Quality report 2015-16

Draft for Consultation
Issued; 21st April 2016

Please note the information contained in this report is subject to validation and will be updated prior to finalisation.

Contents:

About the Trust's quality report

About the Trust

Royal Brompton & Harefield NHS Foundation Trust is the largest specialist heart and lung centre in the UK and amongst the largest in Europe. We work from two sites, Royal Brompton Hospital in Chelsea and Harefield Hospital near Uxbridge. As a specialist trust our doctors, nurses and other healthcare staff are experts in their chosen fields and we are known throughout the world for our expertise, standard of care and research success.

We offer some of the most sophisticated treatment that is available anywhere in the world and treat patients from all over the UK and around the globe. Over the years our experts have been responsible for several major medical breakthroughs – such as performing the first combined heart and lung transplant procedure in Britain, implanting the first coronary stent (to unblock an artery) and founding the largest centre for cystic fibrosis in the UK.

Some useful facts about the Trust:

- In 2015-16 we cared for 190,897 patients at our outpatient clinics and 40,044 patients of all ages on our wards.
- We are Europe's top-ranked respiratory research centre and our cardiac, cardiovascular and critical care teams are rated in the top three most highly cited health research teams in England.
- Our Heart Attack Centre at Harefield has pioneered the use of primary angioplasty for the treatment of heart attacks and has one of the fastest arrival-to-treatment times in the UK (23 minutes compared to a national average of 56), a crucial factor in patients' survival.
- Europe's largest unit for the treatment of cystic fibrosis is based at Royal Brompton Hospital.
- Our on-site foetal cardiology service enables clinicians to begin caring for babies while still in the womb; many are scanned at just 12 weeks, when the heart measures just over a millimetre.
- The Ventricular Assist Device (artificial heart) programme at Harefield Hospital is one of the world's most established programmes with a long history of clinical and scientific excellence.
- We are the country's largest centre for the treatment of adult congenital heart disease, staffed by a specialist team including four full-time specialist consultants.
- Harefield has one of the most advanced cardiac catheterisation laboratories of its kind in Europe. The state-of-the-art equipment includes a remote-controlled robot that uses high-tech 3D mapping enabling precise catheter manipulation and the reduction of exposure to X-rays for patients and staff.
- Every year we help almost 12500 adults who have breathing problems caused by diseases such as COPD (chronic obstructive pulmonary disease) and severe asthma.

- We provide specialised care for patients with suspected or diagnosed cancer affecting the chest (thoracic oncology). We have a specialist 'lung laser' device which uses a special wavelength laser beam to assist the surgeon in removing tumours from patients' lungs with minimal damage to neighbouring healthy lung tissue.

What is a quality report?

A quality report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. All NHS providers strive to achieve high quality care for all, and the quality report provides the Trust an opportunity to demonstrate our commitment to quality improvement and show what progress we have made in 2015-16. The quality report is a mandated document which is laid before parliament before being made available to the public on NHS Choices website.

What is included in a quality report?

The quality report is a mandated document that contains specific mandatory statements and sections. These statements cover areas such as our participation in national audits, research activity, and our registration as a healthcare provider with the Care Quality Commission (CQC).

There are also three areas that are mandated by the Department of Health (DH) which give us a framework in which to focus our quality improvement programme, these are patient safety, patient experience and patient outcomes. To identify the Trust quality improvement priorities for 2015-16 and to reflect the priorities of our patients, the public, staff, and people we work with, there was a voting system. People were asked to choose the topics that were most important to them that fell within the three areas mandated by the DH.

The section on the Trust's quality priorities highlight:

- the areas identified for improvement for 2015-16
- what the priority was
- how we performed against the targets
- and what that means for patients

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

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

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

Statement of directors' responsibilities

The directors of Royal Brompton & Harefield NHS Foundation Trust have prepared this Quality Report 2015-16, as required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

The directors are satisfied that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015-16;
- the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2015 to March 2016
    - papers relating to quality to the Board for the period April 2015 - March 2016
    - feedback from NHS England dated xx/05/2015
    - feedback from governors dated xx/05/2015
    - feedback from local Healthwatch organisations dated xx/05/2015
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/xx/16
    - the national inpatient survey 2015
    - the national staff survey 2015
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated xx/xx/16
    - the CQC Intelligent Report Monitoring dated May 2015

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

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

By order of the Board:

Neil Lerner
Deputy Chairman
xx May 2016

Robert J Bell
Chief Executive
xx May 2016

Part 1: Chief executive statement

Royal Brompton & Harefield NHS Foundation Trust helps patients of all ages who have heart and lung problems. From the moment they arrive, our patients become part of a community of people who have benefited from more than 160 years of expert diagnosis, treatment and long-term care. Our care extends from pregnancy, through childhood, adolescence and into adulthood and, because this is a specialist trust, patients come from all over the UK, not just from our local areas.

We are committed to providing patients with the best possible specialist treatment for their heart and lung condition in a clean, safe place, ensuring that evidence-based care is provided at the right time, in the right way, by the right people.

Our mission is to be 'the UK's leading specialist centre for heart and lung disease'. The Trust will achieve this mission by a strategy of focused growth in aspects of heart and lung treatment, particularly in congenital heart disease, arrhythmia, advanced lung diseases and heart failure. We have set three strategic goals to ensure we achieve this:

- Service excellence
- Organisational excellence
- Productivity and investment

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

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

The period from 1 April 2015 to 31 March 2016 has been the sixth full year in which the organisation has operated as a Foundation Trust. During the year, the Trust has achieved all of the governance targets and indicators set out in the Risk Assessment Framework issued by Monitor apart from the indicator relating to the 62 day cancer wait target and the 18 week referral to treatment time target for incomplete pathways. These target failures were forecast in the Forward Plan submitted to NHS Improvement and are mainly due to late referrals from referring centres for surgical treatment of lung cancer and operational pressures in respect of the 18 week pathway. The Trust continues to be registered by the Care Quality Commission without conditions.

Significant events for 2015-16:

- In the Intelligent Monitoring report, published by the CQC in May 2015, the Trust was placed in band 3 which indicated a relatively low risk (band 1 being highest risk and band 6 being lowest risk).
- The Trust has been working closely with its commissioners at both local and national level. Excellent links have been built up and there is a Clinical Quality Review Group in place, where information about the quality of our services can be discussed in an open and transparent manner with our commissioners on a regular basis. A particular focus for improvement has been in relation to waiting times for surgical treatment for lung cancer. This has been a quality priority during 2015/16 and will continue to be so during 2016/17.

The Trust remains committed to the provision of high quality services for patients of all ages. The Trust intends to develop its services, and premises, in the future to ensure on-going delivery of this commitment.

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

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

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.

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

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust, its Board and management team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate with the exception of the matters identified in respect of the 18 week referral to treatment incomplete pathway indicator as described on page xx of this report.

Signed:

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

Part 2: Review of quality priorities for improvement

Part 2a: Quality priorities for improvement 2015-16

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

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

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

The Quality Priorities chosen for 2015-16 were:

What is patient safety?

Patient safety is ensuring we treat and care for people in a safe environment and protecting them from avoidable harm (DH definition)

What is patient experience?

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

Quality priority one

Improving our Organisational Safety Culture

What are the aims?

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

How did we measure this?

We will measure through a number of different methods, through the outcomes of the Staff Safety Climate Survey, an increase in reporting of incidents via the DATIX system, executive patient safety walk rounds, training staff in Quality Improvement Methodology, Root Cause Analysis and Being Open, human factors and simulation training.

The Safety Climate Survey was undertaken between October and December 2015. 865 members of front-line staff completed the survey. The scores shown in the table below are reported as the percentage of staff responding positively to the question posed.

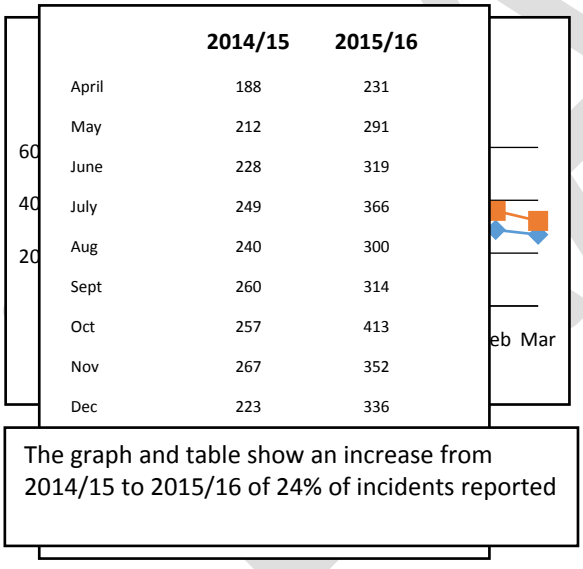
Domain	Overall score
Teamwork – the perceived quality of teamwork and collaboration	78%
Safety – The perceived level of commitment to and focus on patient safety	72%
Job satisfaction - Employees' general feelings of positivity regarding their work	80%
Stress recognition - Employees recognition of how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

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

Executive patient safety walk rounds

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

An increase in reporting of incidents via the DATIX system



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

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

Training

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

Quality priority two

Improving the Patient Experience for the cardiac surgery pathway

What are our aims?

We aim to improve the patient experience through improved management of the 18 week pathway and by reducing the number of operations cancelled for non-clinical reasons.

How will we measure this?

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

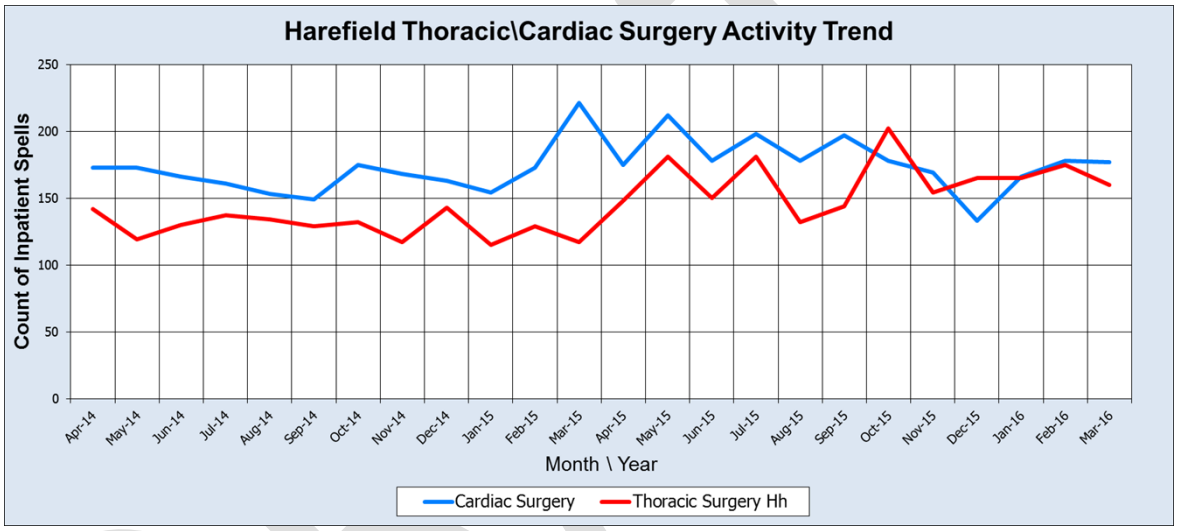
Progress and Outcomes

At Royal Brompton Hospital:

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

At Harefield Hospital:

- between April 2015 and February 2016 there was a significant (43%) increase in cancellations of cardiac surgery for non-clinical reasons, 294 in 2015/16 compared to 205 in 2014/15. The main cause of the increase was additional pressure on ward-beds (i.e. hospital admissions being cancelled) as a consequence of growing thoracic surgical activity as we strive to admit cancer patients promptly for surgery (see chart below), thus restricting the no. of beds available for cardiac surgery. In response to these pressures, a regular cancellations review meeting has been initiated and the team are aiming to increase the number of 'day-of-surgery' admissions in order to reduce length of stay and where possible.
- There was a small (5%) reduction in 2015/16 in the number of patients whose pathway exceeded the 18-week target (from 276 to 261).



Quality priority three

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

What are the aims?

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

How did we measure this?

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

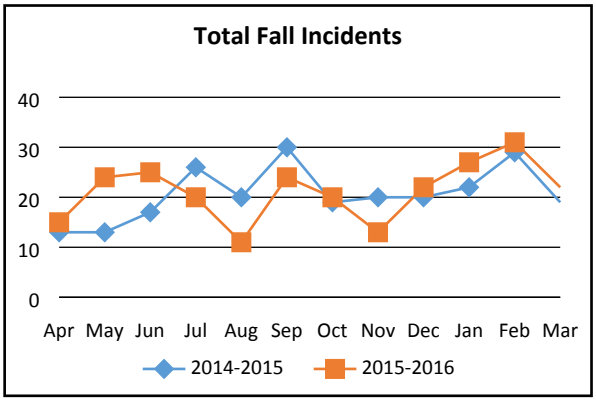
Pressure Ulcers

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

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

Patient Falls

- Monthly audits and point prevalence – link to safety thermometer
- Regular falls prevention incident reporting feedback sessions with nursing staff
- Falls group- looks at all falls trust-wide
- Weekly reports of patient falls to ward sisters, charge nurses, matrons. Report includes a section on whether or not the falls risk assessment was completed



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

Quality priority four

Improving the management of patients with Cancer

What are the aims?
We intend to continue the focus on improving overall waiting times for the 62 day cancer pathway. In addition, we want to ensure that cancer patients receive the best possible experience whilst in our care, receiving the appropriate interventions and information at the right time.

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

Progress and Outcomes
A 2015/6 Performance Overview report was completed by the Cancer Manager in March 2016 in order to provide an update on quality priority 4 – "Improving the management of patients with cancer". The report concluded that, whilst the cancer waiting-time target is a challenge, we need to continue to work with our network of referring hospitals to assist in improving the lung cancer referral pathway for all patients. The external Cancer Service Review (being undertaken by Dr Pallav Shah (RB&H) and Dr Sanjay Popat (Royal Marsden) as a follow-up to their 2014 review) will be available by the end of April 2016. It will focus on the parts of the lung cancer pathway that can be improved so that patients can be seen and diagnosed earlier, and then referred promptly for treatment, thus reducing overall waiting-times.

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

The following report was completed by the Lung Division Cancer manager in March 2016 and aims to provide an update on quality priority four - Improving the management of patients with Cancer.

Introduction
This Lung Cancer Service Performance Overview 2015/16 report aims to provide an interim overview for lung cancer services at Royal Brompton & Harefield NHS Foundation Trust. There has been a separate review commissioned by Professor Tim Evans to be completed by Dr Pallav Shah and Dr Sanjay Popat which will report in April 2016.

The Trust acknowledges the difficulties of meeting the 85% 62 day cancer target and that this has not been met for some time. It should be noted that the difficulties in meeting this target are not new for the Trust. There has been, since the change in cancer waiting times

reporting in 2009, some allowances and adjustments made by commissioners and the CQC. In September 2010 a review by the CQC identified that without making a suitable allowance, specialist trusts performance would be 'unfairly represented' and proposed a 79% target. In addition to the reallocation process this helped improve performance but did not necessarily help improve the overall cancer pathway.

In recognition Monitor and NHS England in 2013/14 reviewed all pathways and re-established the 85% target for all Trusts that manage cancer patients on the 62 day pathway regardless of the specialist nature or complexities of patients.

The purpose of this paper is to therefore provide information relating to some of the broader aspects of quality and safety relating to the lung cancer service.

In assessing the safety and quality of the lung cancer service understanding the surgical outcomes of the thoracic surgery department is important. The latest national data from The Society of Cardiothoracic Surgeons (SCTS) that focuses on lung cancer and thoracic surgery was published last year and uses the time period 2011-2014. Furthermore it will also be important to understand the current patient experience and comparisons against other national lung cancer centres.

A summary of total activity, 30 and 90 day mortality, in-hospital mortality, surgical procedure type and national patient experience results will provide a broad aspect of the safety and quality of the service.

Total Activity

The latest full financial year for analysis is 2014/15. The data for this has been published for all thoracic surgery procedures and provides a full year of patient activity. The latest 15/16 activity up to Q3 is also displayed for information.

There were a total of 2,293 thoracic surgical procedures performed in 2014/15 of which 341 were for first time primary lung cancer, around 15% of the workload for the thoracic surgery department. Table 1 from the thoracic outcomes and surgical activity report for 14/15 breaks this down further.

Table 1

	Total No. of	Total lung	% of total operation	Primary Lung Cancer	Metastatic Disease			Other*
					Colorectal	Sarcoma	Other	
EL	148	79	53.38%	57	4	0	5	13
GL	144	91	63.19%	16	41	20	7	7
MD	349	142	40.69%	72	11	0	11	48
SJ	436	125	28.67%	23	5	27	5	65
RBH	**1077**	**437**	**40.58%**	**168**	**61**	**47**	**28**	**133**
EB	324	94	29.01%	60	3	1	5	25
VA	311	103	33.12%	52	6	0	5	40
DK	118	30	25.42%	10	0	1	0	19
NM	412	84	20.39%	49	4	0	3	28
NA	51	17	33.33%	2	3	0	0	12
HH	**1216**	**328**	**26.97%**	**173**	**16**	**2**	**13**	**124**
Trust	**2293**	**765**	**33.36%**	**341**	**77**	**49**	**41**	**257**

* 'Other' lung resections include pulmonary resection for benign tumours and various types of infections and pathologies.

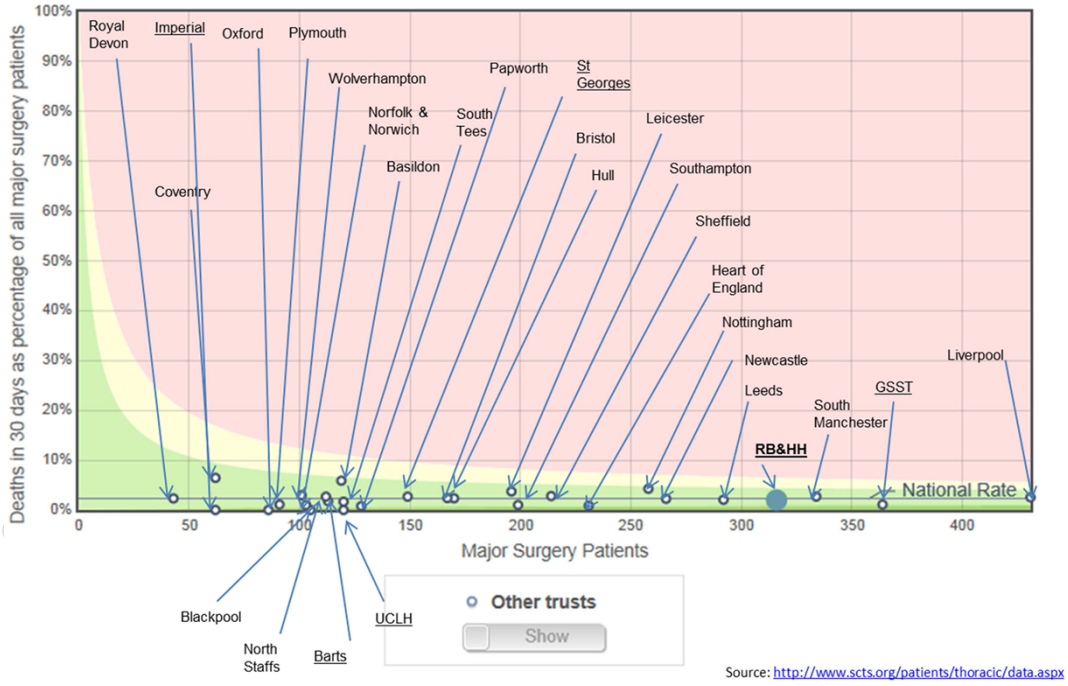
There were a total of 1,840 thoracic surgical procedures performed across the Trust by the end of Q3 for the financial year 15/16 (table 2), with an un-validated position of 315 treatments for first time primary lung cancer.

Table 2

Total Thoracic Surgical Activity to date 15/16				
	Q1	**Q2**	**Q3**	**totals**
Harefield	359	383	379	1121
Royal Brompton	248	230	241	719
Trust	**607**	**613**	**620**	**1840**

otal first time primary lung cancer resections comparison, England NHS Trusts, 2012

Graph 1



Source: http://www.scts.org/patients/thoracic/data.aspx

Graph 1 displays the total number of primary lung cancer resections completed by each thoracic surgical unit in England for 2012. This is the latest data for this national activity at present. RB&HH, as marked in bold, demonstrates that the Trust is in the top four in England, in terms of total first time primary lung cancer resections performed with a better than England average post-operative death rate (after 30 days).

30 and 90 day mortality primary lung cancer resections

Patients who have had a first time primary lung cancer resection and are alive after 30 days and 90 days is a monitored outcome for good surgical performance and is reported centrally.

The latest data that has been submitted across thoracic surgical centres in England was published for patients who were diagnosed and had an operation for primary lung cancer in 2012. Table 3 shows that for 2012 the observed mortality rate for patients who died (any cause) after 30 days of a lung cancer operation at the Royal Brompton & Harefield NHS Trust was 2.0% against the England total of 2.2%. Observed mortality after 90 days was 3.3% against the England total of 4.5%.

Table 3

Name	Total Ops		
		Died within 30 days (any cause)	Died within 90 days (any cause)
Royal Brompton & Harefield NHS Foundation Trust	316	6 (2.0%)	10 (3.3%)
England Total	4952	107 (2.2%)	224 (4.5%)

There is further work on going with the national lung cancer audit and the society of cardiothoracic surgeons to produce the latest comparable mortality figures for 2013/2014, this should be available soon. There is also an internal audit under way to produce this for the quarterly thoracic surgery governance day and will hopefully become a formalised indicator that will be discussed each month from April 2016.

In-hospital mortality

In-hospital mortality rates, the number of patients who die following surgery in hospital, are another indicator of good surgical performance.

The most recent national rate published by the SCTS for all thoracic surgery mortality is 1.4% for 2012-13. RBH and HH both have a mortality rate which is below the national rate. The SCTS publish mortality rates following operations for primary lung cancer however the number of these operations in this Trust are too small and varies greatly among the Consultant surgeons to gain any significant conclusions in comparing this data. For 2014/15 the observed mortality at the Trust within thoracic surgery was 1%. (Table 4)

We are able to risk stratify thoracic surgical mortality data with the 'Thoracoscore', a risk model for in-hospital mortality for thoracic surgery. A Thoracoscore is calculated for each surgical patient based on a number of fields captured in the database namely; age, sex, BMI, co-morbidity, ASA grade, dyspnoea score, ECOG score, priority of operation and type of operation. A predicted mortality rate for a group of patients is calculated by the average of their Thoracoscores. The risk stratified data has become increasingly robust with 99.5% Thoracoscores complete across both hospitals for 2014-15.

Table 4

	No. of deaths/total procedures	Observed Mortality	Predicted Mortality	Performance
Trust	23/2294	1.00%	1.66%	Stat. sig. better than expected

Surgical Procedure Type

The Society of Cardiothoracic Surgery (SCTS) has been reporting a steady decline in the number of pneumonectomies being performed with the rate of lobectomies and sublobar resections subsequently on the rise. This shift in proportion is considered a marker of good quality of service. While a pneumonectomy is a somewhat less complex procedure to lobectomies and indeed sleeve lobectomies, it can result in poorer outcomes for the patient.

The SCTS reports a national rate of pneumonectomy to be approximately 9%, lobectomies approximately 73% and sublobar resections approximately 18% for primary lung cancers in their 2011 Blue Book. The most recent reported rate pneumonectomies for primary lung cancer is 6% (2012-2013).

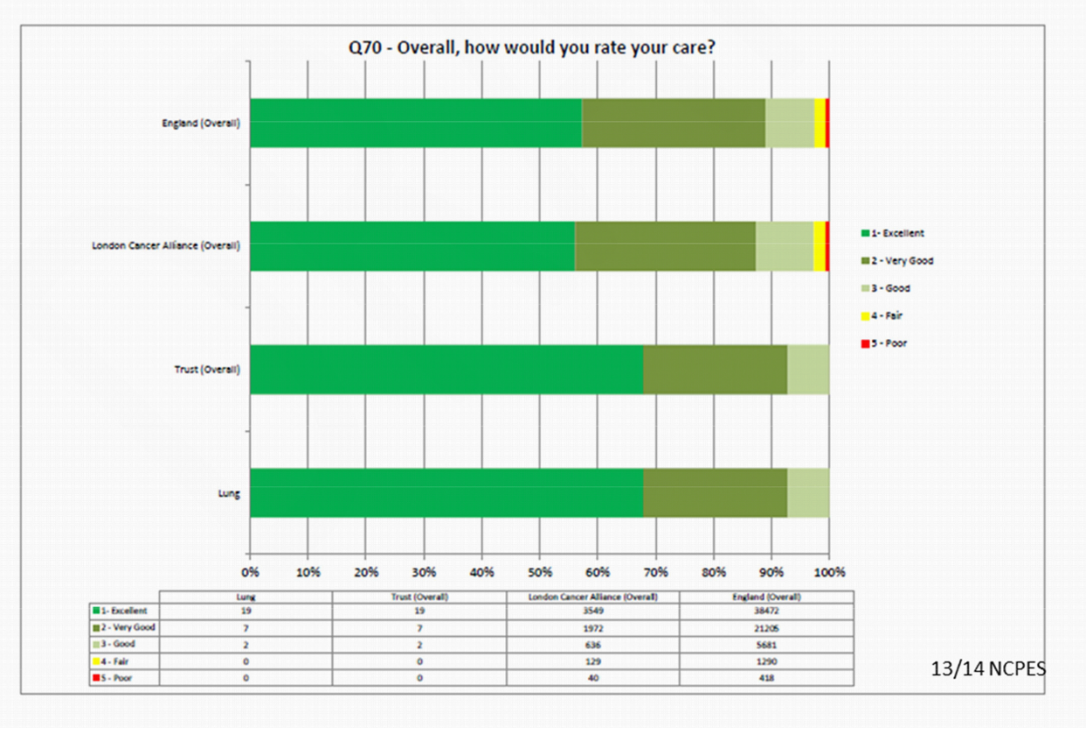
In 2014/15 the Trust had a pneumonectomy rate of 3.52% (n=12/341) for primary lung cancer, this figure has increased from the trust rate reported in 2013-14 of 2.42% (n=9/372) for primary lung cancer. However this new figure has decreased from the Trust rate of 4.29% in 2012-13 (n=14/326) and is significantly lower than the national rate of 9% reported by the SCTS 2011. The number of lobectomies has not changed significantly from the figure reported in 2013-14 (n=286/372). However the number of sublobar resections has dropped approximately by 5% since the rate reported in 2013-14. (COR, 2015).

Patient Experience

Since 2011 all NHS Trusts that provide cancer services have been involved in a national patient survey, there have been four published surveys to date. The 2015 National Cancer Patient Experience Survey (NCPES) is currently underway. It is being led by Quality Health and undertakes an exercise of sending questionnaires to all patients who have received a first time treatment for cancer across 148 Acute Trusts in England. As of February 2016 the overall national response rate at this stage is 62%, the response rate for Royal Brompton & Harefield NHS Foundation Trust is 60%. The final results of the survey are due to be published in the autumn of 2016.

The overall outcomes from the latest NCPES are from 2013/14, overall the Trust does well, despite there being a small sample group and a small sample period. As noted below, table 5, around how patients rate their care, at RBH we perform better than the England, London and tumour site average.

Table 5



	Lung	Trust (Overall)	London Cancer Alliance (Overall)	England (Overall)
1- Excellent	19	19	3549	38472
2 - Very Good	7	7	1972	21206
3 - Good	2	2	636	5681
4 - Fair	0	0	129	1290
5 - Poor	0	0	40	418

Survey results and findings do need to be further analysed and there can be some limitations to how services can be improved by surveys alone. Therefore In 2012 the cancer services team participated in a piece of research with Oxford University and the Kingsfund using an accelerated form of experience based co-design (Locock L, 2014). This approach to working with patients and staff to improve overall experience at the Trust has now been in-grained within the team. The research developed into a standard approach for events for both patients and staff to discuss their pathway and way of working across the day to see where improvements could be made. There are two events planned for 2016/17 in July and

August that will aim to focus on patients with secondary cancers, a group of patients not surveyed in the National Cancer Patient Experience Survey.

Health and Wellbeing Events for people with cancer have been developed following the National Cancer Survivorship Initiative (Richards et al 2011). They are designed to provide an opportunity to gain information and support to help manage the consequences of cancer and make positive life-style changes (NCSI 2013). Half day events were held in March, June and October 2015 with further events planned this year, the next in June 2016. The half day provided patients who attended talks from various specialists around physically activity and healthy eating, mindfulness and emotional wellbeing as well as 'market stalls' designed to provide further advice and information on lung cancer, welfare rights and complementary therapies.

The lung cancer service aims to continue with these three tested ways of introducing the patients and carers voices and experiences back into improving the service into 2016/17.

Conclusion

The Trust is aware that whilst the cancer waiting time target is a challenge, we need to continue to work with our referring partners to assist in improving the lung cancer pathway for all patients. The further Cancer Service Review by Dr Shah and Dr Popat will also assess the appropriateness of which parts of the lung cancer pathway can be improved so that patients can be seen, diagnosed earlier and referred quickly for treatment, this will ultimately lead to improving overall waiting times.

However it is also clear that there are various clinical and patient experience indicators of lung cancer performance, that in addition to the cancer waiting times performance, should be considered as part of the over quality and safety of the service provided at the Royal Brompton & Harefield NHS Foundation Trust.

In terms of lung cancer resections alone, the Trust is in the top four performing hospitals in the country and has a better than average in-hospital mortality rate, as well as a better than England average for 30 and 90 day post- operative mortality rate for first time primary lung cancer resections. It is therefore important that these indicators are also monitored on a regular basis and form part of the overall assessment of the lung cancer service going forward.

Quality priority five

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

What are the aims?

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

How are we measuring this?

For AKI – incidence of RRT, readmission rates, incidence of KDIGO AKI1, AKI2, AKI3, % CCL risk assessments completed, % risk assessment pre CT scan, % appropriately monitored and adjusted aminoglycosides, glycopeptides. Audit of laboratory alerts leading to change in patient management.

- Group convened cross site late September to discuss plan and review baseline data from CDW
- Software switched on in Labs to highlight abnormal results – 2.11.2015
- Monthly reporting agreed -commenced end of November 15

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

- The introduction of the revised NEWS observation charts pilot started in December 15
- Education initiative for medical staff at Jan 16 Governance day. Nursing staff education to be arranged
- Roll out of the observation chart to all other areas commencing 1st May 2016
- Monthly audits to commence June 2016 (5 charts per ward) initially as the modified charts are being introduced and once we have assurance that the forms are being used correctly and NEWS scores calculated appropriately quarterly audits will be undertaken.

Quality priority six

Safer Use of Medicines and Medical Devices

What are the aims?

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

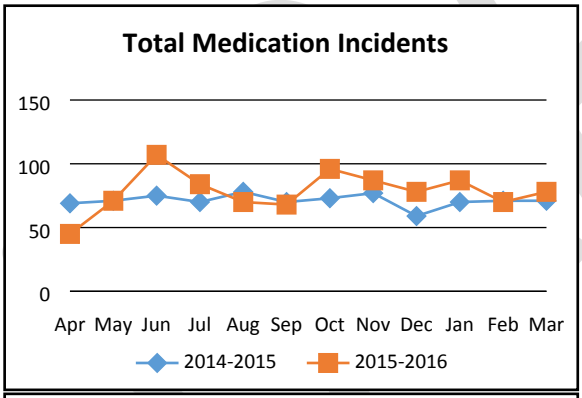
How did we measure this?

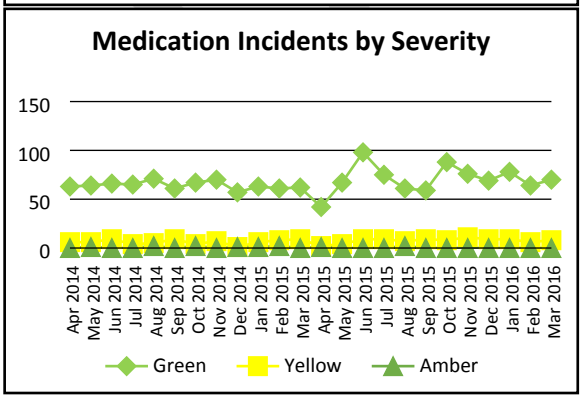
We will monitor the number of medication and device incidents reported by severity per month

Medicines

- Medication safety groups in place for wards and critical care
- Meetings held quarterly
- Newsletter to be agreed
- Medication related incidents discussed at incident reporting feedback session

The graph and table show an increase from 2014/15 to 2015/16 of 9% of medication related incidents reported



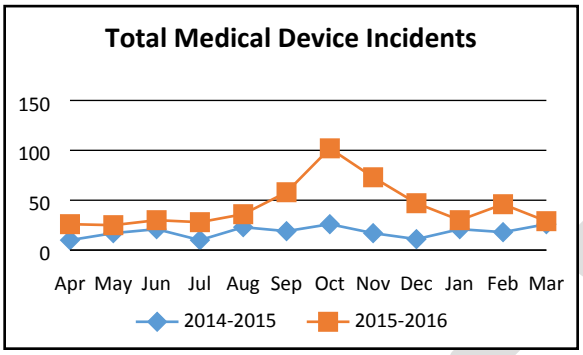


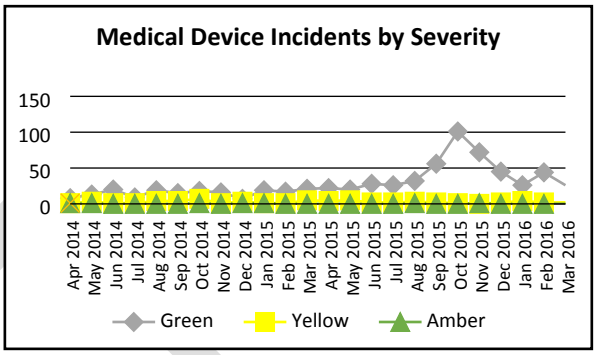
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-2015	69	71	75	70	78	70	73	77	59	70	71	71
2015-2016	45	71	107	84	70	68	96	87	78	87	70	78

Medical Devices

- Cross-site Medical Devices Safety Group in place with quarterly meetings
- Specimen device incident report circulated and presented at June CGHD
- Feedback sessions

The graph and table show an increase from 2014/15 to 2015/16 of 9.5% of medical device related incidents reported





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

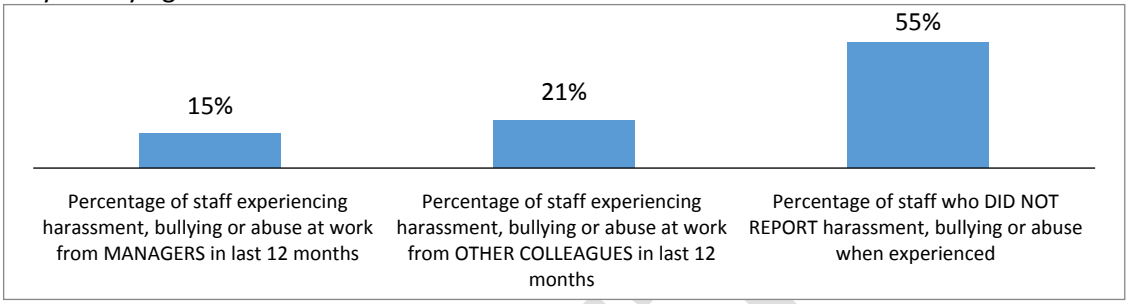
Duty of Candour

The lead for Duty of Candour is Elizabeth J Haxby, Lead Clinician in Clinical Risk. The Adverse Incident policy makes specific reference to Duty of Candour.

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

Staff Survey

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



The 'Working Together Better for Patients' initiative has now been running for three years, and offers departments the opportunity to take part in a team based course to try and target any areas where there has been a particular issue with conflicts between staff. Historically these courses have been run on a voluntary basis, with departments/managers putting their area forwards should they deem it necessary. However, going forwards, it could be beneficial to run mandatory sessions for departments or specific staff groups that report high levels of harassment and bullying in the staff survey.

In areas that report higher levels of harassment and bullying from managers, refresher courses in leadership and management could become mandatory for all team leaders. Alternatively, a refresher course could be made mandatory for all managers across the Trust every 3 years.

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

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

The Trust offers all full time permanent staff up to £2000 per annum as a study budget for courses relevant to their post or career development. The Learning and Development department also run a variety of courses cross site, including First line leadership development, Advanced leadership development, Coaching and Coach training, Clinical Leadership Development as well as personal development courses.

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

The Nursing Development team also run a huge range of courses across the Trust, including professional development study days, critical care courses, clinical skills courses and many more.

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

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

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

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

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

3. Projects

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

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

Part 2c: Performance against national quality indicators

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

Indicator	From local Trust data		Benchmark Comparisons					Benchmark Data Source
	2014-15	2015-16	Most recent results for Trust	Time period for most recent Trust results	Best result nationally	Worst result nationally	National average	
Domain 3: Helping people recover from episodes of ill health or following injury								
Percentage of emergency readmissions to our own hospitals occurring within 28 days of the last, previous discharge from hospital after admission.			No benchmark available					
% of patients aged 0-15 readmitted within 28 days	0.20%	0.32%						
% of patients aged over 15 readmitted within 28 days	3.06%	2.72%						
Domain 4: Ensuring that people have a positive experience of care								
Percentage of Inpatients who would recommend the provider to friends or family needing care[1]	98.10%	96.98%	97.61%	Feb 2015-16	100%	74.17%	95.67%	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Percentage of staff who would recommend the provider to friends or family needing care *Source: national NHS staff survey*	97%	91%	91%	Q2 2015-16	96.48%	58.36%	78.96%	https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/data/
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm								
Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)	95.87%	95.49% (Q3 YTD)	95.59%	Q3 2015-16	100%	61.5%	95.48%	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2015-16/
Rate of *clostridium difficile* (number of infections/100,000 bed days)	0.5[2]	0	No benchmark available					
Patient safety incidents reported to the National Reporting & Learning System								http://www.nrls.npsa.nhs.uk[3]
• Number of patient safety incidents	2469[4]	3716 as of 7/4/16	-	-	2672	275	1129	
• Rate of patient safety incidents (number/100 admissions)	1.13	TBC[5]	23.82	Q3+4	108.54	16.33	-	
• Percentage resulting in severe harm or death	0.16% (=4/2469)	0.054% (=2/3716) as of 7/4/16	0%	2014-15 (next update on 19/04/16)	0%	0.3%	0.1%	

[1] For 2014/15 the FFT scores have replaced the previously reported score for 'Responsiveness to inpatients' personal needs' as FFT scores have become the patient experience metric for CQUIN

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

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

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

[5] This rate is now worked out as (number/1000 beddays) by NRLS therefore years can't be compared to one another.

Friends and Family test

Patient feedback comments:

"Very pleasant staff, always someone in attendance or near at hand. Staff very willing to help and provide or seek answers to questions, Catering was very good and a plentiful supply of hot drinks available."

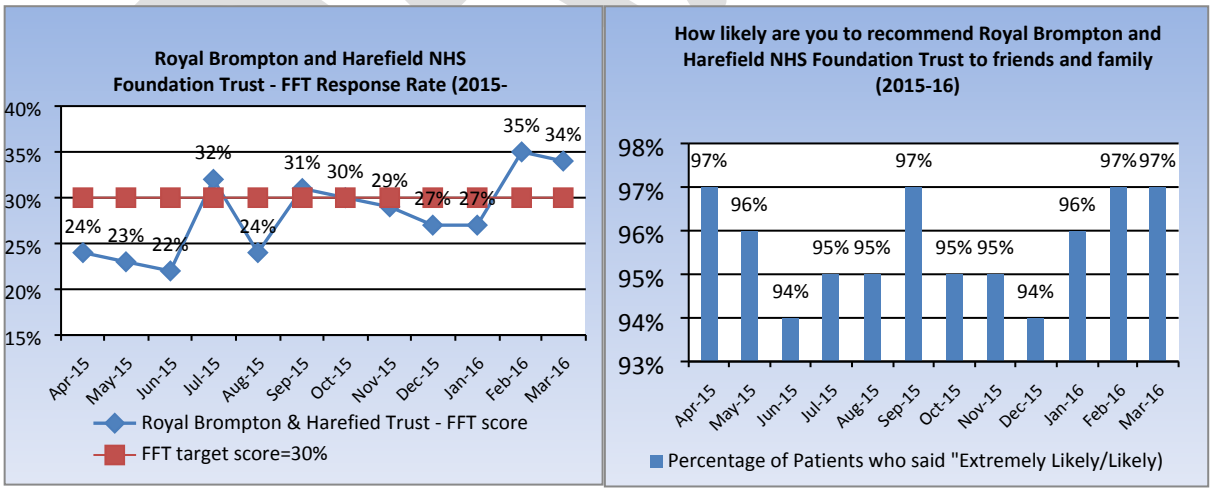
"The patience of the professionals on the ward to understand the needs of complaints of my illness and the support they have given me is terrific thank you so much."

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

The Friends and Family Test (FFT) provides a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and make improvements where necessary to ensure that patients have a positive experience of care. Results of the test are published every month on the NHS England and NHS Choices websites.

Royal Brompton & Harefield NHS Foundation Trust started using the Friends and Family Test in December 2012. The data is collected by paper questionnaires given to all patients on the day of discharge. The FFT target score first set by the Department of Health was 15%, this was increased to 25% in April 2014, and the Trust has managed to achieve and exceed these targets. As from 1st January 2015 the FFT target increased to 30%, and this was achieved for the final quarter of the year.

Chart 1: FFT response and recommend scores for 2015-16 (Source: Picker Institute Europe)



The FFT recommend scores for Royal Brompton & Harefield NHS Foundation Trusts has been consistently high = >90%. However there are some comments which appear to suggest that the concept of the Friends and Family Test is not well understood by all, for example:

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

Friends Family Test Benchmarking – March 2016 (Source NHS England)

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

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

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

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

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

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

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

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

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

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

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

Actions taken as a result of patient feedback in 2015

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

1. Facilities

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

2. Information & Communication

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

3. Compassion in Practice

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

Complaints

The following information about formal complaints received by the Trust is reviewed on a monthly basis by the operational management team: (This table will be updated reflect the year total figures as they become available)

Period	1st April 2015 – 31st January 2016			
	Within 25 days	Over 25 Days	Total	%
Royal Brompton Hospital	40	6	46	87.0
Harefield Hospital	20	11	31	69.0
Trust Total	**60**	**17**	**77**	**77.9**

Amendments to the NHS complaints regulations removed the stipulation to respond to complaints within set timescales, allowing organisations to individually negotiate response dates with complainants, ensuring that they are kept informed of any delays in the investigation. During the year 2015/2016 this Trust in line with many others retained an internally set standard which aims for 25 working days from receipt of a formal complaint to a response being sent from the Chief Executive, with a target of 90% for achievement. The exception to this is where a different timescale is negotiated with the complainant in recognition of a particularly complex investigation.

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

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

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

Following the investigation complaint outcomes are described as either Complaint Upheld (the majority of the complaint is justified), Complaint Partially Upheld (some aspects of the complaint are justified) or Complaint Not Upheld.

Complaints Received	Site	Upheld	Partially Upheld	Not Upheld	Number of Complaints Re-Opened	Still Open
51	Royal Brompton Hospital	28	12	10	7	1
40	Harefield Hospital	18	10	9	3	3
91		46	22	19	10	4

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

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

Of the 40 complaints received at Harefield Hospital during the year 2015/2016 70% were upheld or partially upheld and 22% not upheld. 3 complaints (8%) were reopened at the complainants request and they were provided with a further written response or meeting. 3 complaints received in March 2016 have not yet been responded to.

Private patient complaints at the Trust are treated under the same Trust policy as NHS complaints and are therefore included in the number of complaints received; the 25 working day performance statistics and the outcomes are also measured.

The K041 data return to the Health and Social Care Information Centre is now submitted quarterly. These figures will not include complaints received from private patients as this return is only for patients receiving NHS funded treatment. NHS Complaints led by other organisations are also not included, so that complaints about NHS care do not get counted twice.

The Trust continues to improve its care and service delivery through regular review of complaints, and identification of learning via the Divisional and trust wide Governance processes. Staff undertaking investigations are supported through regular case review meetings and learning events. A focus on finding effective ways of identifying whether the response was helpful for the complainant has led to the involvement of the Director of Patient Experience and a pilot of telephone interviews post complaint, which will be used to improve our processes.

Part 3: Formal statements of assurance

CQC registration

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

The CQC has not taken enforcement action against Royal Brompton & Harefield NHS Foundation Trust during 2015-16. Royal Brompton & Harefield NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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

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

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

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

Provision of NHS services

During 2015-16 Royal Brompton & Harefield NHS Foundation Trust provided 16 NHS services. Royal Brompton & Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 16 of these NHS services.

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

Use of the CQUIN Payment Framework

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

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

What is a CQUIN measure?

CQUIN is a payment framework that enables commissioners (who pay us for providing services) to reward excellence by linking a proportion of the Trust's income to the achievement of local quality targets.

What is clinical audit?
Clinical audit is a quality improvement process that seeks to improve patient care and outcomes. This is done through a systematic review of care against specific criteria followed by implementation of change, if required.

Participation in clinical audit

The national clinical audits and national confidential enquiries that Royal Brompton & Harefield NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2015-16 are listed below:

Clinical Audit Topic	National Clinical Audit	Did the Trust participate in 2015/16	Clinical Audit Lead
Peri-and Neo-natal			
Perinatal mortality	MBRRACE-UK	√	**Val Hedley**
Children			
Paediatric asthma	British Thoracic Society	√	**Ian Balfour-Lynn**
Paediatric intensive care	PICANet	√	**Margarita Burmester**
Paediatric cardiac surgery	NICOR Congenital Heart Disease Audit	√	**Rodney Franklin**
Acute care			
Emergency use of oxygen	British Thoracic Society	√	**Nick Hopkinson**
Non- invasive ventilation -adults	British Thoracic Society	√	**Anita Simonds**
Cardiac arrest	National Cardiac Arrest Audit	√	**Richard Young**
Adult critical care	ICNARC CMPD	√	**Jeremy Cordingley**
Emergency Laparotomy	NELA	√	**Lakshmi Kaupparao** **Tom Pickworth**
Elective procedures			
Coronary angioplasty	NICOR Adult cardiac interventions audit	√	**Charles Ilsley** **Simon Davies**
CABG and valvular surgery	Adult cardiac surgery audit	√	**Rashmi Yadav** **Fabio de Robertis**
Cardiovascular disease			
Acute Myocardial Infarction & other ACS	MINAP	√	**Rob Smith** **Simon Davies**
Heart failure	Heart Failure Audit	√	**Rakesh Sharma**
Cardiac arrhythmia	Cardiac Rhythm Management Audit	√	**Wajid Hussain** **Julian Jarman**
Lung cancer	National Lung Cancer Audit	√	**Eric Lim**
Blood transfusion	Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery	√	**David Cummings**
End of life			
Care of dying in hospital	NCDAH	√ (RBH)	**Lauren Berry**

National Confidential Enquiries; Mental Health and Non-invasive ventilation

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

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

Participation in research

As a specialist tertiary centre focussing on heart and lung disease across the whole age spectrum; staying at the forefront of research and innovation is vital to the delivery of our services and is part of the overall mission of the Trust; to

"undertake pioneering and world class research into heart and lung disease in order to develop new forms of treatment which can be applied across the NHS and beyond".

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

- To support and develop research-active staff – increasing critical mass and productivity of research leaders and ensuring that all staff are appropriately trained and supported.
- To exploit opportunities to attract and retain research funding – increasing the value of research funding coming to the Trust and ensuring high quality delivery of studies, to time and on target
- To promote and increase engagement in Trust research – by raising awareness of research activities amongst all staff and patients/carers
- To provide effective and well managed research facilities, research resources and administrative support.

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

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

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Royal Brompton & Harefield NHS Foundation Trust during 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 4400. These patients were recruited into over 140 clinical research projects.

Of these accruals, 2161 were into NIHR portfolio studies and 1347 patients were consented to donate their tissue for retention within the Trust's ethically approved Biomedical Research Unit Biobanks during 2015-16. In addition 47 patients have consented to participation in the National 100k Genome project for rare diseases.

Data quality

Statement on relevance of data quality and actions to improve data quality

In Royal Brompton & Harefield NHS Foundation Trust, data quality is seen as everybody's responsibility. Such an approach helps the Trust ensure that very high standards in data quality are maintained throughout the organisation.

The Trust uses the following initiatives to maintain very high quality of data and therefore a high quality service to all service users:

- Fortnightly batch tracing of service user records against Patient Demographics Service (PDS)
- Routine back office cleansing of difficult to trace records against PDS
- Prompt reporting and investigation of all data quality issues
- Regular briefing of frontline staff at team meetings
- Routine checking and updating of service user information with service users

GP Details and NHS number coding

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

Data from PAS (April 2015 - March 2016)

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	97.17%	99.2%
	Outpatients	97.45%	99.4%
Inclusion of patient's valid general medical practice code	Inpatients	99.71%	99.9%
	Outpatients	99.89%	99.8%

Information governance toolkit attainment levels 2015-16

During 2015/16, the Trust achieved the minimum level 2 compliance against all of the elements of the Information Governance Toolkit as required by Monitor. The Information Governance Team undertook a thorough review of the evidence supporting the declaration made on 31st March 2016. An overall score of 69% was achieved.

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

What is the information governance toolkit? Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The toolkit provides NHS organisations with a set of standards against which we declare compliance annually.

Clinical coding error rate

Royal Brompton & Harefield NHS Foundation Trust carried out an internal audit in February 2016. This was based on 200 randomly selected records from June to August 2015 data.

The results of the clinical coding audit are below.

Clinical Coding Audit Results

Primary diagnosis correct %	Secondary diagnoses correct %	Primary procedure correct %	Secondary procedures correct %	Unsafe to Audit %
98.0%	97.61%	96.95%	97.34%	98.0%

Performance against key healthcare targets 2015-16

There are national healthcare targets that enable the regulators and other institutions to compare and benchmark the performance of organisations. Trusts are required to report against the targets that are relevant to them. The table below shows the key healthcare targets that this Trust reports to the Trust board and also externally.

Indicator	Target/ threshold	2015-16 Q1 Score	2015-16 Q2 Score	2015-16 Q3 Score	2015-16 Q4 Score	2015-16 score	Indicator met
Clostridium difficile - Cases due to lapses of care	12	0	0	0	0	0	Yes
MRSA – Trust attributable to Trust	0	0	0	0	0	0	Yes
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	94%	100.0%	100.0%	100.0%	95.88%	-	Yes
Maximum 62 day wait from GP referral to treatment for all cancers (post local breach re-allocation)	85%	47.17%	69.05%	50.00%	62.26%	-	No
Maximum 62 day Consultant upgrade to first definitive treatment	85%	30.77%	56.25%	72.22%	61.54%	56.67%	No
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	100%	<5	<5	<5	100%	Yes
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	100%	99.05%	95.92%	96.64%	-	Yes
Percentage of incomplete patients waiting less than 18 weeks	92%	92.34%	92.13%	92.06%	90.23%	91.69%	No

Updated: 20th April 2016

18 Week Referral to Treatment Time Data Considerations

During 2015/16, the Trust invited the elective care intensive support team to review and make recommendations on its RTT processes in order to confirm/improve compliance with national requirements and ensure that the Trust was making best use of available capacity and resources – and they reported in September 2015. The Trust's Access Policy was updated and approved in November 2015 to reflect latest guidance and spot-checks of data quality have been undertaken in line with the recommendation contained in 'Results of quality reports assurance 2014/15' which was published by Monitor in March 2016. Challenges remain with data quality and preparations are under way for implementation of a new (Lorenzo) PAS in Quarter 2 of 2016/7. This system contains additional functionality which will help to improve data quality. An extensive training programme has been developed in conjunction with the deployment of the new PAS.

An overview of the quality of care

This overview refers back to indicators presented previously in this Quality Report. It is largely based on the quality priorities which were selected by the Board in consultation with stakeholders. These have been augmented by other indicators and grouped under three themes:

Patient Safety

- Improving our Organisational Safety Culture (see page xx)
- Improving the identification and management of patients at risk of pressure ulcers and falls (see page xx)
- Safer use of medicines and medical devices (see page xx)

Clinical Effectiveness

- Improving the management of patients with cancer (see page xx)
- Improving the management of the deteriorating patient (see page xx)
- Participation in Clinical Audit (see page xx)

Patient Experience

- Improving the patient experience for the cardiac surgery pathway (see page xx)
- Friends and Family Test (see pages xx and xx)

In addition, a summary of our performance against the indicators contained in the Risk Assessment Framework is given on page xx of this report.

Part 4: Statements from our stakeholders

Statements from Healthwatch

Statement from Healthwatch Hillingdon

Healthwatch Hillingdon
xx May 2016

Statement from Healthwatch Central West London

Statement from Local Authority Oversight and Scrutiny Committees

Adult Social Care and Health Scrutiny Committee; Royal Borough of Kensington and Chelsea

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

Statement from NHS England

Statement from Hillingdon Clinical Commissioning Group

Comments from our Governors

xx May 2016

Glossary

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

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

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

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

NHS Improvement	NHS Improvement brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. NHS Improvement is an operational name for the organisation which formally comes into being on 1 April 2016.
NHS number	A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
NICOR - National Institute for Cardiovascular Outcomes Research	NICOR is part of the Centre for Cardiovascular Preventions and Outcomes at University College London.
O	
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but is not admitted to a ward and is not staying in the hospital.
Outpatient survey	An annual, national survey of the experiences of patients who have been an outpatient. All NHS trusts are required to participate.
P	
PAS – Patient Administration System	The system used across the Trust to electronically record patient information e.g. contact details, appointments, admissions.
Patient record	A single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information.
Paediatric Intensive Care Unit (PICU)	A special ward for children who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.
Pressure ulcers	Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients than in people who are fit and well, as patients are often not able to move about as normal.
Primary coronary intervention (PCI)	Often known as coronary angioplasty or simply angioplasty. A procedure used to treat the narrowed coronary arteries of the heart found in patients who have a heart attack or have angina.
Priorities for improvement	There is a national requirement for trusts to select three to five priorities for quality improvement each year. This must reflect the three key areas of patient safety, patient experience and patient outcomes.
Paediatric early Warning Score (PEWS)	A modified paediatric early warning score to trigger alerting of physical deterioration in a similar manner to the NEWS

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

Appendix A

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

Introduction

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

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

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

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

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

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

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

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

AIMS

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

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

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

- We will join the IHI Open School and encourage staff to improve and develop their knowledge and professional development in relation to patient safety and quality improvement.

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

TEAM

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

PATIENT PARTNERS

1. We will continue to engage with patients, their families and carers through a variety of media
2. We have posted our pledges (Appendix 2) on our website and share our plans and progress with staff , governors, patients , the public and our partner organisations.
3. We will continue to enhance our patient experience feedback work building on the national surveys and FFT to develop opportunities to collect real time feedback about wards, departments and services

COMMUNICATION & IMPLEMENTATION STRATEGY

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

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

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

ACUTE KIDNEY INJURY (AKI)

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

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

DETERIORATING PATIENT (Adult and Paediatric)

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

Failure to recognize, intervene, escalate and manage the deteriorating patient is a well-recognized cause of prolonged hospital stay, requirement for transfer to a higher level of care and avoidable cardiac arrest in both adult and paediatric patients . The Trust was an early adopter of an EWS following NICE guidance 50 in 2008 and has since moved to the NEWS based on the 2012 joint RCP/ RCN document[6] . In Paediatrics the trust is a partner in an NHS adopted international portfolio study (22 centres) and has developed a bespoke score matched care algorithm. Failure to recognize deterioration and or escalate has been a feature of both incidents and claims within the Trust and the SIP will act as a driver of continued improvement in this cross-cutting theme. The overall plan for improving recognition and management of the deteriorating patient is shown in driver diagram 2 (attached PowerPoint)

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

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

The recent NHS England patient safety alert[7] set out a series of actions required to r improve the recognition and management of sepsis. Which unless treated quickly can lead rapidly to death (50% mortality from septic shock) .Recent epidemiological studies(3),(4) and data from the Intensive Care National Audit and Research Centre (ICNARC)(5), estimate that 35,000 people die from sepsis in England each year. The mortality rate for sepsis in children is estimated to be 10 – 15%. The following are said to be key to reducing these figures; Timely recognition and diagnosis of sepsis, Fast administration of intravenous antibiotics, Quick involvement of experts including intensive care specialists. The Trust currently lacks robust data on the overall incidence of sepsis, including hospital acquired (CRBSI, VAP, HAP) although there is detailed surveillance of surgical wounds which is regularly analysed and reported resulting in the development of a Brompton Harefield Infection Score (BHIS[8]) which is being piloted with the aim of reducing SSIs in high risk patients (current rate for 2014

[6] https://www.rcplondon.ac.uk/resources/national-early-warning-score-news

[7]

Alert reference number: NHS/PSA/R/2014/015

[8] Nursing Times Infection Control Award 2013

3.2%). The SSI reduction programme will be extended to include all wounds during the lifetime of this plan. This project will aim to acquire baseline data on the incidence of sepsis, the impact of introducing the SEPSIS 6 system and compliance with it as well as improving antimicrobial stewardship. The overall plan for improving recognition and management of the Sepsis is shown in driver diagram 3 (attached PowerPoint)

ELDERLY CARE (>75years)

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

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

PRESSURE ULCERS

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

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

MEDICATION AND DEVICES SAFETY

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

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

CANCELLATIONS

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

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

PROCEDURAL COMPLICATIONS

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

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

Appendix B

Royal Brompton and Harefield NHS Foundation Trust

'SIGN UP TO SAFETY' Pledges

'Listen, Learn, Act'

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

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

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

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

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

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

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

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

5. Support

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

Driver Diagram for Safety Improvement Implementation Plan

Safety Improvement Plan RBHNFT 2015-18