audits. To aim to achieve greater than 90% in all audited criteria as a minimum.
- Reduction in the number of Datix incident forms completed of moderate severity or higher.

PRIORITY 2

Achieving improvement in relation to seven day working priorities

Why is this one of our priorities?

NHS England has committed to offering a much more patient-focused service moving towards routine NHS services being made available seven days a week. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality.

North West London (NWL) as a sector accepted the opportunity to be a national First Wave Delivery Site for the new seven day services programme (as launched by the Prime Minister at the conservative party conference). As part of this programme, all acute trusts have agreed to achieve delivery of the four prioritised Clinical Standards by April 2017, this includes THHFT.

NHSE, Monitor & the TDA wrote to all acute trusts in England to ask that they establish a 2015/16 baseline for four of the 10 Clinical Standards for seven day service. The four standards were selected with the Academy of Medical Royal Colleges as having the most impact on reducing weekend mortality:

- Standard 2: Time to First Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant Directed Interventions
- Standard 8: On-going Review (planned for 2016/17)

How are we doing so far?

Our aims for 2015/16 were:

No.	Item	Progress
1.	2015/2016 CQUIN standard 3 – Multi professional team review for 95% of patients in Medicine and Surgery	Working to progress
2.	2015/2016 CQUIN standard 4 – Shift handovers with 95% to meet national standards in Medicine and Surgery	Working to progress
3.	2015/2016 CQUIN standard 5 – 7 day consultant presence in radiology, quarter 4 report showing 95% of all urgent tests and 95% of all non-urgent tests are reported within the London and national standards time frame	On track
4.	2015/2016 contract – SDIP – standard 2 – Time to first consultant review	On track
5.	Better Care Fund (BCF) – standard 9 – Transfer to Community, Primary and Social Care	On track

Our aims for 2016/17, in addition to embedding and building on the achievements from 2015/16, are:

Model of Care (Standards 2 & 8)

- Define clinical outcomes
- Develop Model of Care to meet clinical outcomes and determine consultant requirement
- Test proposed model of care against current clinical capacity and evidence base
- Plan delivery of agreed model of care
- Implement a model that achieves the first and on-going consultant review

Radiology & Diagnostics (Standard 5)

- Imaging inpatients within 24 hours of request
- Timely reporting compliant with national standards
- Practical and functional pathways for radiological diagnostics & interventions agreed
- Formalised network across NWL for specialised reporting

Interventions (Standard 6)

- Robust pathways for inpatient access to interventions in place 24 hours a day, 7 days a week (critical care, interventional radiology, interventional endoscopy, emergency general surgery, renal replacement therapy, urgent radiotherapy, thrombolysis, Percutaneous Coronary Intervention (PCI – coronary angioplasty) and cardiac pacing.

Discharge Improvement (Standard 9)

- Single NWL-wide discharge assessment form
- Current state overview of each Clinical Commissioning Group (CCG) Individual CCG Implementation Plans/ Roadmaps
- Delivery of workshops required as part of the implementation roadmap
- Single Points of Access in place for each CCG that include the minimum required services and that accept & use the common NWL assessment form

THHFT has appointed a lead Clinician to help achieve the key milestones outlined above.

PRIORITY 3

Delivering compassionate care and improving communication

Why is this one of our priorities?

We have received feedback from patients and their families that this is an area that we need to continue to focus on. Listening to feedback, as part of our communication with patients, enables our staff to gain a real insight into the patient's experience of care and make further improvements. Ensuring staff are responsive to patients needs and communicate effectively is a key priority.

How are we doing so far?

The CQC found during their inspection in October 2014 that patients reported that they felt well cared for and the Trust was given a 'good' rating for the caring domain as part of their assessment process.

We have implemented *John's Campaign,* a national initiative to enable carers to support their loved ones outside of visiting times in accordance with their wishes. This provides for a better patient experience and can alleviate patient anxiety during a hospital stay. Key staff from different professional groups have undertaken the Alzheimers' Society Foundation Certificate in Dementia Awareness which focuses on providing patient-centred care.

The Trust has continued to deliver training for our staff on improving the patient experience of care via a Customer Care training programme. To date 47% of our staff have attended this training. The elements of compassionate care and communication continue to be monitored via our local patient experience survey and the aim will be to realise improvement in this area.

Initiatives introduced include patient stories being presented at every Trust Board meeting, a refreshed Experience and Engagement Group involving public governors, Healthwatch Hillingdon and representation from the voluntary sector and improvements made to the availability of written information for patients.

In addition, the Trust participates in the annual national patient survey programme (awaiting results – due to be published early May). The Friends and Family Test has also been fully rolled out to all patient areas with valuable feedback being provided in the commentary from patients and their families. During 2015/16 over 25,000 patients took up this opportunity and answered the FFT question.

Results from our local surveys and the FFT can be seen in Part 3 of this report; also included are some of the themes from the feedback which include elements of communication and what we have done to improve on this.

There will be an increased focus on staff undertaking customer care training in 2016/17 to ensure more of our staff are better equipped to enhance communication with our patients and their families.

Our aims for 2016/17 are:

- To achieve >96% satisfaction in the Friends and Family Test survey
- Realise a reduction in complaints related to key themes including communication and staff attitude

- Improvement in national patient survey metrics for areas related to compassionate care and communication

PRIORITY 4

Safer staffing – improved recruitment and retention to ensure delivery of safe care

Why is this one of our priorities?

We need to ensure that we have safe staffing levels for medical, nursing and allied health professional (AHP) staff groups. This allows for improved continuity of care, effective communication and improved quality and safety of care for our patients. There are significant recruitment challenges with these staff groups across London and nationally. The Trust needs to agree effective and robust recruitment and retention strategies to ensure that we reduce our vacancies in these staff groups and that we reduce our reliance on agency staffing.

We also want to ensure that staff appointed at the Trust are recruited to our values and deliver safe and compassionate care to our patients. This is a priority as it assists with staff morale and it ensures a higher quality of care. It also improves retention with regard to a better staff experience with their environment of work and the teams they work within. This was a safety priority identified by our stakeholders at the Quality Report consultation event.

How are we doing so far?

The Medical Staffing department are currently working with the surgical division providing information on vacancies and examining new ways of working. There is still a lot of work to be done with the other clinical divisions on planning recruitment to their outstanding vacancies.

For AHPs, numerous initiatives have already been introduced. Some of these include promoting our hospitals at University Open Days and via recruitment flyers for use at local events. Attendance at Careers Fairs has led to candidates applying for roles, and being interviewed for posts. In Occupational Therapy (OT) and Physiotherapy (PT), graduate Mailing Lists have been created to create personal links with potential candidates. Services have continued to take AHP students as many of our AHPs have been attracted to work here having been with us on clinical placement

Therapies have also successfully piloted a buddy scheme to support new joiners and rotational positions for staff have been expanded across dietetics, OT and PT. Rotations with other Trusts have been explored although not yet established. Advanced roles have been developed with an additional Extended Scope Physiotherapist trained to work alongside the orthopaedic team.

For nurse staffing there has been a continuous drive to reduce nurse vacancies throughout the year with a rolling programme of recruitment days at the Trust, attendance at university job fairs and targeted European campaigns. The recruitment team has worked closely with the medical and surgical divisions to implement bespoke recruitment plans for areas with specialised needs. However we have continued to have staffing gaps with reliance on agency due to increased capacity with additional wards being open to meet the demand for inpatient beds. This has put pressure on the system with regard to being able to ensure an adequate staffing resource to all our inpatient areas.

Enhanced nurse induction programmes have been developed to support the increased volume of newly qualified nursing staff and those from overseas.

Our aims for 2016/17 are:

Nurse Staffing

- To significantly reduce vacancy levels in specific clinical areas: A&E, the Acute Medical Unit and Fleming ward
- To develop a peripatetic nursing team to respond to additional short-notice staffing requirements
- To embed a proactive recruitment programme based on anticipated demand surge
- To continue to develop and implement retention initiatives

Medical Staffing

- To have a Medical Locums bank in place where gaps can be filled with our own Trust doctor to reduce the need for agency workers and be within the caps for agency usage
- To recruit to the outstanding vacancies once the divisions have developed their recruitment plan and shared this with Medical Staffing

Allied Health Professionals

- A workforce review will be completed within sonography and radiographers will complete sonography training
- A shared competency framework will be established for OTs and PTs on the acute wards
- A development programme to support Band 5 OTs and PTs to move to Band 6 posts within the Trust
- Pharmacy will be a pilot for central recruitment of pre-registration pharmacists which is envisaged to improve recruitment.

Our quality priorities will be monitored by clinical and management teams through their divisional performance reviews and via quarterly reports to the relevant Board Committee. The results will also be published in the 2016/17 Trust Annual Report.

Part 2.2 Formal statements of assurance from the Board

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:

Provision of NHS Services

During 2015/16 The Hillingdon Hospitals NHS Foundation Trust provided medicine, surgery, clinical support services and women's and children's NHS services. The Hillingdon Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by these relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of the relevant health services by the Hillingdon Hospitals NHS Foundation Trust for 2015/16.

Participation in clinical audit (all year end data TBC)

National audits

During 2015/16 37 national clinical audits and three national confidential enquiries covered relevant health services that The Hillingdon Hospitals NHS Foundation Trust provides.

During that period The Hillingdon Hospitals NHS Foundation Trust participated in 95% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Hillingdon Hospital NHS Foundation Trust was eligible to participate in during 2015/16, and for which data collection was completed during 2015/16, 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	Participated	Cases submitted
Acute Myocardial Infarction	Yes	100%
Bowel Cancer Audit Programme	Yes	100%
Adult Critical Care Case Mix Programme	Yes	Figure to be confirmed
National Paediatric Diabetes Audit (Royal College of Paediatric and Child Health)	Yes	100%
Elective Surgery (National Patient Reported Outcome Measures (PROMS) Programme)	Yes	Hip – 255 Knee – 377 Hernia – 43 Varicose Veins - 26
Emergency Use of Oxygen	Yes	100%
Falls and Fragility Fractures Audit Programme National Hip Fracture Database	Yes	100%
Falls and Fragility Fractures Audit Programme National Inpatient Falls Audit	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database	Yes	Audit launched in January 2016. Trust has registered to participate for data collection commencing March 2016.
Inflammatory Bowel Disease (Biologic Audit)	Yes	100%
Major Trauma Audit	Yes	31%
National Audit of Intermediate Care	N/A	Service not in place to enable Trust to submit to this audit
National Cardiac Arrest Audit	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (pulmonary rehabilitation)	N/A	
National Comparative Audit of Blood Transfusion: Audit of Transfusion in Children and Adults with Sickle Cell Disease	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Patient Blood Management in Scheduled Surgery	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Lower GI Bleeding and the Use of Blood	Yes	100%
National Complicated Diverticulitis Audit	Yes	100%
National Adult Diabetes Audit : National Foot Ulcer audit	Yes	Trust commenced participation in July 2016
National Adult Diabetes Audit : National In-patient Diabetes Audit	Yes	100%

National Adult Diabetes Audit : National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit : Out-patient Management	No	IT requirements are under review to enable future participation.
Mortality and Morbidity in Diabetes	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	84 cases submitted
National Heart Failure Audit	Yes	72%
National Joint Registry	Yes	Hillingdon – 56% Mount Vernon – 88%
National Lung Cancer Audit	Yes	100%
National Ophthalmology Audit	Yes	Audit commenced in September 2015, Trust is participating
National Prostate Cancer Audit	Yes	100%
National Intensive and Special Care (NNAP)	Yes	100%
National Oesophago-gastric Cancer Audit	Yes	100%
Paediatric Asthma	Yes	100%
National Audit of VTE risk in lower limb immobilisation (College of Emergency Medicine)	Yes	100%
National Audit of Vital signs in children (College of Emergency Medicine)	Yes	100%
National Audit of procedural sedation in adults (College of Emergency Medicine)	Yes	100%
Rheumatoid and early inflammatory arthritis	No	Medical Director and Divisional Director for Medicine have agreed with our Rheumatology team that participation in this audit would not contribute significantly to the quality of the service provided by the Trust.
Sentinel Stroke National Audit Programme	Yes	100%
UK Parkinsons Audit	Yes	100%
Head and Neck Oncology (Data for Head and Neck Oncologists)	N/A	This is N/A to the Trust - for 2015/16 this audit was only applicable to Trusts who have data published as part of the Consultant Outcome Publication process.
Clinical Outcome Review Programmes		
MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Acute Pancreatitis	Yes	100%
NCEPOD Sepsis	Yes	50%

The reports of 14 national clinical audits were reviewed by the provider in 2015/16 and The Hillingdon Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit	Actions
National Pregnancy in Diabetes Audit	A masterclass on diabetes in pregnancy has been given to local GPs. Shared GP guidelines have been updated and are available on the Extranet. Local hospital diabetes in pregnancy guidelines are currently being updated.
BTS Adult Community Acquired Pneumonia	The Trust has an antibiotic guideline app. To support scoring the severity of pneumonia, the CURB score, has

	been incorporated into the antibiotic guidelines app.
National Cardiac Arrest Audit	TO BE ADDED
National Emergency Laparotomy Audit (NELA)	A local protocol and pathway is in development to support formalising a consultant-delivered service for emergency laparotomy patients. This will cover cross disciplinary roles between surgeons, anaesthetists, radiological and laboratory services and theatre and critical care staff
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	To help ensure COPD patients receive specialist respiratory review a COPD hotline (mobile number staffed during working hours) has been put in place since Jan 2016. This has been distributed to all appropriate clinical areas including A&E. To increase the number of patients offered specialist respiratory follow up on discharge, an Integrated care COPD clinic set up as of Feb 2016. All patients seen by the COPD outreach team are offered an appointment. Guidelines for clinic referrals to be circulated to acute medical consultants for all other patients.
Initial management of the fitting child in the Emergency Department	This audit highlighted that blood glucose is not always measured/documented in the fitting child. Current guidelines are being reviewed for update. Following this education will take place.
Mental health in the Emergency Department	Discussion to take place with Central North West London NHS Foundation Trust to review documentation regarding risk assessment and mental state examination.
Assessing for cognitive impairment in older people in the Emergency Department	A&E leads are working with Trust Dementia leads to review what assessment proforma is to be used in the Emergency Department.
Moderate and Severe Asthma in Children in the Emergency Department	TO BE ADDED
National Paediatric Diabetes Audit	Diabetes poor control action board and meetings in place. Paediatric diabetes team have all been trained as a team in health coaching to encourage self-management. A transitional service survey is underway. A flow chart for management of high blood pressure and microalbuminuria is in development.
National Audit of Mortality and Morbidity in Diabetes	For nurse training around diabetes management, weekly walk-in sessions have been put in place, topics include management of high blood sugar (hyperglycaemia) and low blood sugar (hypoglycaemia). In addition to this insulin education training is being provided to junior doctors. The blood glucose and hypoglycaemia management charts are currently being revised so that both the charts can be incorporated into a single chart for ease of use for staff. All diabetes protocols are widely available on the hospital intranet and are promoted by the diabetes specialist team.
National Inpatient Falls Audit	Following this audit we have continued our bi-monthly Falls Steering group, with executive lead support, to oversee the Trust wide strategy for a reduction in Falls. A Falls Working Group is being set up within each Division to report back to the Steering Group and share local learning. A quality improvement project dedicated

	to the assessment of patients having had a fall and their aftercare is currently ongoing to standardise and streamline our approach.
National BTS Emergency Use of Oxygen Audit	The Trust is looking at training needs and documentation improvements. A specific oxygen monitoring chart is being considered to be used alongside the existing section within the prescription chart.
NCEPOD 'Just Say Sepsis'	An inpatient Sepsis Lead is being identified to work alongside the consultant lead in A&E. The sepsis proforma and guidelines will be reviewed and re-published.

The reports of ?local clinical audits (tbc) were reviewed by the provider in 2015/16 and examples of The Hillingdon Hospitals NHS Foundation Trust actions to improve the quality of healthcare provided are as follows:

Audit	Actions
Audit of details regarding Acute Kidney Injury (AKI) on Discharge Summaries to GPs	This audit is against the national standard for patients with a confirmed diagnosis of AK which is that the hospital discharge letter to the GP should contain advice regarding the stage of AKI along with any recommendations for repeat blood tests. During 2015/16 the hospitals' Consultant Lead for AKI has been undertaking the audit and providing targeted clinical training and awareness sessions to support improvement where required. The Trust has also included mandatory questions in the electronic discharge summary system to prompt doctors to include appropriate information.
Clinical Record Keeping Standards	As an improvement in identifying authors of specific entries within clinical notes stamps have been provided to doctors and nurses To raise awareness of Trust standards for record keeping poster has been developed and has been made available within the hospital We are going to agree the 5 main areas for improvement as key indicators for monitoring, these will include documenting date, documenting time, identifying who has written in the notes/use of the name stamp, documenting bleep number.
Safe Sedation at Hillingdon Hospital	Safe Sedation guidelines have been updated to include sedation in Emergency Department, Endoscopy and Radiology. A pre-procedure checklist is also being developed for use in areas providing sedation.
Post-operative Bowel Monitoring	Bowel surgery is part of an Enhanced Recovery Programme (ERP). To support improved documentation of post-operative bowel monitoring the ERP proforma has been updated to include daily post-operative documentation of bowel actions.
Timing of Discharges from ITU and the audit of ITU handback Protocol/discharge summary	This audit has resulted in the improvement in the level of detail and the quality of medical and nursing handover when a patient is discharged from ITU to a ward. Following implementation of the improved discharge document, a re-audit has shown a significant increase in the audit results, including improved documentation of: ceilings of care, nutritional needs, physiotherapy/ rehabilitation needs, psychological/emotional needs, communication/speech and language needs. Overall, there has been positive feedback from staff using the

	revised discharge summary.
Compliance with the Recommendations on Monitoring following Epidural Catheter Removal	Teaching on the Management of Leg Weakness/Motor Block with Epidural/Spinal Analgesia guideline is included on the Acute Pain study days which are held regularly 3 or 4 times a year. The Acute Pain nurses also educate ward staff during their daily Acute Pain rounds on the Surgical wards and ITU. The Consultant Lead for Acute Pain has provided study sessions to the junior doctors as part of their Foundation Programme training.
Bedside Blood Transfusion Practice	The Trust Transfusion Practitioner has undertaken targeted awareness and training on the transfusion process and has updated the mandatory training to focus on the areas identified for improvement within this audit. To continue to drive improvement in standards, the Transfusion Practitioner has increased visibility on the wards and undertakes snapshot checks on transfusion charts - real time feedback is given to the nurse in charge of the shift.
Delirium	New delirium assessment form is being designed & agreed with clinical leads for dementia, this will then be issued for use in the hospital. Additional delirium awareness training will be provided to support implementation of the revised form.
WHO Checklist	A Trust-wide WHO Checklist Policy is going to be produced. This will include all areas of the hospital that use safety checklists (as well as theatres) for example, interventional radiology.
Dementia Carers Survey	The dementia cares survey is part of a larger project to improve dementia care in the Trust. Actions taken to make improvements have been Dementia Resource folders are in place within the Trust, 'John's campaign was launched in the Trust The survey has been amended to include the ward, so the Dementia Specialist Nurse where required, can target awareness and training to raise standards.
Do Not Actively Resuscitate (DNACPR)	TO BE ADDED
Paediatric CAS Card Safeguarding Audit - A&E	To improve awareness of the safeguarding checklist, specifically the requirement to refer to the Health Visiting Team if the child has had more than 3 attendances in 6 months, local communication has taken place within A&E. This has also been added to existing training sessions to improve this standard.

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

The number of patients, receiving relevant NHS health services provided by The Hillingdon Hospitals NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 444 patients.

The Hillingdon Hospitals NHS Foundation Trust has a good research track record for a hospital of its size. Our main research activity is recruiting patients into high quality National Institute for Health Research (NIHR) portfolio adopted multi-centre trials. We participate in commercial research funded by the pharmaceutical industry and non-commercial research which is funded from the Department of Health via the NIHR North West London (NWL) Clinical Research Network (CRN). In 2015/16 we received £380,528 from the NWL CRN for this work. The

funding enables the Trust to employ research nurses and data managers to support the clinicians in this work.

Our Strategic Aims for 2014 to 2019 are:

- To expand the number of patients recruited into high quality clinical trials
- To expand the number of Specialties that are actively participating in clinical trials
- To adapt to the changing National and Regional organisation of clinical research and funding.

This has enabled us to offer a greater number of patients, from different clinical areas, the opportunity to participate in research. In 2015/16 we opened our first research study in Critical Care. We also employed our first Research Midwife and we now have a number of studies running in our Maternity Unit.

Participation in clinical research demonstrates The Hillingdon Hospitals NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to the nation's wider health improvement. This also allows clinical staff to stay abreast of the latest treatment possibilities giving patients access to new treatments that they otherwise would not have.

The Trust has an extensive research portfolio with a balance of observational and treatment trials across many clinical areas including cancer, stroke, haematology, paediatrics, and many of the general medicine and surgical specialities. In 2016/17 we plan to become more research active in Musculoskeletal disorders and Diabetes.

We also support PhD and Masters Students from the local universities giving them access to our patients and staff for their projects. In 2015/16 we approved and supported eight such university student projects.

During 2015/16 we had approximately 65 NIHR Portfolio Studies open or in follow-up and we recruited 444 patients into 39 trials.

All of our research activity is scrutinised for quality and compliance to the standards expected by the Research Governance Framework. In addition we work to comply with the Department of Health NIHR objectives.

Lessons learned from Serious Incidents

During 2015/16, the Trust has reported 34 'Serious Incidents' in accordance with the national Serious Incident reporting framework and the categorisation of serious incident cases. Two 'Never Events' (both misplaced nasogastric tubes) were reported in February and March 2016; these investigations are currently underway. Serious Incident cases include unexpected admissions to neonatal care, grade 3 or 4 pressure ulcers and categories such as unexpected death, sub-optimal care of the deteriorating patient, delayed diagnosis, drug incidents and surgical error. Nine of these cases have been Non-Executive/Executive Director led panel investigations. There were two Grade 3 and two Grade 4 pressure ulcers (these involve partial or full thickness skin loss and damage to the deepest layer of skin) reported during the period.

Protecting patients from avoidable harm is something to which there is universal agreement and the Trust has clearly defined processes and procedures to follow to help to reduce the risk of these events occurring. However where a serious incident does occur lessons need to be learnt

through a process of root cause analysis investigation and actions taken to prevent reoccurrence. Some of the learning from these Serious Incidents during 2015/16 includes the following:

Area	Division	Summary
Effective communication	Maternity	Communication in both verbal and written format should be effective. This refers to communication between staff, across the ward and between organisations.
Record keeping	Maternity	Documentation completed in retrospect, must be marked as such in the patient's notes. It is also best practice to complete records immediately following the event.
Following best practice and guidelines	Maternity	Staff must follow best practice guidelines at all times, for consent, maternal observations, vaginal examination and management of post postpartum haemorrhage.
Clinical Leadership	Maternity	Leadership of the emergency procedure must be clear and concise.
Review of diagnostic imaging	Medicine	There should be a process in place that ensures the requesting consultant, or an appropriate member of their team, review the final radiology report prior to discharging a patient.
Escalation of diagnostic findings	Medicine	There should be consistent pathways and processes in place to communicate and escalate suspected cancer findings in diagnostic reporting.
Identification of patients	Medicine	When requesting a diagnostic test via the Trust's electronic system staff must always search by using the patient's hospital/NHS number.
Triangulating patient identifiers	Medicine	Information on a request number should be triangulated using the patient's surname, date of birth, hospital or NHS number.
Labelling of samples	Medicine	Self-adhesive addressograph labels which detail the patient's demographics should be used when sending samples for processing to histopathology. Handwritten labels should not be accepted from departments within the Trust.
Medication history	Surgery	Medication records are to be ratified as soon as possible following a patient's admission to hospital, including contact with the GP.
Omitted medicines	Surgery	Nursing staff need to record in the prescription chart the reason why prescribed medication has been omitted.
Record keeping	Surgery	Medical staff should document reasons for prescription changes in the patient's record.
Nutritional assessments	Surgery	Nutritional assessments need to be completed and clear clarification made around recommended oral intake of solids and fluids.
Diabetic management	Surgery	Early referral of eligible patients for specialist diabetes advice and management is vital for safe glucose management.
Patient transfers	Surgery	Evening patient transfers to other wards to be arranged and completed before the day shift nurses finish duty.
Resuscitation procedure	Surgery	If in doubt of the resuscitation status of a patient staff must put the cardiac arrest call out and start basic life support.
Patient care and management	Surgery	The importance of team working, clinical handover and effective leadership in holistic patient care and management.
Staffing	Surgery	Agency staffing should be kept to a minimum to support continuity of care and high quality care.
Review of x-rays	Radiology	All routine x-rays should be examined as a whole looking at anything else that could be there not just the reason for the original request.
Patient symptoms	Radiology	The need to explore symptoms being described by the patient and not rely entirely on imaging.
Manual handling requirements	Medicine	Greater consideration should be given to meeting the care/moving and handling requirements of all obese/bariatric patients, where the patient has suffered a stroke these needs will be amplified.
Pressure ulcer prevention	Medicine	The procedure for recording pre-existing tissue damage, assessing risk, developing a management plan, and escalating concerns should be reviewed and improved; tissue viability needs should be reviewed by the MDT as an intrinsic component of the patient's health status.

Pressure ulcer prevention	Medicine	Access to specialist expertise in tissue viability and manual handling should be reviewed and sourced.
Pressure ulcer prevention	Medicine	Information about the range of technical equipment available to support obese or bariatric stroke patients should be readily available on the ward.
Staffing	Medicine	Recognising the impact on the safety and quality of care for all patients if patients with specific needs are accepted without having the required equipment and/or staffing level.
Patient pathway of care	Maternity	It is essential that women are moved from Maternity Triage within an appropriate timeframe to the relevant care setting.
Translation services	Maternity	Necessity to provide an appropriately trained translator to minimise disruption to the patient's diagnosis and treatment pathway
Early warning scoring systems	Maternity	MEWS charts must be routinely used by all staff when women are admitted to Maternity Triage.
Blood sampling	Maternity	When haemolysed blood results are recorded, the full clinical picture should be taken into account and reviewed as if it was an abnormal result.
Clinical handover	Maternity	Current structure of patient handover needs to be improved
Supervision of practice	Radiology	Procedures undertaken by Radiology Registrars should be authorised by a consultant radiologist unless the Radiology Registrar is deemed competent to act without consultant input in specified procedures
Review of imaging results	Radiology / Surgery	Radiology and Surgical teams should jointly review contrast enema results before the decision for surgery is made
Clinical pathway	Surgery	Standardised post-operative care of the patient having a reversal of ileostomy is required
Prescription charts	Surgery	All drugs prescribed for inpatients should be written on a single inpatient drug chart
Discharge communication	Surgery	Clear communication is required with the patient and their family regarding discharge
Referral pathways	Surgery	The Clinical Team who are referring to tertiary centres need to ensure that they follow the agreed referral process and make it clear when the referral is of an urgent nature.
Medical referrals	Surgery	There needs to be clarity on what constitutes a routine referral as opposed to an urgent, critical or life-threatening referral and the acceptable timeframe for these to happen.
Communication with patients	Surgery	There should be a detailed, documented, discussion with patients about their diagnosis, the severity and what to do if symptoms worsen.
Support for patients	Surgery	Clinicians should consider asking for a nurse to be part of the medical consultation to provide support to the patient when breaking bad news.
Patient letters	Surgery	The communication processes for dictating/sending referral letters should be reviewed and all letters should be uploaded to PAS and copies filed in the patient's notes in a timely manner.

Serious incident and never event actions plans based on the learning from investigations are implemented and monitored via clinical divisional governance boards until fully completed. Director-led panel investigation reports and action plans are approved and reviewed by the Trust Board until fully completed. A recent audit conducted by the Trust's internal auditor gave 'reasonable assurance' on learning from incidents processes that are in place within the Trust.

As part of our duty in being open and honest with patients and their families, the findings from serious incident investigations are shared with them and information is provided on the learning and the actions that the Trust is taking forward to prevent reoccurrence.

Statutory Duty of Candour – Key recommendation from the Francis Inquiry

The Duty of Candour was passed by Parliament 6th November 2014 and took effect 27th November 2014. This places a requirement on providers of healthcare to be open with patients when things go wrong. Providers are required to establish the duty throughout their organisation ensuring honesty and transparency are the norm.

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What is the Statutory Duty of Candour?

Where a notifiable safety incident has happened a health service organisation must – as soon as reasonably practicable:

- Notify the patient that a safety incident has happened and apologise
- Provide an account of all the facts known about the incident
- Advise the patient what further enquiries into the incident are appropriate
- Provide reasonable support to the patient
- Follow up in writing confirming the information and results of further enquiries and an apology

What is a 'notifiable safety incident?'

Any unintended or unexpected incident that occurred in the organisation's care that resulted in or appears to have resulted in:

- Death – directly related to the incident; or
- Severe harm, moderate harm or prolonged psychological harm (at least 28 days)

What does moderate harm mean?

Moderate harm means:

- Harm that requires a moderate increase in treatment, and
- Significant, but not permanent, harm;

Moderate increase in treatment means: an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling treatment, or transfer to another treatment area (e.g. intensive care).

How is the Trust implementing the Duty of Candour?

The Trust has ensured that the Duty of Candour has been fully integrated into the Trust's Incident Reporting and Being Open policies. Processes and systems have been implemented to ensure the legal and contractual requirements of the Duty are met. Staff awareness on the Duty has been raised via training and discussions at divisional meetings. Moderate and above severity incidents and action plans are monitored at divisional governance meetings and learning is shared via divisional governance forums and through team discussions. The Trust has put in place a robust monitoring system managed by the governance department staff with performance reports to divisional governance boards and the Clinical Governance Committee.

Goals agreed with our commissioners (CQUINs)

The key aim of the Commissioning for Quality and Innovation (CQUIN) framework is to secure improvements in the quality of services and better outcomes for patients, whilst also maintaining strong financial management.

In 2015/16 there were ten acute CQUIN schemes agreed, of which 5 were national and 5 were locally derived with Hillingdon Clinical Commissioning Group. 4 of the latter were regional schemes, mirrored in other hospitals across NW London. In 2015/16 we have achieved 85% of our acute CQUIN target demonstrating a steady and consistently good performance. In 2014/15 we achieved 87.1%. Having either fully or partially achieved all of our CQUINs for 2015/16 will mean that the quality of our services and the care that we deliver to our patients has improved.

CQUIN Targets 2015/16	Achievement	Commentary
National Schemes		
Improving communication with GPs for patients with kidney damage	Partial (30%) achievement	This is the first year that the Trust has been working on this CQUIN and results have improved significantly over time. By the end of the year the Trust was achieving 60% compliance with the national target.
Improving services for patients with a sepsis	Partial (70%) achievement	This is another first year CQUIN. The Trust is now consistently screening >90% of eligible emergency admissions for possible sepsis. Administration of antibiotics in less than an hour is proving more challenging.
Improving services for patients with dementia and their relatives/carers.	Partial (96%) achievement	
Developing IT systems to support integrated care	100% achievement	
Reducing unneccessary admissions and A&E attendances	100% achievement	
Regional Schemes		
Reducing unneccessary follow-up appointments for outpatients	100% achievement	
Working towards implementaion of 7 day services	Partial (70%) achievement	The Trust has achieved 70% of targets for working towards providing 7 day services. There is still room for further improvement in some areas for example, access to diagnostic tests and multidisciplinary assessment for patients admitted in the evening
Improving communication with GPs for patients who have long term conditions (COPD, Diabetes, Dementia, Heart Failure)	100% achievement	
Timely referral to specialist cancer centres for patients with a positive diagnosis	100% achievement	
Local Scheme		
Providing 'recovery at home' for appropriate elderly patients (HomeSafe)	100% achievement	

The CQUIN framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to achievement. 2.5% of The Hillingdon Hospitals NHS Foundation Trust's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between The Hillingdon Hospitals NHS Foundation Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Total CQUIN income for 2015/16, is expected to be £2,835,226 (85%) for National and Local schemes and £83,022 (100% of potential available income) for Specialised CQUIN schemes. In the previous year (2014/15) total income was £2,968,267 (87.1% of potential available income) for National and Local schemes and £126,404 (95.9% of potential available income) for Specialised Commissioning.
In January 2015 Tiaa (our internal auditors) conducted an audit to form an opinion on the design and operation of controls over the Trust's procedures for achieving CQUIN targets. They looked in detail at processes employed and governance arrangements as well as the systems used to provide evidence of achievement. Their overall assessment was of 'substantial assurance'.

Further details of the agreed goals for 2016/17 are available electronically at: www.thh.nhs.uk.

Care Quality Commission registration

The Hillingdon Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered without conditions.

The Trust was inspected by the CQC in October 2014 as part of its planned and more detailed inspection regime. The final reports were published on 10 February 2015.The Trust was rated as 'Requires Improvement' overall. The Trust was issued with formal warning notices against:

• Regulation 10 – Assessing and Monitoring the Quality of Service Provisions
• Regulation 12 – Cleanliness and Infection Control.

The Trust was also issued with five Compliance Notices against:
• Regulation 13 – Management of Medicines
• Regulation 15 – Safety and Suitability of Premises
• Regulation 16 – Safety, Availability and Suitability of Equipment
• Regulation 20 – Records
• Regulation 22 – Staffing.

The Board considered the overall rating ('Requires Improvement') to be fair. All of the recommendations were accepted and the Board was determined to make the necessary improvements. The concerns raised by the CQC in relation to the 'systems to assess and monitor the quality of service provision with robust and effective processes to ensure minimal risk to patient safety' were of immediate concern to the Board.

The findings provided a real impetus to ensure our assessment of the quality of our services fully encompassed review of systems and processes that our staff members follow, in addition to achieving key quality indicators and positive patient outcomes. As a result of the Trust actions against the Warning Notices the Trust increased compliance rates for staff training for all statutory and mandatory training and achieved >80% compliance as per Trust targets. The Trust also adopted cleaning targets in line with the National Specification for Cleaning standards (NSC) and met or exceeded the NSC targets across all clinical areas during 2015/16. The Trust

undertook significant work to upgrade ventilation systems in the main theatres and it also completed overseas recruitment visits to attract nursing staff to the Trust whilst reducing the turnover of nurses. Our safeguarding children and adults arrangements and processes have also been strengthened.

The CQC re-visited the Trust on 5th and 7th May which resulted in:

- The de-escalation of the Warning Notices against regulations 10 and 12
- Changing the four red 'inadequate' ratings in the safety domain against A&E, Medicine, Surgery and Services for Children to 'requires improvement'
- An overall rating for safety as 'requires improvement'
- A requirement notice against Regulation 12: Safe Care and Treatment for Cleanliness and Infection Control

Overview of ratings based on re-inspection of the Trust on 5th and 7th May 2016; report published on 7th August 2016.

Our ratings for Hillingdon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Mount Vernon Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for The Hillingdon Hospitals NHS Foundation Trust

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

The Trust has been working through a detailed improvement plan since the Care Quality Commission (CQC) published its report and this has been presented to the Trust Board and to

our commissioners on a monthly basis and is available for view via the Public Board papers on the Trust website.

A 'root cause analysis' review, was undertaken to examine how the situation, which was identified by the CQC, arose. This was overseen by the Board. There has been important learning for the Trust and for the Board. As a result an accountability framework is now being developed to ensure there is clarity of responsibilities and accountabilities at every level.

The Trust's ambition is to achieve an 'outstanding' (with 'good' as a minimum) CQC rating at future inspection. Moving forward, the Trust has agreed a programme of mock inspection using internal peer review supported by TIAA, the Trust's internal auditor. Several internal audits being conducted as part of the Trust's internal audit programme examine practice and processes that support the regulations of the Health and Social Care Act (HSCA). A workshop was also held for ward sisters / charge nurses and department managers to ensure they fully understand the responsibilities of their role in achieving the fundamental standards and the requirements of the HSCA.

The Hillingdon Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

The Hillingdon Hospitals NHS Foundation Trust submitted records during April 2015 to December 2015 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:

— which included the patient's valid NHS number was:

- 98.6% for admitted patient care
- 99.8% for out-patient care and
- 96.3% for accident and emergency care.
-

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

- 100% for admitted patient care;
- 100% for out-patient care; and
- 100% for accident and emergency care.

The Trust's Board and management seek to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported in relation to the quality indicators outlined in the Quality Report, but recognises that it is nonetheless subject to the inherent limitations outlined within the statement from the Chief Executive Officer earlier in this report.

Information Governance Toolkit

The Hillingdon Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2015/16 was 82%. This is termed as satisfactory (green) with all requirements level 2 or above.

Clinical coding error rate

The Hillingdon Hospitals NHS Foundation Trust was not subject to the Payment by Results Clinical Coding Audit during 2015/16 by the Audit Commission.

Action taken to improve data quality

The Hillingdon Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue the comprehensive monitoring programme for data quality across the organisation through divisional based groups led by the Director of Operational Performance.
- The quality of RTT 18 week incomplete pathway data will continue to be reviewed monthly at the elective performance meetings and divisional data quality groups including diagnostic waiting lists.
- Trust Board Indicators assurance - regular review and local auditing
- Expanding the Data Quality Programme to include other key datasets used at key committees.
- A focus on 18 week Referral To Treatment (RTT) training across the Trust for new and existing staff members.

Part 2.3 Performance against Core Quality Indicators 2015/16

In this part of the report the Trust is required to report against a core set of national quality indicators to provide an overview of performance in 2015/16. The following page provides information which has been obtained from the recommended sources and is presented in line with the detailed Monitor guidance.

	2014/15 Performanc	2015/16 Target	2015/16 Performanc	London Trusts	National	Benchmark Sourc	Benchmark Period	Lowest Performing Trust	Highest Performing Trust
1: Summary Hospital-Level Mortality (SHMI)	0.88 [Lower Than Expected]	n/a	0.89 [Lower Than Expected]	n/a	n/a	HSCIC	Oct-2014 to Sep-2015	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST 1.177 Band 1 (Higher Than Expected)	THE WHITTINGTON HOSPITAL NHS TRUST 0.652 Band 3 (Lower Than Expected)
2: the percentage of patient deaths with palliative care coded at *diagnosis*	24.7%	n/a	29.1%	n/a	26.5%	HSCIC	Oct-2014 to Sep-2015	THE WHITTINGTON HOSPITAL NHS TRUST 0.2%	IMPERIAL COLLEGE HEALTHCARE NHS TRUST 53.5%
3: Emergency readmissions to hospital within 28 days of discharge from hospital: children of ages 0-15 [Standardised] (Crude) 4: Emergency readmissions to hospital within 28 days of discharge from hospital: Adults of ages 16+ [Standardised] (Crude)	**The latest HSCIC publication was on Dec-2013 covering 2011/2012 data** **The next publication is due Aug-2016** **see https://indicators.ic.nhs.uk/webview/** **Section Compendium of population health indicators > Hospital Care > Outcomes > Readmissions** **Last Checked 14/04/2016**								
5: Clostridium difficile	18 Cases (12.7 Cases per 100,000 Beddays)	8 Cases (Lapes of Care Only)	12 Cases (8.1 Cases per 100,000 Beddays)	15.9 Cases per 100,000 Beddays	15.1 Cases per 100,000 Beddays	PHE	Apr-2014 to Mar-2015	The Royal Marsden 37 Cases (62.2 Cases per 100,000 Beddays)	Alder Hey Children's (+3 other Trusts) 0 Cases (0 Cases per 100,000 Beddays)
6: Venous Thromboemolism (VTE)	92.6%	95%	94.5%	95.7%	95.8%	NHS England	Apr-2015 to Dec-2015	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST (2015/2016 Q3 only) 61.5%	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (+3 other Trusts) (2015/2016 Q3 only) 100%
7: PROMS (Health Gain), Groin Hernia, EQ-5D Index/VAS	0.095 / 3.723	n/a	0.106 / 1.568	n/a	0.084 / -0.504	HSCIC	Apr-2014 to Mar-2015	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST -0.066 BARTS HEALTH NHS TRUST -7.262	WESTON AREA HEALTH NHS TRUST 0.176 CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST 6.102
8: PROMS (Health Gain), Hip Replacement (Primary), EQ-5D Index/VAS	0.438 / 10.15	n/a	0.428 / 13.684	n/a	0.437 / 11.953	HSCIC	Apr-2014 to Mar-2015	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST 0.279 EAST CHESHIRE NHS TRUST 6.298	MID ESSEX HOSPITAL SERVICES NHS TRUST 0.577 BARNSLEY HOSPITAL NHS FOUNDATION TRUST 18.131
9: PROMS (Health Gain), Knee Replacement (Primary), EQ-5D Index/VAS	0.322 / 6.538	n/a	0.23 / 1.764	n/a	0.315 / 5.783	HSCIC	Apr-2014 to Mar-2015	SOUTH TYNESIDE NHS FOUNDATION TRUST 0.185 COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST 0.193	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST 0.555 IMPERIAL COLLEGE HEALTHCARE NHS TRUST 13.889
10: Percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family of friends		n/a	Q1 & Q2 - 77%; Q3 - not completed; Q4 - TBC	Not available	Q1 - % Q2 - % Q3 - % Q4 - not available	NHS England			
11: Trust's responsiveness to personal needs of our patients	72%	n/a	TBC	n/a	n/a	HSCIC	Apr-2014 to Mar-2015	Croydon 68.8%	QueenVictoria Hospital 88.2%
12: [a] The number, and where available, rate of patient safety incidents reported within the period, and; [b] the number and percentage of such patient safety incidents that resulted in severe harm or death	5679 (34.86/1000 beddays) 47 (0.8%)	n/a	5891 (35.31/1000 beddays) 23 (0.4%)	34.27/1000 beddays 0.6%	36.24/1000 beddays 0.5%	NPSA	Oct-2014 to Mar-2015	THE DUDLEY GROUP NHS FOUNDATION TRUST 3.57/1000 beddays SOUTH WARWICKSHIRE NHS FOUNDATION TRUST 5.19%	WYE VALLEY NHS TRUST 82.21/1000 beddays POOLE HOSPITAL NHS FOUNDATION TRUST 0.05%
13: Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Fully Compliant	Fully Compliant	Fully compliant	n/a	n/a	n/a	n/a	n/a	n/a

Data Inconsistencies

A number of indicators are showing changes to 2015/16 data that was published in last year's Quality Report. There are several reasons for this as follows:

1. The statutory timescale within which the Quality Report is published is very tight. Not all of the latest data was available at the time of publication last year and so the Trust has taken the opportunity to update 2014/15 indicators with full year updates which are now available.
2. National Indicators based on statistical methods by definition require re-basing (e.g. standardised readmissions, HSMR, SHMI).
3. Data quality or data completeness issues may have affected last year's indicators. If these have been identified then they have been rectified in this year's report.

Supporting Information about the indicators required in accordance with the Quality Account regulations Update

The Hillingdon Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Indicator 1: SHMI
The Summary Hospital-level Mortality Indicator (SHMI) for the Trust for year 2015/16 is 0.88 (source HSCIC, benchmark period October 2014 - September 2015) and is within the 'lower than expected' range. This is an improved performance when compared to an 'as expected' rate of 0.916 in year 2014/15. The Trust intends to improve the quality of its services by continuing to progress the implementation of the London Quality Standards, which should be reflected in a sustained SHMI performance.

Indicator 2: Palliative Care Coding
Use of the palliative care codes has stabilised over the last few years and our coding rate (for deaths specifically) is marginally higher than last year and in line with the national average. The Trust intends to improve this percentage and so the quality of its services by continuing to monitor performance via the integrated quality and performance report (reviewed monthly by the Board) and continue to ensure that reporting systems are robust and efficient through audit.

Indicator 5: Clostridium difficile
The Trust has seen a reduction in the incidence of *Clostridium difficile* (C.diff) infection since 2014/15 with a total of 12 cases in 2015/16 against a trajectory of eight compared with the previous year end total of 18 cases against a trajectory of 16. A Root Cause Analysis (RCA) is undertaken for all cases of Trust attributed C.diff and the Consultant in charge of care, Consultant Microbiologist, Infection Control Nurse, Ward Sister and responsible Matron are generally part of this process.

During 2015/16 all RCA investigation reports were presented to the Clinical Commissioning Group (CCG) representative for review and scrutiny and to establish agreement regarding any lapses in care. Of the 12 cases presented to the CCG only one case was considered to be due to a lapse in care and therefore potentially avoidable as antibiotics were not prescribed in accordance with the Trust Antimicrobial Guidelines. The remaining 11 cases were predominantly elderly patients presenting as emergency admissions, acutely unwell with a history of clinically indicated antibiotic treatment in line with Trust Antimicrobial Guidelines.

Antimicrobial Stewardship is an important element in the prevention of hospital acquired C.diff and there is now a full time antimicrobial pharmacist working in the Trust helping to increase awareness and knowledge of good prescribing practice and stewardship. The infection control team is now fully established and this has strengthened surveillance opportunities and ward

based teaching. The Trust intends to improve performance on this indicator and so the quality of its services by progressing a refreshed annual infection control action plan with robust oversight by the Infection Control Committee during 2016/17.

Indicator 6: Venous Thromboembolism (VTE)
The VTE risk assessment compliance for 2015/16 is 94.5% compared with 92.6% for 2014/15. After the previous year's root cause analysis (RCA) of reasons for difficulty in delivering on the target an action plan was developed and is monitored within the Trust clinical governance system up to the Quality and Safety Committee.

The Trust has taken actions to further improve performance on this indicator and so the quality of its services which includes:

- improved staff education including junior doctors during their induction and nursing staff during education on documentation and drug administration;
- improved documentation with checklists, which include VTE assessment, in medical notes;
- involvement of ward pharmacists as part of the multidisciplinary team to draw attention to any omissions on drug charts; modification of the drug chart to aid in ease of VTE risk assessment has been approved;
- and standard clinical practice that no patient is admitted to a clinical area without a VTE assessment completed.

The Trust has mitigated the risk of VTE to patients by producing an information leaflet distributed to every inpatient regarding the risk of VTE during their hospital stay and post-discharge and how to minimize that risk.

The Trust has taken steps to understand the risk to patients and to share learning by RCA of all identified cases of VTE during the past year found to be Hospital Acquired Thrombosis (HAT) - defined as a VTE which occurs during admission or within 90 days of discharge from hospital.

Of 33 cases of HAT identified: more than 80% had a VTE risk assessment on admission; even those without documented assessment had appropriate thromboprophylaxis (TP) – except in one case. 64% developed a VTE despite appropriate TP and a number were complex cases where re-assessment of VTE risk status and adjustment of TP might have prevented development of VTE. A few cases might have benefitted from extended TP post-surgery – although this would not have been a NICE guideline or evidence-based practice. Prescribing and documentation of TED stockings which might have reduced the risk of VTE was poor.

This information has been shared with the teams involved in order that lessons can be learned and future performance improved.

Indicator 7, 8 and 9: Patient Reported Outcome Measures (PROMS) Health Gain
For the purposes of the Annual Quality Report the PROMS data being reviewed is for the full year 2014/15. This is due to the fact that the 2015/16 data is not yet available for review due to post-operative patients still submitting post-operative information.

In 2014/15 the Trust saw an increase in the number of patients being issued with pre-operative questionnaires. This is the first questionnaire that is issued pre-operatively to patients in the process and is issued by the hospital. Subsequent PROMS questionnaires are issued by an external company that administers the post-operative PROMS data collection for the Trust.

Our PROMS pre-operative issue rates for hip and knee replacements are higher than for groin hernia and varicose veins and this is due to the fact that questionnaires are given to patients at the pre-operative joint school.

Indicator 7: Groin hernia
There was an improvement in the hospital's PROMS results for groin hernia between 2013/14 and 2014/15 and the Trust is performing higher than the national average. The Trust intends to improve performance on this indicator and so the quality of its services where the pre-operative nursing teams at both hospital sites will try and improve the issue rates for groin hernia and varicose veins in particular.

Indicator 8: Hip replacement:
There has been a slight improvement in two of the three hip replacement outcomes (EQ5D VAS and Oxford Hip Score) and the performance against the remaining outcome (EQ5D- Index) is very similar to the previous 12 months results. When benchmarked, the hospital's results are very similar to the national average. The Trust intends to improve performance on this indicator and so the quality of its services by monitoring issue rates and improving the patient's overall experience.

Indicator 9: Knee replacement:
The PROMs results for knee replacements have deteriorated compared with the previous 12 months and currently sit below the national average. The Trust intends improve on this indicator and so the quality of its services; the reasons for the deterioration are being further investigated by the clinical and managerial teams and the required actions will be taken forward during 2016/17.

The EQ5D outcome measures report a patient's overall experience of surgery whereas the Oxford Knee Score (OKS) is more of an objective clinical measure. The results for the OKS are very similar to that of the national average which may indicate that there is further work to be done on improving the patient's overall experience and managing their expectation of surgery.

Indicator 10: Friends and Family Test question 12d – Staff Survey
The narrative provided covers two quarters; due to this year's staff survey there was no quarter three survey and quarter four is still live and we are yet to receive the findings:

For the two quarters of 2015/16, during which the Staff FFT operated, the results show an average of 77% of staff are 'likely' to recommend the Trust as a place in which to receive treatment whilst 72% are 'likely' to recommend the Trust as a place to work

The Trust intends to take the following actions to improve staff response rates and performance and so the quality of its services:

- Increase electronic access to the questionnaire to increase participation rate
- Promote action taken as a result of feedback provided by staff through the Bulletin, intranet, staff meetings and team briefings
- Continue to implement the staff engagement initiatives detailed in the strategy.

Indicator 11: Responsiveness to personal needs of our patients
This is a composite score from 5 questions taken from the 2015 national survey of inpatients:
(Last year figure – 63.4%) TBC for 2015/16 in May 16.

- Being involved in decisions about your care and treatment
- Finding someone to talk to about worries and concerns
- Being given enough privacy when discussing your condition and treatment
- Informing patients about medication side effects to watch out for after going home
- Knowing who to contact if worried about condition or treatment after leaving hospital

The Trust intends to take the following actions to improve performance on this indicator and so the quality of its services: Actions to be agreed once NPS results available

Indicator 12: Patient Safety Incidents
The Trust's rate of reporting for patient safety incidents has increased from 34.86 (per 1000 bed days) in 2014/15 to 35.31* (per 1000 bed days) in 2015/16. This is a positive improvement as part of an improved patient safety culture.

Comparative data from the National Reporting and Learning Service (NRLS) shows that the Trust is in the middle 50% of reporters for Acute (Non-Specialist) Organisations with a rate of 36.97 (per 1000 bed days)**. This compared to a median reporting rate of 35.34 (per 1000 bed days) for the reporting period. Organisations that report more incidents usually have a better and more effective safety culture. It is well recognised that you can't learn and improve if you don't know what the problems are.

The number of patient safety incidents that resulted in severe harm or death has decreased from the previous year by 0.4%. The Trust intends to take the following actions to improve further on this key patient safety indicator and so the quality of its services:

- Continue to raise awareness of the importance of incident reporting and in particular near misses and no/low harm incidents (this will ensure learning to avoid the more harmful incidents from occurring)

- Ensure there is more robust feedback on actions taken provided to reporters to ensure staff see the value of reporting patient safety incidents

- Continue to ensure there is detailed root cause analysis investigation of all moderate/severe/death reported incidents to support learning and changes in practice.

*Excluding Pressure Ulcers Internal Transfers (PUIT) and Pressure Ulcers Admitted With (PUADM)

**Unable to compare NRLS data with previous reporting periods as indicator changed during 2015 from incidents per 100 admissions to incidents per 1,000 bed days.

Indicator 13: Access to healthcare for people with a learning disability

The Trust has remained fully compliant with this key indicator as part of its quarterly and annual declaration to Monitor. The Trust intends to continue to raise awareness amongst its staff and ensure that its best practice guidance on caring for patients with a learning disability is followed so as to maintain performance on this indicator and so the quality of its services.

Definitions of the two mandated indicators for substantive sample testing by the Trust's auditors are:

1. Referral to Treatment Time waiting times – 18 week pathway
2. Accident and Emergency department 4 hour target

Part 3 Other key quality information and improvements we have made in 2015/16

In this part of the report we have included other key quality indicators which have been selected by the Board in consultation with stakeholders. They represent those indicators that are of national importance that patients will want to know about and they include targets used by Monitor as part of Monitor's Risk Assurance Framework. The indicator set includes patient experience, patient safety and clinical effectiveness indicators. The indicators covered in this year's report are consistent with those from last year's Quality Report. Narrative has been provided on some of these indicators to outline our performance.

	2014/15 Performance	2015/16 Target	2015/16 Performance	London Trusts	National	Benchmark Source	Benchmark Period
1: In Hospital Standardised Mortality Ratio	102.1 (94.9 - 109.7)	<100	92.1 (84.3 - 100.4)	84.7 (83.3 - 86.0)	100	Dr Foster	Apr-2015 to Dec-2015
2: Readmissions to hospital within 28 days	107.2 (104.3 - 110.2)	<100	105.3 (101.2 - 109.4)	101.0 (100.3 - 101.7)	100	Dr Foster	Apr-2015 to Sep-2015
3: Non clinically justified single sex accommodation breach, rate per 1,000 finished consultant episodes	0	0	0	0.3	0.3	NHS England	Apr-2015 to Feb-2016
4: Cancer: Two week wait from GP referral to seeing a specialist (suspected cancer)/(breast symptoms)	98.0% 95.7%	93% 93%	97.0% 96.3%	94.4% 93.2%	94.8% 93.4%	NHS England	Oct-2015 to Dec-2015
5: Cancer: 31 day maximum wait from diagnosis to first treatment	99.3%	96%	99.2%	97.6%	97.9%	NHS England	Oct-2015 to Dec-2015
6: Cancer: 31 day maximum wait from diagnosis to subsequent treatment, drug or surgery	100% 100%	97% 94%	100% 100%	99.7% 96.4%	99.6% 96.2%	NHS England	Oct-2015 to Dec-2015
7: Cancer: 62-day maximum wait from referral by GP/screening service/consultant upgrade to treatment	92.2% 97.8% 98.7%	85% 90% n/a	91.8% 98.6% 97.6%	81.6% 93.5% 92.3%	83.5% 93.5% 90.6%	NHS England	Oct-2015 to Dec-2015
8: Referral to treatment waiting times - admitted	95.2%	90% (Up to end Sep 2015)	92.4%	88.2%	87.8%	UNIFY2	Apr-2015 to Jun-2015
9: Referral to treatment waiting times - non admitted	98.5%	95% (Up to end Sep 2015)	98.6%	95.2%	95.3%	UNIFY2	Apr-2015 to Jun-2015
10: Referral to treatment waiting times - Incomplete	97.7%	92%	96.1%	92.3%	92.5%	UNIFY2	Apr-2015 to Jan-2016
11: Fractured neck of femur emergency patients in theatre within 36 hours	86.4%	90%	90.0%	n/a	n/a	Local Indicator	n/a
12: Total time in A&E: 4 hours or less (All Types/ Type 1)	94.1% 84.2%	95% 95%	92.0% 79.2%	92.7% 88.3%	92.4% 88.6%	NHS England	Apr-2015 to Feb-2015
13: Number of last minute elective operations cancelled for non clinical reasons	0.70%	0.50%	0.51%	0.78%	0.82%	NHS England	Apr-2015 to Dec-2015
14: Percentage of patients not treated within 28 days of having operation cancelled for non-clinical reasons	2.9%	0%	1.57%	8.10%	6.30%	NHS England	Apr-2015 to Dec-2015
15: 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	82.8%	95%	80.3%	n/a	n/a	Local Indicator	Ceased Qtr 1 2015/2016
16: 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 (excluding late Referrals)	97.4%	95%	96.1%	n/a	n/a	Local Indicator	Ceased Qtr 1 2015/2016
17: Stroke patients: Percentage of Patients that have spent at least 90% of their time on the stroke unit	98.2%	80%	99.1%			Local Indicator	Ceased Qtr 4 2012/2013
18: Stroke patients: Percentage of high risk Transient Ischaemic Attack (TIA)/mini stroke patients who are treated within 24 hours	100%	n/a	100%			Local Indicator	Ceased Qtr 4 2012/2013
19: Meticillin-Resistant Staphylococcus Aureusis (MRSA)	0.7 Cases per 100,000 Beddays	0	0.7 Cases per 100,000 beddays	1.8 Cases per 100,000 beddays	1.8 Cases per 100,000 beddays	PHE	Apr-2014 to Mar-2015
20: Inpatient Experience Programme (local survey results)	90%	>/= 88%	87%	n/a	n/a	Local Indicator	Apr-2014 to Mar-2015
21: Outpatient Experience Programme (local survey results)	91%	>/= 88%	87%	n/a	n/a	Local Indicator	Apr-2014 to Mar-2015
22: Maternity Experience Programme (Local survey results)	88%	>/=87%	86%	n/a	n/a	Local Indicator	Apr-2014 to Mar-2015
23: Independent assessment of cleanliness of hospital* - Very High Risk areas - High risk areas	97% 97%	98% 95%	98% 96%	n/a	n/a	Local Indicator	Apr-2014 to Mar-2015
24: Percentage of complaints responded to within agreed timescale	88.5%	90%	70.7%	n/a	n/a	Local Indicator	Apr-2014 to Mar-2015

Definitions for the indicators are included in Monitor's 'Risk Assessment Framework' (available on http://www.monitor.gov.uk/raf).

Indicator 1 – Hospital Standardised Mortality Rate

The Hospital Standardised Mortality Ratio (HMSR) for the Trust for year 2015/16 is 93.2 (84.9-102.2) (source Dr Foster data, benchmark period April-Nov 2015) and is below the national benchmark of 100 but is above the London average of 85.4 (83.9-86.9). The Trust weekday and weekend HSMR have been in the 'as expected' range throughout the year. The Trust is tracking the HSMR monthly and has a robust Mortality Review Process in place for all deaths occurring in hospital. In line with the recent NHS England Guidance: Avoidable Mortality, the Trust has formed a Mortality Surveillance Group to oversee the Mortality Review Process and draw up a policy which will clarify and document the roles and responsibilities, governance arrangements and reporting requirements of the process.

Indicator 2 – Re-admissions to hospital within 28 days

It remains a key priority for Hillingdon Hospitals to manage risk of readmission for our patients.

Over a period of ten months in 2015/16 (January to October) THHFT implemented an ambitious project to gather information regarding the underlying causes of readmissions; information that would help to give both the hospital and our commissioners a more detailed understanding of the multiple factors contributing to current readmissions rates.

More than 500 ward-based investigations were conducted, from which 75 were selected for more in-depth analysis. The majority of readmissions were found to be unavoidable due to deterioration or exacerbation of existing long term conditions such as chronic obstructive pulmonary disease (COPD). In some cases, lifestyle choices of the patient (e.g. smoking or alcohol consumption) were found to be significant contributory factors.

Where it was felt that readmissions may, potentially, have been avoided, for example by providing new or improved services, suggestions for improvement were captured and shared with relevant stakeholders both in the Trust and in the wider health and social care environment. Themes included: improving communication between the hospital and community matrons, providing excellent end of life support for patients and their families/carers, and focusing on supporting patients and carers to develop and enhance the knowledge, skills and confidence required to manage key aspects of their own care and potentially prevent them from needing to go into hospital.

The Trust has also implemented a risk stratification tool that is being used to identify patients with the highest risks of readmission so that they can be given additional support to help keep them at home when they are ready to leave hospital.

Indicators 4-7 - Cancer performance

Cancer performance is being well maintained for all the national waiting times standards. The quality of services is monitored annually via the national peer review programme. Tumour specific work programmes also reflect areas for service development.

Indictors 8-10 - Referral to treatment waiting times (To be included post Deloitte external testing)

Indicator 11 – Fractured neck of Femur

2014/15 performance: 86.4%
2015/16 performance (as of M9 - 1 month reporting delay): 89.2%

There has been an improvement this year in the number of patients that have sustained a fractured neck of femur receiving surgery within 36 hours. The main reason for the delay in

taking patients to theatre is patients having multiple co-morbidities which requires them to have a longer preoperative period to optimise medical fitness prior to surgery.

The multi-disciplinary team continue to review each patient that has a delay to theatre so ensuring that any avoidable delays can be identified and lessons learnt. The fractured neck of femur data is also presented and reviewed in the Orthopaedic Audit morning.

Indicator 12 - Accident and Emergency (A&E) waiting times
The year-end performance against the A&E access target was 92%. Overall demand increased by 2.6%, in addition to 9% growth in emergency attendances in 2014/15.

In recognition of the challenges facing the Trust, a detailed diagnostic piece of work was jointly commissioned by Hillingdon CCG and THH to identify areas for improvement that would serve to enhance patient flow.

The live action plan utilises a three pronged approach which focuses on:

- Reducing inappropriate attendances
- Achieving the four hour standard and reducing admissions
- Safely and effectively discharging patients

Average attendances of greater than 160 patients per day presents an ongoing challenge for the clinical team working in a confined physical space. Initiatives have therefore been targeted at reducing attendances from the community, diverting patients to ambulatory care pathways and expediting discharge from the base wards to reduce the amount of time each patient spends in the Emergency department.

Further learning is expected from The Cumberland Initiative (a movement to encourage systems thinking, simulation and modelling of healthcare scenarios to improve NHS quality of care delivery and save money) whose leads are reviewing patient discharge from hospital to home or to community / social care.

Indicator 13 - Number of last minute elective operations cancelled for non-clinical reasons

2013/14 performance: 0.85%
2014/15 performance: 0.7%
2015/16 performance: 0.51%

The Trust continues to improve performance with regards to reducing the number of operations / procedures cancelled on the day. This remains a priority for the Trust and each month a detailed report is provided to the Trust Board regarding the reason for each cancellation.

In 2015/16 the most common reason for cancelling a patient's operation was due to a medical complication with a previous patient which resulted in their operation taking longer than expected, leaving insufficient theatre time to finish all the cases.

Indicator 15 – Percentage of women who have seen a midwife or maternity healthcare professional within 12 weeks and six days of pregnancy
Although we continue to achieve a greater than 95% target to book women within the 12+6 week time frame there continues to be a challenge with regard to late bookers. The CCG and Hillingdon Public Health have committed to working with us to find a solution as the main challenges lie within the community and with public messaging regarding education and

information provision. The main challenges have been around key engagement and support particularly from Public Health who are undergoing major service reconfiguration. This has led to the relevant working representative being made redundant due to lack of funding. This has been raised as a significant concern with the Clinical Quality Group (CQG) who have agreed to escalate. As a Trust we will continue to work with commissioners to enable this piece of work to commence.

Indicator 21- Outpatient local patient experience survey
There continues to be detailed analysis of the FFT and local patient experience survey provided by patients attending outpatient departments. During April 2015 outpatient departments commenced a pilot to capture FFT feedback electronically; this has proved to be successful and it is now embedded into practice. It offers patients choice as an alternative to completing paper surveys and it has proved to be beneficial to the outpatient teams in capturing real time patient experience feedback. Current feedback is very positive regarding staff attitude and the service that they provide. There are a high number of comments received via FFT and local surveys stating staff are friendly and welcoming and that they communicate clinic delays to patients plus offer them beverages, which patients feel offers a personal touch.

Top priority for patients is to be seen at their appointed clinic time, due to the nature and demand on some clinics this remains a challenge. The outpatient matrons are continually working with service managers exploring ways of increasing clinic capacity; which can then lead to patients being seen on time. To support this there has been an increase in the number of specialities running weekend and evening clinics. Utilisation of ad hoc clinic rooms and the provision of staff to provide additional clinic activity is also better utilised and provides additional clinic capacity to reduce over booked clinics and reduction of waiting times enabling more patients to be seen on time.

Indicator 22 - Maternity local patient experience survey
We have strengthened the Maternity Services Liaison Committee and have been able to recruit three new user representatives to work with us in ensuring the woman's voice is heard.
Significant work has been done by the team to drive up the Friends and Family responses which had dropped during SaHF transition. We continue to display "you said-we did" information learning from FFT comments and complaints as well as sharing learning with the staff. We are hoping to continue to progress our programme of liaising with hard to reach groups as this has proved a valuable exercise in understanding expectation and culture.

Indicator 23 - Independent assessment of cleanliness of hospital
Since adopting the NSC {National Specifications for Cleanliness in the NHS} and audit frequencies in February 2015 the Trust-wide score has consistently met or exceeded the NSC targets for Very High Risk areas i.e. 98% achievement against a target of 98%; for High Risk areas i.e. an achievement of 96% against a target of 95%; Significant Risk areas i.e. an achievement of 90% against a target of 85%; and Low Risk areas i.e. an achievement of 85% against a target of 75%.

Managerial audits undertaken by the Trust have verified the scores achieved in the regular technical cleaning audits and furthermore, two six-monthly external audits undertaken by independent assessors have also validated the Trust's technical cleaning scores.

Indicator 24 - Percentage of complaints responded to within agreed timescales
In 2015/16 the Trust received 457 complaints, of which 89.1% were acknowledged within three working days. As the investigation period is typically 30 working days, the number of complaints on which responses were due during the financial year differs because of investigation time overlap at the beginning and end of the year.

There were 430 complaint responses due during 2015/16, of which 70.7% (304) were completed within the timescale agreed with the complainant. This is disappointingly lower than achieved last year. Underlying reasons include increased overall volume in complaints received and also staffing challenges due to sickness absence and vacancies within the complaints management team and the operational divisions. This led to significantly low performance in June and July; this recovered in subsequent months. The monthly performance ranged from a low of 12.7% in June through to 100% in both August and December.

To ensure a similar situation does not happen in the future, and to build on the service improvement already implemented to improve the timeliness and quality of responses to complainants, the following actions are underway:

- Complaints management process being strengthened to ensure quality-focused time-driven investigatory reports.
- Up-skilling of individual staff within the complaints team and closer working between the PALs and Complaints teams to create a flexible, multi-skilled workforce.
- Activity monitoring to identify surges in activity at an early stage to ensure appropriate allocation of resources.
- Divisional teams taking a proactive role in resolving concerns at an early stage, with increased personal contact with complainant.
- Provision of complaints investigation training for divisional and clinical teams.

Improving Patient Safety

During 2015/16 the Hillingdon Hospitals NHS Foundation Trust has continued to be a member of the Imperial College Health Partners (ICHP) Patient Safety Collaborative (PSC). This is one of 15 PSCs set up to help improve the safety of patients and ensure continual learning sits at the heart of healthcare in England. As the Academic Health Science Network (AHSN) for North West London, ICHP works with its partner organisations and service users to focus on specific areas of local clinical need. Its vision is to support its partners to embed safety in every aspect of their work. This means that:

- Patient and carer views are obtained and heard at all levels as a critical indicator of safety
- There is a strong ethic of team working and shared responsibility for patient safety
- Effective safety measurement and monitoring systems are in place in all clinical settings
- Clinical processes, practices, equipment and environment ate standardised and simplified

Our PSC is forging ahead and making great progress with a number of initiatives already underway. The Hillingdon Hospitals NHS Foundation Trust is involved in some of these key patient safety programmes of work and these include membership at the Foundations of Safety best practice forum, developing the role of the patient safety champion, supporting a prescribing improvement model and work to ensure effective medicines optimisation.

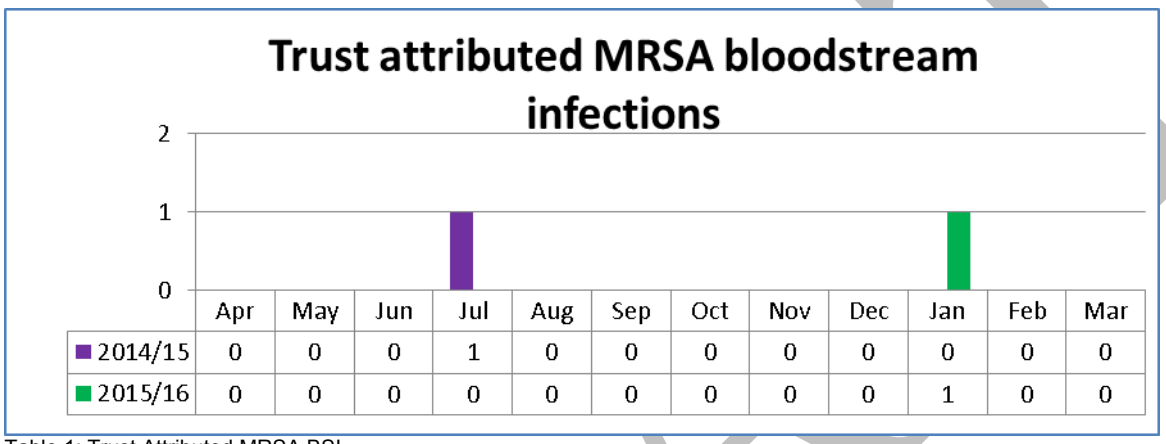
The PSC programme of work is aligned with and supports the national *Sign up to Safety* campaign which the Trust signed up to in the latter part of 2014 and is outlined earlier in this report.

Infection Control Prevention and Control

Meticillin Resistant *Staphylococcus aureus*

Following a Post Infection Review (PIR) undertaken by the community the Trust was attributed one Meticillin Resistant *Staphylococcus aureus* (MRSA) positive case. The blood culture was taken within 48 hours of admission and was originally attributed to the community, however following the PIR it was agreed with the Consultant Microbiologist and Consultant Paediatrician that the positive blood culture was due to specimen contamination not a bacteraemia in the absence of clinical symptoms and a second negative culture (Table 1).

Annual compliance measured with the MRSA screening policy for elective and emergency cases was 94% and 88% respectively.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	0	0	0	1	0	0	0	0	0	0	0	0
2015/16	0	0	0	0	0	0	0	0	0	1	0	0

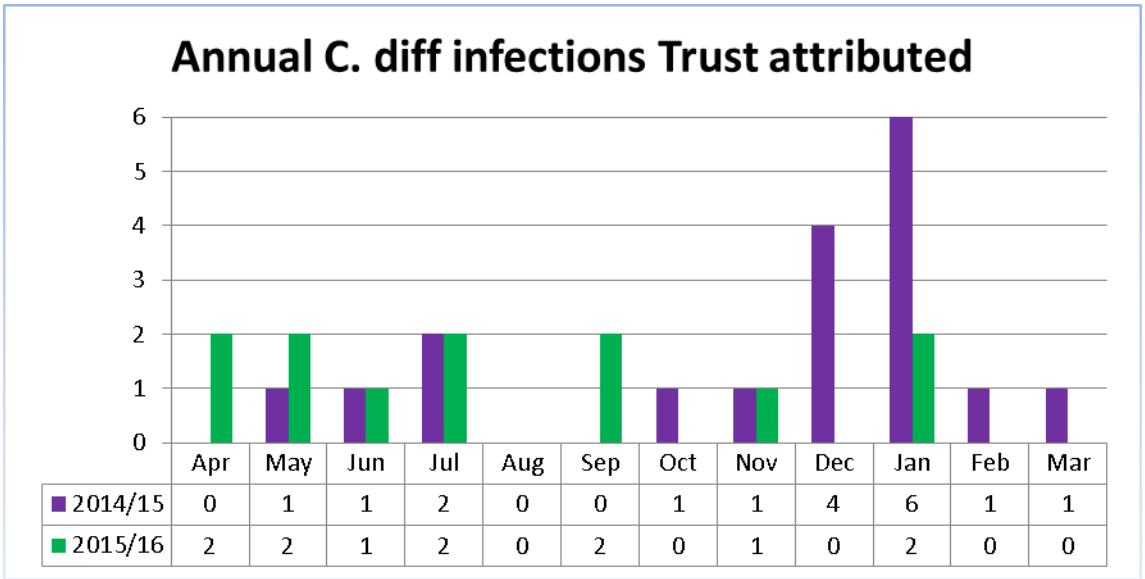
Table 1: Trust Attributed MRSA BSI

Clostridium difficile infection

The Trust has seen a reduction in the incidence of *Clostridium difficile* (C.diff) infection since 2014/15 with a total of 12 cases in 2015/16 against an annual trajectory of eight compared with the previous year end total of 18 cases against a trajectory of 16. A Root Cause Analysis (RCA) is undertaken for all cases of Trust attributed C.diff and the Consultant in charge of care, Consultant Microbiologist, Infection Control Nurse, Ward Sister and responsible Matron are generally part of this process (Table 2).

During 2015/16 all RCA were presented to the Clinical Commissioning Group (CCG) representative for review and scrutiny and to establish agreement regarding any lapses in care. Of the 12 cases presented to the CCG one case was considered to be due to a lapse in care and therefore potentially avoidable as antibiotics were not prescribed in accordance with the Trust Antimicrobial Guidelines. The remaining 11 cases were predominantly elderly patients presenting as emergency admissions, acutely unwell with a history of clinically indicated antibiotic treatment in line with Trust Antimicrobial Guidelines.

Antimicrobial Stewardship is an important element in the prevention of hospital acquired C.diff and there is now a full time antimicrobial pharmacist working in the Trust helping to increase awareness and knowledge of good prescribing practice and stewardship. The infection control team is now fully established and this has strengthened surveillance opportunities and ward based teaching.

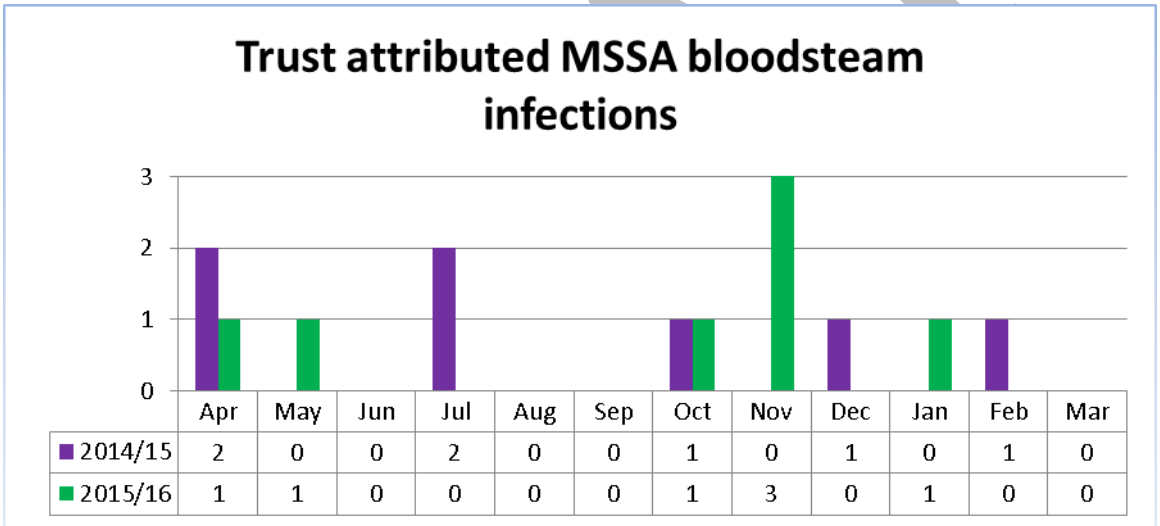


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	0	1	1	2	0	0	1	1	4	6	1	1
2015/16	2	2	1	2	0	2	0	1	0	2	0	0

Table 2: Trust Attributed C. diff Infections

Meticillin Sensitive *Staphylococcus aureus*

In Q4 one case of Meticillin Sensitive *Staphylococcus aureus* (MSSA) was attributed to the Trust, taking the total reported to seven MSSA cases in 2015/16. There is no mandated threshold for MSSA.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	2	0	0	2	0	0	1	0	1	0	1	0
2015/16	1	1	0	0	0	0	1	3	0	1	0	0

Patient Experience - Listening to our patients

We aim to be a listening and learning organisation, in which concerns that are raised by patients are understood, shared and responded too. Listening to feedback enables our staff to gain a real insight into the patient's experience of care. We use a number of different approaches, all of which provide us with information about what we are doing well and where we need to improve.

- National and local surveys
- Friends and Family Test
- Compliments/Complaints
- PALS concerns

What our inpatients have told us:

92% for treating patients with dignity and respect
86% for communication, involvement and information
91% for confidence and trust in our doctors and nurses
86 % for meeting physical needs Source: 2015/16 local inpatient survey based on 9 months data on responses from 1832 inpatients

How we have responded to our patients' feedback about their experience?

Complaints

Although often uncomfortable to hear, complaints provide us with the opportunity to learn from our patients and their families and improve the services and care we provide. When reviewing a complaint, an action plan is drawn up to address failings identified. Examples of specific improvement actions implemented as a result of complaints include:

Issue identified
A patient suffered delay in receiving their follow up appointment following a urodynamic test

What we have done about it:
A formal pathway has been developed by the gynaecology service to ensure all patients receive a follow up appointment within 6 weeks of a urodynamic study.

Issue identified
A patient did not receive adequate pain relief after an operation

What we have done about it:
New pain relief administration pumps have been purchased
Staff have received additional training on pain relief and the use of the new pumps.

National Patient Survey

A survey of inpatients is part of the annual mandatory survey programme for acute trusts; this assists organisations to find out about the experience of patients when receiving care and treatment at their hospitals. The results of the 2015 survey are based on responses from 453 patients who completed the survey, giving a response rate of 37%, the average response rate of all trusts was 45%.

This survey has highlighted the many positive aspects of the patient experience:

- Overall: 79% rated care 7+ out of 10
- Overall: treated with respect and dignity 76%
- Doctors: always had confidence and trust 73%
- Hospital: room or ward was very/fairly clean 95%

- Hospital: toilets and bathrooms were very/fairly clean 93%
- Care: always enough privacy when being examined or treated 87%

Based on the patients' responses to the survey the Trust scored: (Need to wait for CQC report for this information)

There are 5 questions where the Trust has a score that is significantly higher than the 2014 score. These are:

- A&E Department: not given enough privacy when being examined or treated
- Hospital: room or ward not very or not at all clean
- Hospital: felt threatened by other patients or visitors
- Discharge: not told who to contact if worried
- Discharge: Staff did not discuss need for further health or social care services

The Trust scored significantly lower than the 2014 score in 1 question:

- Surgery: results not explained in clear way

There were 2 areas where the trust scored 'better' than most other hospitals:

- Planned admission: not offered a choice of hospitals
- Hospital: patients using bath or shower area who shared it with opposite sex

In comparison with others the Trust has been rated as worse in questions associated with:

- Admission
- Environment and food
- Clinical care
- Surgery
- Discharge

The CQC adult inpatient survey provides a helpful annual check of our inpatients' experience and enables the trust to compare our performance with that of other trusts. Overall the 2015 survey results show that there are a number of areas where patients have reported a worse experience compared to the previous year.

The survey results have been triangulated with other sources of feedback to help identify the themes that should be our focus for improvement during 2016/17. There are a number of transformational programmes underway that have links to the areas for improvement to some of the themes set out above including Transforming Inpatient Care and workforce transformation. Improving patient experience is identified as a positive outcome from these programmes.

Improving communication with patients is embedded in priority three on this report, we will be scoping out specific initiatives and actions that will make a difference to these areas. The local survey programme will enable the Trust to monitor progress on any initiatives and report into the Trust's Experience and Engagement Forum.

Maternity Experience Survey

The Maternity Picker Survey, published in October 2015, was sent to women who delivered their baby in February 2015. The 2015 survey showed a decline in the experience received compared to the previous report of 2013. Although not complacent with regard to the results, the service has identified that there were mitigating circumstances linked to the SaHF transition planning where vacancies for senior midwifery posts were not allowed to be filled as part of

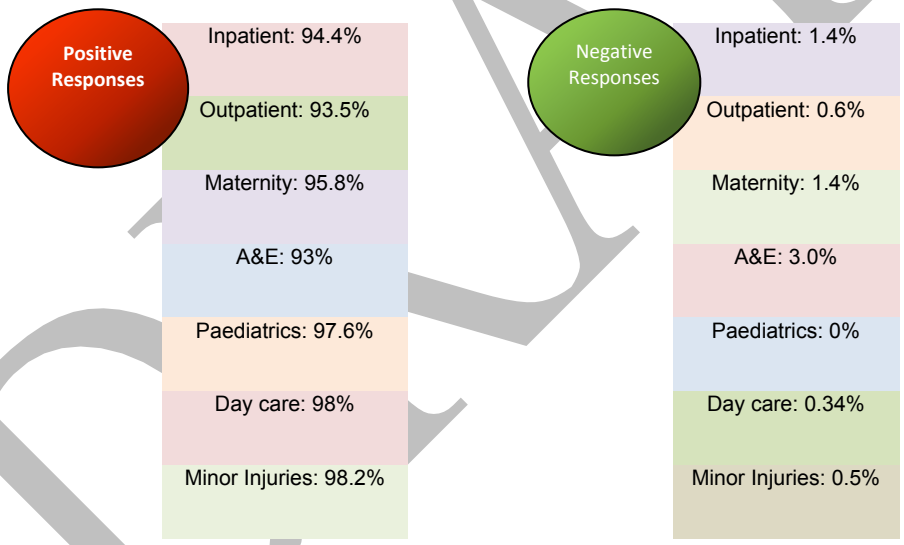
TUPE (Transfer of Undertakings (Protection of Employment) Regulations) - Ealing Senior Midwives were offered vacant posts across the sector. This meant that key leadership roles were left vacant. This included the Postnatal Ward Sister, Infant feeding Midwife and two community team leader posts.

We will be undertaking a mock Picker Survey for women who delivered this February (2016) to measure any improvement in service following the transition of Ealing patients and having filled the senior posts that had been left vacant. The service receives highly positive responses in the Friends and Family Test and has worked hard to improve response numbers which has been a challenge. We also display "you said we did" information on the wards as part of our commitment to improve services.

Friends and Family Test

The Friends and Family Test (FFT) provides a simple and standardised way of collecting patient experience feedback. The FFT question asks patients to consider their recent experience in the hospital ward/department or clinic and rate how likely they would be to recommend the area to a friend or family member.

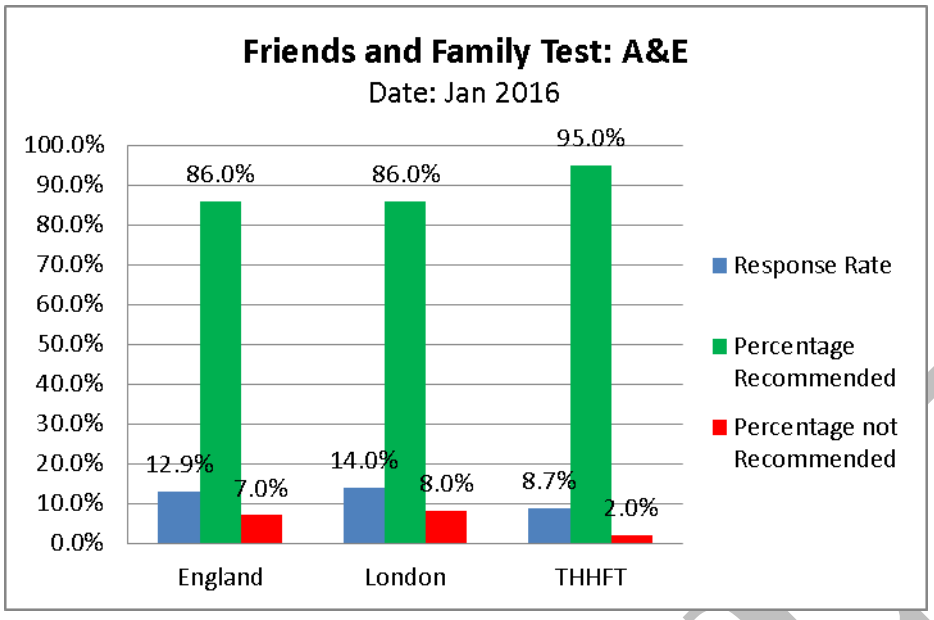
Patients should be given the opportunity to complete an FFT survey. During 2015/16 over 25,000 (April 2015 to March 2016) took up this opportunity and answered the FFT question. Our results for this period are set out below:



How do our FFT results compare with others?

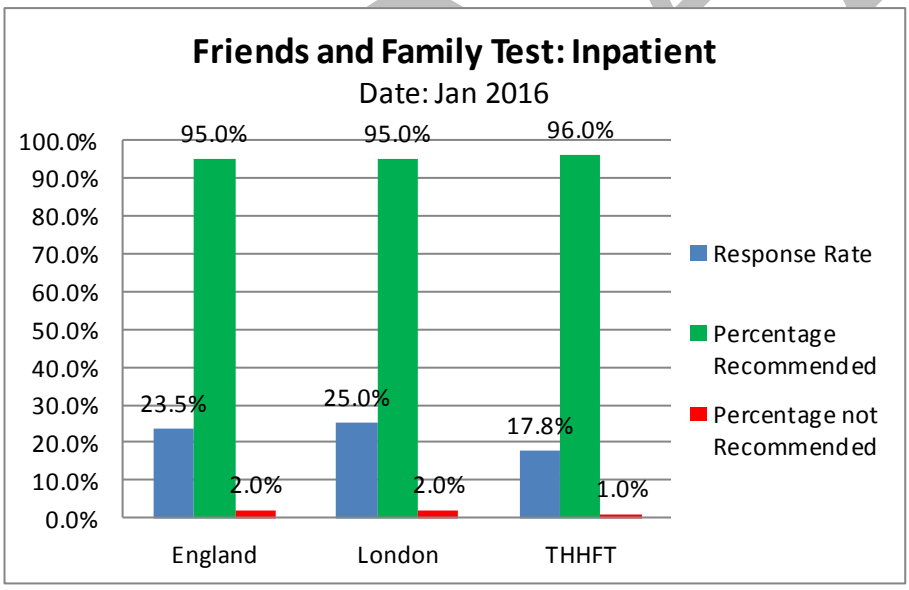
The graphs below show the FFT results and response rate for A&E and inpatients for 2016 (the most recently published data – January 2016).

Response rate and percentage of positive and negative results for A&E



The response rate for A&E in January is lower than the England and London rate. We do significantly better however than England and London in relation to the percentage of people who recommend the service and a positively lower percentage for those who do not recommend.

Response rate and percentage of positive and negative results for Inpatients



The percentage of people who would recommend is higher than the England and London score. We have the lowest percentage of patients who would not recommend in relation to London and England. The response rate for inpatients in January was lower than the London and England rates.

What patients have told us is good about their experience

Accident & Emergency'
Staff were very helpful and attentive. We were well informed of what was happening. We felt confident that everything that was needed was done'

Inpatient ward
'They made my stay an absolute pleasure. I wish to thank everyone for their compassion and care'

Maternity
'Excellent care, couldn't fault anything. Thank you so much, felt completely safe and in excellent hands'

What patients have told us could be improved

Waiting times in Accident & Emergency are too long

Action
Hospital wards have become specialty based enabling doctors to undertake timely ward rounds leading to earlier discharge of patients in the day and improved patient flow from A&E.

Patients feel that they are asked the same questions by different professionals

Action
The development of the Hillingdon Care Record which is a mobile application running on Trust iPads will enable clinical staff to view the medical history of patients reducing the need for patients to provide the same information to different professionals.

Antenatal clinic is very busy, waiting area is very small with a lack of seating. Better system required for informing about clinic delays

Action
A review of antenatal capacity is being undertaken to look at numbers of patients attending and appropriateness of appointments.

Staff Survey Headlines

In 2015, the Trust delivered overall an encouraging staff survey result. In terms of the standard and quality of care we provide, 65% of our staff said they 'would recommend the Trust as a place to work'. This is 4% higher than the average for acute Trusts. There was a slight increase (66% in 2015) in the percentage of staff that would be happy with the standard of care provided by the Trust to friends or relatives. However, this was lower (4%) than the average for acute Trusts (70%).

The Trust will take the following actions to maintain and further improve its performance:

- Build on work to date on developing highly effective teams to continue to improve quality of care
- Increase access to learning and development opportunities at all levels within the Trust to build clinical skills sets and improve the patient experience
- Increase opportunities for work based learning to promote learning and broaden clinical skills to elevate the standard of care
- Continue to work collaboratively with divisions to devise and implement bespoke local initiatives to drive learning, knowledge and innovation.

As requested by Monitor the following are our most recent findings on key findings (KF) from the staff survey:

- **KF19:Organisation and management interest in and action on health/well-being:** The Trust scored 3.61 on this question and compared with other Trusts our score is above (better than) average compared with other acute Trusts who scored 3.57

- **KF21: Percentage of staff believing the organisation provides equal opportunities for career progression/promotion:** Over the last three years the number of staff responding positively to this finding has increased with 83% this year. Other acute trusts reported 87%. In terms of breakdown by ethnic categorisation, 90% of staff by White ethnic backgrounds said they believed that the organisation provided equal opportunities for career progression/promotion compared to 73% of BME (Black and minority ethnic) staff. Benchmarked against other acute Trusts, they reported 89% (White) and 75% (BME) respectively.
- **KF25 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:** 31% for white staff and 25% for BME staff. This is a 4% increase for both groups over the previous year.

- **KF26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months:** 23% of staff who answered this question in the survey said they had experienced this in the last 12 months. This is below (better) than average compared to other similarly sized Trusts that reported 26%. This was a slight increase on our performance in 2014 (22%). In terms of breakdown by ethnic categorisation, 24% of staff by White ethnic backgrounds said they had experienced harassment compared to 22% of BME staff. Benchmarked against other acute Trusts, they reported 25% (White) and 28% (BME) respectively.
- **KF27: Percentage of staff reporting most recent experience of bullying, harassment or abuse:** 43% of staff who answered this question in the survey said they had reported bullying, harassment or abuse in the last 12 months. The Trust was in the highest (best) 20% of Trusts. Other acute Trusts reported 37% of staff reporting on this.

Equality and Diversity

Staff

More than 92% of staff completed their core equality and diversity training and remain compliant with refresher training. Over the last year the Trust has invested in a range of interventions to address feedback from the 2014 staff survey response. This has included:

- Promoted the “Ready Now” NHS Leadership Academy programme for black and minority ethnic communities (BME) staff
- Rolled out our popular Customer Care programme

- Included Employee relations cases in Board level KPIs
- Work with external consultants to scrutinise Trust systems and process against the nine protected characteristics. This emanated in focus groups which have provided rich data that will formulate an action plan in 2016
- Implemented new development programmes for Agenda for Change Bands 3-5 and 6-7, previously not included in internal Leadership Programme, and rolled out the Leadership 100 programme to additional cohorts at Bands 8 and above

In response to experiences of discrimination, the Trust is embarking on a variety of projects including –

- Establish Equality, Diversity and Inclusion (EDI) Steering Group with Board level leadership to drive Trust EDI priorities
- Rollout of *'Speak In Confidence'* anonymous dialogue system which enables staff to raise concerns they may have and to escalate anonymously

The Trust has a growing BME workforce broadening the talent and diversity of our workforce. The Trust is committed to creating a working environment in which its employees are treated fairly, feel valued and are engaged. It is working hard to promote equality in everything it does by embedding its CARES values of which 'equity' is one.

The Staff survey results enable us to compare metrics for the responses from white and BME staff and the new Workforce Race Equality Standard (WRES) provides a measure of the experiences of our White and BME workforce in accessing learning and development and career opportunities.

Action on staff survey results and equality and diversity issues for the workforce

- Data: There is ongoing work to improve our data collection and reporting and recent work with external consultants to review our procedures and processes along the nine protected characteristics. Findings will be implemented.
- Bullying and Harassment: Build on the work with '*Speak In Confidence'* which has prioritised the issue of bullying and harassment. At a local level broaden the capacity and capability of our CARES Ambassadors in providing individual and local support to victims of bullying and harassment.
- Review our zero tolerance campaign around the issue
- Increase range of learning and development opportunities offered to staff particularly those at bands 1-4
- Improve education and training governance including the improving of access to learning opportunities along the nine protected characteristics.
- Broaden our range of cultural awareness and Equality and diversity training to support recruitment and selection and key decision points.

Patients

The Trust is committed to equality, diversity and human rights. This means we work to make sure our staff and patients and communities are treated fairly and with respect. We aim to develop an inclusive culture where diversity is fully embedded into business practice. We also aim to influence change around reducing health inequalities and improving the patient experience whilst promoting a culture that embraces diversity and delivers measurable benefits.

The Trust prides itself in the fact that it does engage and will continue to engage the service users and staff to deepen its understanding of the equality themes. Engaging with our local communities that we serve and providing opportunities for service users to feed back on their experience is an important feature of our work.

Our equality objectives for 2015/16 were:

1. Caring for patients with dementia

Improvements in dementia care have continued throughout the year. Ensuring all relevant patients are screened for potential signs of dementia, and referred for follow up as indicated, has remained a priority, with over 1950 patients over 75 years admitted as an emergency having been assessed within 72 hours of admission.

Staff education has similarly remained a priority, with all staff receiving dementia awareness training on joining the Trust. This is delivered by the Dementia Clinical Nurse Specialist and is presented from the eyes of a patient, using the critically acclaimed “Barbara’s Story” DVD; this has now been seen by 3569 staff. Doctors, nurse and therapists receive more detailed bespoke clinical training and several go on to undertake the Alzheimers’ certificate or, for specific staff, a specialist module at university.

As well as welcoming cares to support their loved ones outside of visiting hours, experience for inpatients with dementia has been improved by the provision of more activities such as reminiscence rummage boxes, “fidget blankets”, singing and music sessions and provision of books, puzzles and board games. We continue to advocate an inclusive approach for patients with dementia, and aim to incorporate dementia-friendly design and facilities across all the Trust.

Future work is being driven by patient and carer feedback. All carers are offered the opportunity to complete a short survey about their experience while at the Trust. We will be participating in the National Dementia Audit early in 2016/17, the results of which will provide more guidance about which service developments we should prioritise.

2. Caring for people with a learning disability

In order to provide assurance that the Trust is listening and responding to the needs of patients with a Learning Disability, the Head of Safeguarding has attended a variety of forums where there are carers and service users. This is an excellent opportunity to hear the views of people to respond to their questions, and improve outcomes.

The Trust ensures staff awareness with regard to the need to listen and make reasonable adjustments for those with learning disability. Clinical and non-clinical staff receive awareness training as part of their mandatory safeguarding training making them more aware of the needs of learning disability patients and their carers.

The Good Practice Guidelines for staff working with people with learning disabilities remain in place. There are also care pathways for patients with learning disabilities in A&E, outpatients and the radiology department which continue to be used for patients with learning disabilities.

Patients with a learning disability can provide feedback to the Trust on their experience through completing an easy-read survey.

3. Improving services for people with a sensory disability

The Trust has engaged with service users with a sensory disability to capture their feedback on their experiences of accessing our services and receiving care. These included both positive and negative viewpoints. This has been invaluable in terms of ensuring our services are responsive to the needs of this group of service users. Some of these service users have expressed an interest to be involved in the design of new services. This will be taken forward by a task and finish group in 2016/17.

In 2015/16 the Trust has installed additional hearing induction loops based on feedback from patients. The introduction of the hearing loop system not only improves communication for these patients but also ensures their privacy, dignity and well-being.

Signage has been improved across both sites to ensure easier way-finding for patients and visitors. In addition the Trust has a contract with One Stop Language Services for the provision of BSL for patients using our services.

Annex 1 Statements from our stakeholders

Statement from Hillingdon Clinical Commissioning Group (CCG) (awaited)

Healthwatch Hillingdon's response to The Hillingdon Hospitals NHS Foundation Trust (the Trust) Quality Report 2015/16 (awaited)

Statement from External Services Scrutiny Committee (awaited)

The Hillingdon Hospitals NHS Foundation Trust response to the consultation

The Hillingdon Hospitals NHS Foundation Trust thanks all its stakeholders for their comments about the 2015/16 Quality Report…..

Independent Auditor's Report to the Council of Governors of The Hillingdon Hospitals NHS Foundation Trust on the Quality Report (awaited)

Annex 2 - Statement of Directors' responsibilities in respect of the Quality Report

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

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report. In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period April 2015 to 27th May 2016 (date of statement)
- papers relating to quality reported to the Board over the period April 2015 to 27th May 2016 (date of statement)
- feedback from commissioners dated May 2016
- feedback from governors dated May 2016
- feedback from local Healthwatch organisations dated May 2016
- feedback from Overview and Scrutiny Committee dated May 2016
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25th May 2016
- the latest national patient survey published May 2016
- the latest national staff survey dated 23rd February 2016
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 19th April 2016
- CQC Report dated (May 2015 re-inspection) 7th August 2015

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

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

By order of the board

…….. Date……Chairman

…….. Date……Chief Executive

Glossary

A	
Ambulatory Care Pathway	Allows patients who are safe to go home to be managed promptly as outpatients, without the need for admission to hospital, following an agreed plan of care for certain conditions.
B	
Berwick Review	Commissioned following the Mid Staffordshire Hospitals enquiry and publication of the Francis Report. The review includes recommendations to ensure a robust nationwide system for patient safety.
C	
Care Pathway	Anticipated care placed in an appropriate time frame which is written and agreed by a multidisciplinary team.
Care Quality Commission (CQC)	The independent regulator of health and social care in England. www.cqc.org.uk
Care Quality Commission (CQC) Intelligent Monitoring System	A form of monitoring to give CQC inspectors a clear picture of the areas of care that need to be followed up within an NHS acute Trust. Together with local information from partners and the public, this monitoring helps the CQC to decide when, where and what to inspect. 160 acute NHS Trusts are grouped into six priority bands for inspection based on the likelihood that people may not be receiving safe, effective, high quality care. Band 1 is the highest priority Trusts and band 6 the lowest.
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.
Clinical Negligence Scheme for Trusts (CNST) – Maternity	Administered by the NHS Litigation Authority (NHSLA), provides an indemnity to members / their employees in respect of clinical negligence claims. Trusts are assessed on their level of risk management against detailed standards.
Clostridium Difficile infection (C-Diff)	A type of infection that occurs in the bowel that can be fatal. There is a national indicator to measure the number of *C. Difficile* infections that occur in hospital.
Commissioning for Quality and Innovation (CQUIN)	A payment framework enabling commissioners to reward quality by linking a proportion of the Trust's income to the achievement of local quality improvement goals.
Community Acquired Pneumonia	Inflammatory condition of the lung usually caused by infection and acquired from normal social contact (that is, in the community) as opposed to being acquired during hospitalisation.
Computerised Tomography (CT)	This is an X-ray procedure that combines many X-ray images with the aid of a computer to generate cross-sectional views and, if needed, three-dimensional images of the internal organs and structures of the body
D	
Department of Health (DH)	The government department that provides strategic leadership to the NHS and social care organisations in England. www.dh.gov.uk
Deprivation of Liberty Safeguards (DoLS)	The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
Diabetic Ketoacidosis (DKA)	Consistently high blood glucose levels can lead to a condition called diabetic ketoacidosis (DKA). This happens when a severe lack of insulin means the body cannot use glucose for energy, and the body starts to break down other body tissue as an alternative energy source. Ketones are the by-product of this process. Ketones are poisonous chemicals which build up and, if left unchecked, and will cause the body to become acidic – hence the name 'acidosis'

Dr Foster	An organisation that provides healthcare information enabling healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency.
E	
Eighteen (18) week wait	A national target to ensure that no patient waits more than 18 weeks from GP referral to treatment. It is designed to improve patients' experience of the NHS, delivering quality care without unnecessary delays.
Electronic Document Records System	This helps the Trust to manage clinical records in electronic format making records management more efficient and ensuring patient records are more accessible to clinicians.
F	
FAIR assessment for dementia	Find, Assess, Investigate and Refer (FAIR) - The identification of patients with dementia and other causes of cognitive impairment that prompts appropriate referral and follow up after they leave hospital and ensures that hospitals deliver high quality care to people with dementia and support their carers.
Foundation Trust (FT)	NHS foundation Trusts were created to devolve decision making from central government to local organisations and communities. They still provide and develop health care according to core NHS principles - free care, based on need and not ability to pay.
Friends and Family Test (FFT)	An opportunity for patients to provide feedback on the care and treatment they receive. Introduced in 2013 the survey asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment.
G	
'Getting it right first time' (GIRFT)	The 'Getting it right first time' (GIRFT) report published by Professor Briggs in late 2012, considered the current state of England's orthopaedic surgery provision and suggested that changes can be made to improve pathways of care, patient experience, and outcomes with significant cost savings.
Governors	The Hillingdon Hospitals NHS Foundation Trust has a Council of Governors. Governors are central to the local accountability of our foundation Trust and helps ensure the Trust board takes account of members and stakeholders views when making important decisions.
GP Commissioners	GP Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services.
H	
Health and Social Care Information centre (HSCIC)	The HSCIC is an Executive Non Departmental Public Body (ENDPB) set up in April 2013. It collects, analyses and presents national health and social care data helping health and care organisations to assess their performance compared to other organisations.
Healthwatch (formerly LINk)	Healthwatch is a new independent consumer champion that gathers and represents the views of the public about health and social care services in England. http://www.healthwatch.co.uk
Hospital Episode Statistics (HES)	The national statistical data warehouse for the NHS in England. 'HES' is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations.
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares Trusts against a national average.
I	
Independent mental Capacity Advocate (IMCA)	IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they

	live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.
Indicator	A measure that determines whether the goal or an element of the goal has been achieved.
Inpatient	A patient who is admitted to a ward and staying in the hospital.
Inpatient Survey	An annual, national survey of the experiences of patients who have stayed in hospital. All NHS Trusts are required to participate.
K	
Keogh Review	A review of the quality of care and treatment provided by those NHS Trusts and NHS foundation Trusts that were persistent outliers on mortality indicators. A total of 14 hospital Trusts were investigated as part of this review.
L	
Local Clinical Audit	A type of quality improvement project involving individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team.
London Health Programme Standards	Programme to improve the quality and safety of acute emergency and maternity services based on achieving key standards of practice.
M	
Mandatory	Mandatory means 'must' as outlined by an organisation for the role of the staff member.
Mental Capacity Act (MCA)	The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Examples of people who may lack capacity include those with: dementia, severe learning disability, brain injury, a mental health condition, a stroke or may experience unconsciousness caused by an anaesthetic or sudden accident
Meticillin-resistant staphylococcus aureus (MRSA)	A type of infection that can be fatal. There is a national indicator to measure the number of MRSA infections that occur in hospitals.
Meticillin-sensitive Staphylococcus aureus (MSSS)	MSSA can cause serious infections, however unlike MRSA MSSA is more sensitive to antibiotics.
Monitor	The independent regulator of NHS foundation Trusts. http://www.monitor.gov.uk
Multidisciplinary team meeting (MDT)	A meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients.
N	
National Clinical Audit	A clinical audit that engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and all NHS Trusts are expected to participate in the national audit programme.
National Reporting and Learning System (NRLS)	The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports submitted from health care organisations. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

Never events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Trusts are required to report nationally if a never event occurs.
National Early Warning Scoring system	An early warning scoring system used to track patient deterioration and to trigger escalations in clinical monitoring and rapid response by the critical care outreach team. The scoring system used to trigger escalation is based on routine observations of respiratory rate, oxygen saturation levels, blood pressure, temperature, pulse rate and level of consciousness combined to give weighted scores that in turn trigger graded clinical responses.
NHS Litigation Authority (NHSLA)	Established to indemnify NHS Trusts in respect of both clinical negligence and non-clinical risks. It manages both claims and litigation and has established risk management programmes against which NHS Trusts are assessed.
NHS number	A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
O	
Operating Framework	An NHS- wide document outlining the business and planning arrangements for the NHS. It describes the national priorities, system levers and enablers needed to build strong foundations whilst keeping tight financial control.
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but is not admitted to a ward and is not staying in this hospital.
Overview and Scrutiny Committee (OSC)	OSC looks at the work of NHS Trusts and acts as a 'critical friend' by suggesting ways that health-related services might be improved. It also looks at the way the health service interacts with social care services, the voluntary sector, independent providers and other Council services to jointly provide better health services to meet the diverse needs of the area.
P	
PAS- Patient Administration System	The system used across the Trust to electronically record patient information e.g. contact details, appointment, admissions.
Pressure ulcers	Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients than in people who are fit and well, as patients are often not able to move about as normal.
Priorities for improvement	There is a national requirement for Trusts to select three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and patient outcomes.
PROMs (Patient Reported Outcome Measures)	PROMs collect information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. Hospitals providing four key elective surgeries invite patients to complete questionnaires before and after their surgery The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations.
Pulmonary Embolism (PE)	A blood clot in the lung.
R	
Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge from hospital.
Root Cause Analysis (RCA)	A method of problem solving that looks deeper into problems to identify the root causes and find out why they're happening.
S	
Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. http://www.hscic.gov.uk/thermometer

Secondary Uses Service (SUS)	A national NHS database of activity in Trusts, used for performance monitoring, reconciliation and payments.
Sepsis	A potentially fatal whole-body inflammation (a systemic inflammatory response syndrome) caused by severe infection.
Serious Incidents	An incident requiring investigation that results in one of the following: • Unexpected or avoidable death • Serious harm • Prevents an organisation's ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern • Never events
Shaping a Healthier Future (SaHF)	A programme to improve NHS services for people who live in North West London bringing as much care as possible nearer to patients. It includes centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and incorporating this into one co-ordinated system of care so that all the organisations and facilities involved in caring for patients can deliver high-quality care and an excellent experience.
Single sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender.
Statutory	Statutory means 'by law'.
Streamlining for London Programme	Collaboration between HR for London, NHS Employers and Skills for Health. The focus is on bringing people together to compare performance, share best practices, overcome issues and work collectively to drive change that leads to improved efficiency and patient safety.
Summary Hospital-level Mortality Indicator (SHMI)	The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
V	
Venous thromboembolism (VTE)	An umbrella term to describe venous thrombus and pulmonary embolism. Venous thrombus is a blood clot in a vein (often leg or pelvis) and a pulmonary embolism is a blood clot in the lung. There is a national indicator to monitor the number of patients admitted to hospital who have had an assessment made of the risk of them developing a VTE
W	
Whole Systems Integrated Care (WSIC)	The Whole Systems Integrated Care programme aims to improve the quality and experience of care for patients and service users, save money across the local health and social care system, and enhance professional experience by helping people n health and social care work more effectively together.

Languages/ Alternative Formats

Please call the Patient Advice and Liaison Service (PALS) if you require this information in other languages, large print or audio format on: 01895 279973. www.thh.nhs.uk

Fadlan waydii haddii aad warbixintan ku rabto luqad ama hab kale. Fadlan la xidhiidh 01895 279 973

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ ਵਿੱਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਪਤਾ ਕਰਨ ਲਈ 01895 279973 ਤੇ ਸੰਪਰਕ ਕਰੋ

برائے مہربانی جے تہانوں اے اطلاع کسے اور زبان یا انداز وچ چاہی دی اے تے پتہ کرن لئی 01895 279 973 تے رابطہ کرو

தயவுசெய்து, வேற்று மொழிகளில் இத் தகவல்கள், கட்டுமானம் தேவையெனில், கேளுங்கள்.! தயவுசெய்து 01895 279973 இலக்கத்துடன் தொடர்பு கொள்ளுங்கள்.!

Jeżeli chcialbyś uzyskać te informacje w innym języku, w dużej czcionce lub w formacie audio, poproś pracownika oddzialu o kontakt z biurem informacji pacjenta (patient information) pod numerem telefonu: 01895 279973.

如果你需要這些資料的其他語言版本、大字体、或音頻格式，請致電01895 279 973 查詢。

إذا كنت تود الحصول على هذه المعلومات بلغة أخرى، بالأحرف الكبيرة أو بشكل شريط صوتي، يرجى الاتصال بالرقم التالي 01895279973 .