APPENDIX A
DRAFT

Royal Brompton & Harefield NHS
NHS Foundation Trust

Quality Account 2010-11

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

Contents

Part 1: Chief Executive Statement

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

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

- Service Excellence
- Organisational Excellence
- Productivity and investment

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

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

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

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

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

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

BOB BELL
Chief Executive Royal Brompton & Harefield NHS Foundation Trust

Part 2: Priorities for Improvement

Introduction

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

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

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

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

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

Patient Safety:

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

Patient Experience

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

Patient Outcomes

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

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

Out of Intensive Care Cardiac arrests

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

Rationale

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

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

Definitions

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

Quality Standards

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

Improvement Plan

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

End of Life Care

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

Rationale

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

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

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

Definitions

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

Quality Standards

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

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

Improvement Plan

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

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

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

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

Availability of patient records

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

Rationale

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

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

Definitions

Patient Record: a single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information.

Quality Standards

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

Improvement Plan

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

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

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

Rationale

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

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

Definitions

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

Quality Standards

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

Improvement Plan

To be agreed based on quality standards once finalised.

CQUIN Payment Framework 2011/12

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

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

* as a % of the CQUIN scheme available

VTE Prevention

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

Rationale

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

Quality Standards

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

Improvement Plan

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

Patient Experience – Personal Needs

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

Rationale

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

Quality Standards

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

Improvement Plan

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

Pressure Ulcers

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

Rationale

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

Quality Standards

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

Improvement Plan

Indicator for grade 2 and 3 pressure ulcers:

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

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

Falls

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

Rationale

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

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

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

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

Quality Standards

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

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

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

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

Part 3: Review of Quality Performance

Introduction

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

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

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

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

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

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

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

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

Compliance Framework

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

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

Governance Rating	Score 0.0	Status – Green

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

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

Quality and Risk Profile (QRP)

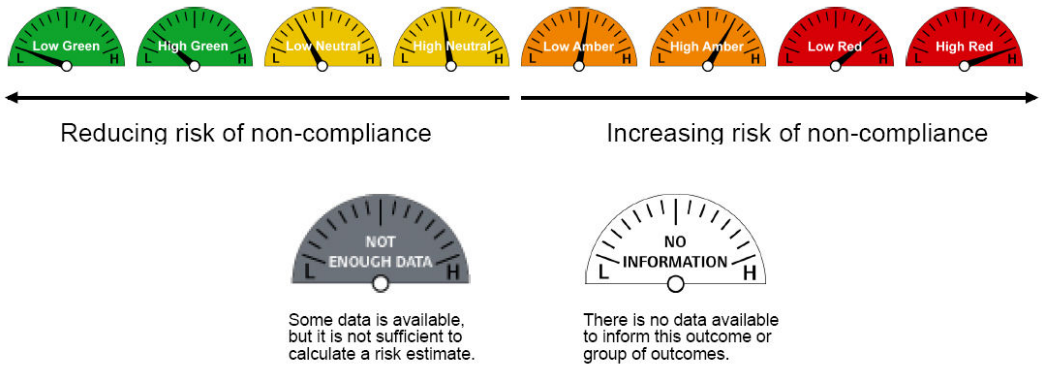
From 1 October 2010, all health and adult social care providers are legally responsible for making sure they meet essential standards of quality and safety and must be licensed with Care Quality Commission (CQC).

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

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

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

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

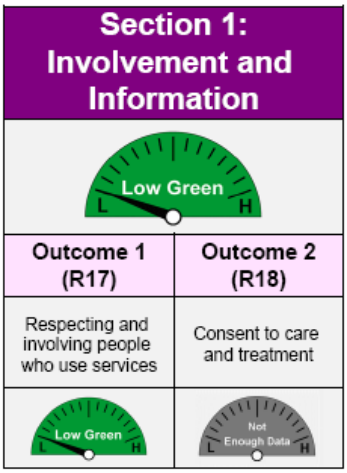


The essential standards

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

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

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



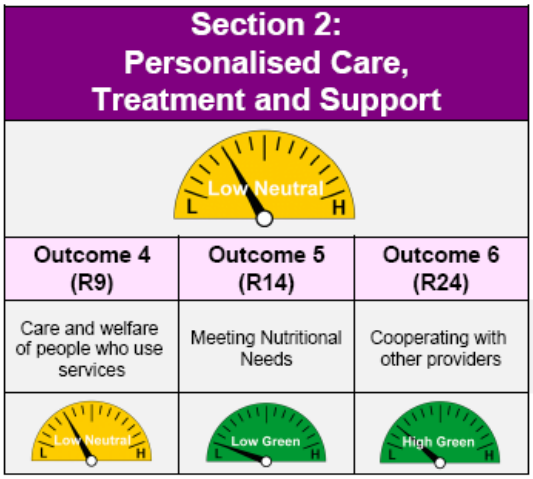
Scores range from low green to high red

Low green is the best possible score

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

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

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



Scores range from low green to high red

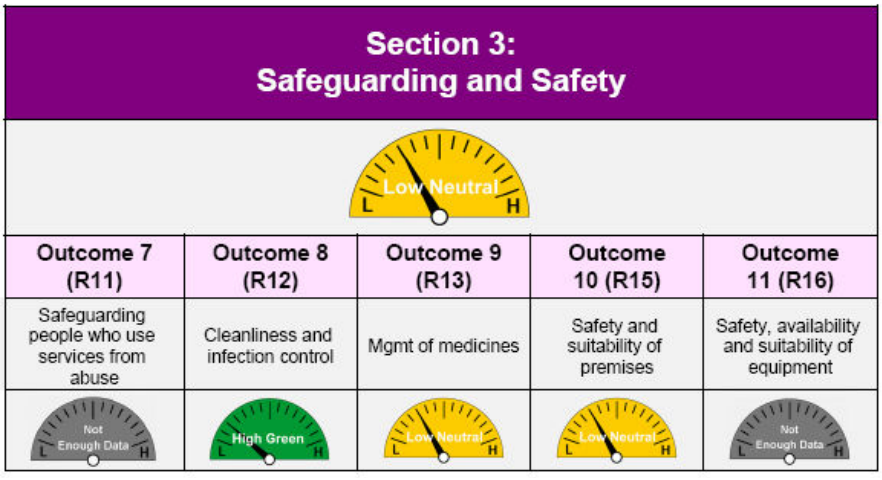
Low neutral is a better than average score

Low green is the best possible score

High green is the second best possible score

Standard 3: You can expect to be safe

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



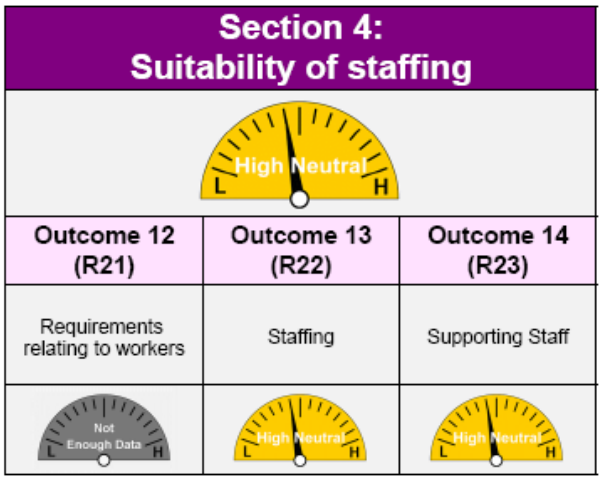
Scores range from low green to high red

Low neutral is a better than average score

High green is the second best possible score

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

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



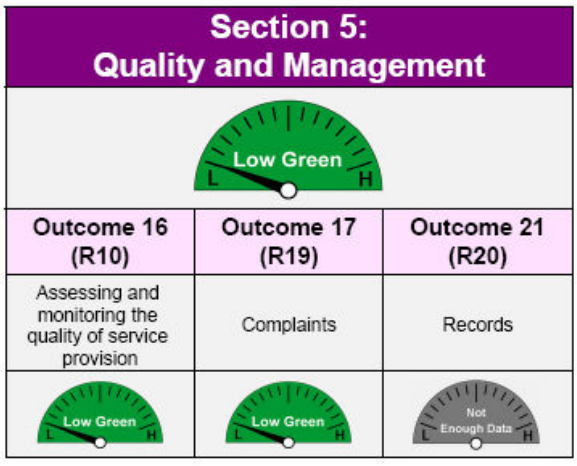
Scores range from low green to high red

High neutral is a better than average score

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

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

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



Scores range from low green to high red

Low green is the best possible score

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

Commissioning for Quality and Innovation (CQUIN) 2010-11

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

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

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

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

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

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

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

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

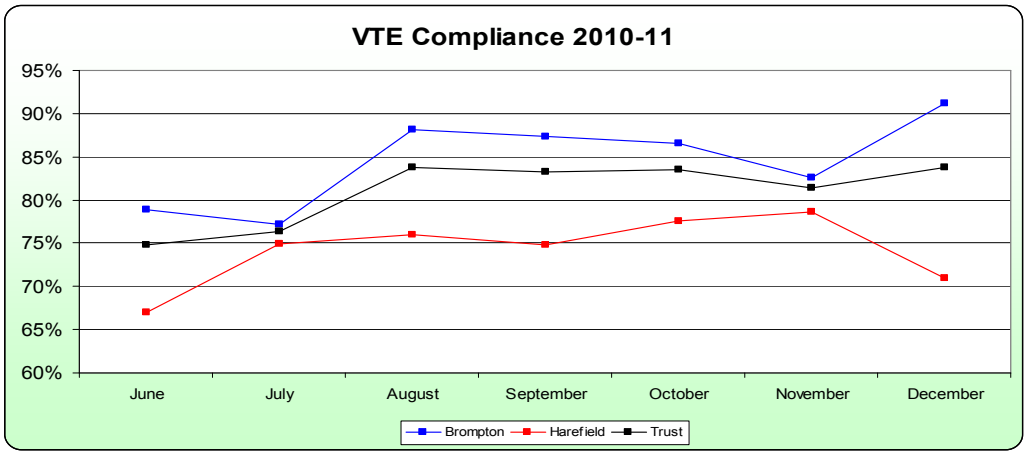
Improve venous thromboembolism (VTE) prevention

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

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

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

VTE compliance since reporting began in June 2010



Improve patient experience as per adult inpatient survey

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

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

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

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

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

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

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

Trust inpatient survey scores 2009 and 2010

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

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

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

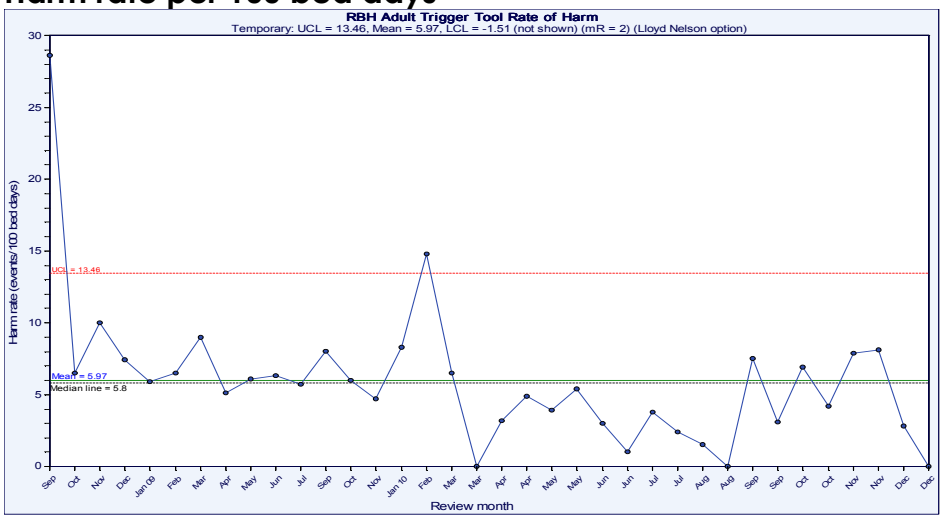
Implement the IHI global trigger tool (GTT)
The GTT was developed by the Institute for Health Improvement in the US to improve patient safety through a systematic approach that proactively identifies key triggers and enables focussed intervention that over time reduce the incidence of hospital acquired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

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

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

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

Harm rate per 100 bed days



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

Future Plans

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

Increase effectiveness of outpatient care planning

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

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

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

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

Preventing pressure ulcers

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

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

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

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

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

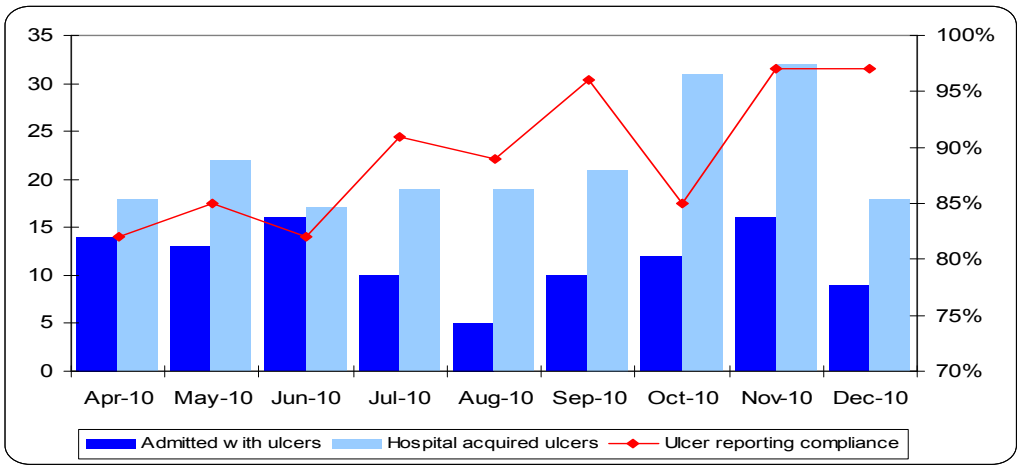
Q3 has shown an improvement in reporting compliance across the trust, rising from 83% in Q1 to 92% in Q2 and 93% in Q3.

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

Quarter 4 figures will be included in the final report.

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

Pressure ulcer reporting



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

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

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

Current actions in progress

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

product in practice has reduced hospital acquired oral pressure ulcers.

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

Participation in clinical audits

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

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

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

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

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

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

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

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

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

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

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

National clinical audits

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

Local clinical audits

Patient Identification

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

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

PAR Score

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

Bleeding following cardiac surgery

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

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

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

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

Participation in Research

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

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

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

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

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

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

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

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

Data Quality

NHS Number and General Medical Practice Code Validity

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

At 1st March 2011

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

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

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

Information Governance Toolkit attainment levels

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

Clinical coding error rate

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

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

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

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

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

Review of Priorities for Quality 2010-11

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

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

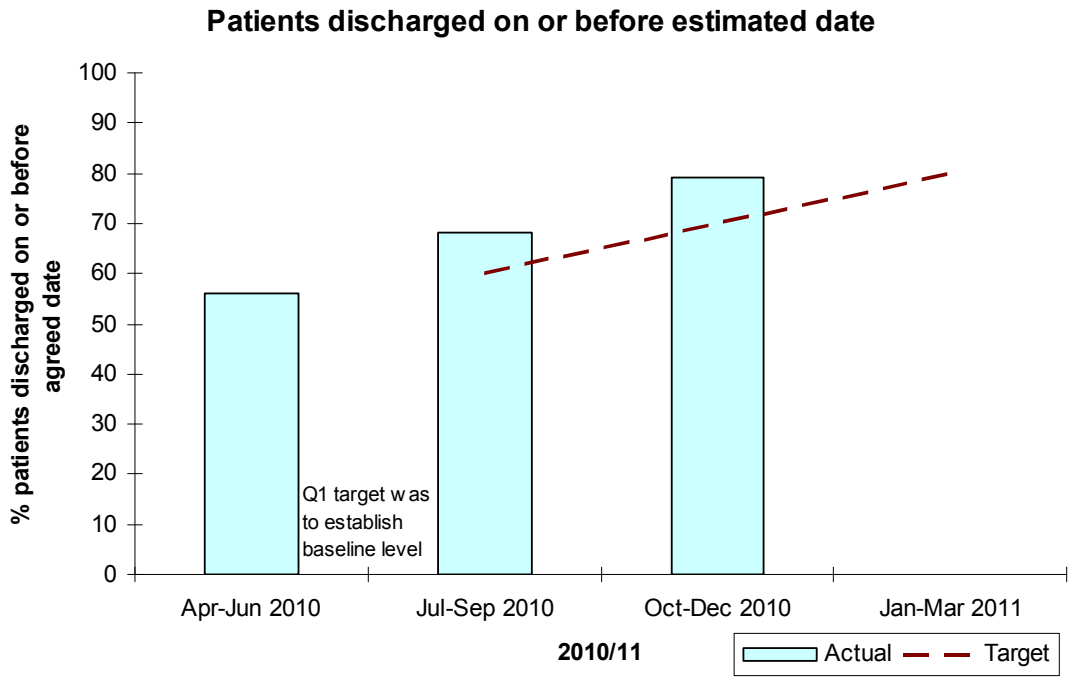
- Patient Experience – making the discharge process easier for patients
- Clinical Effectiveness – providing more training for staff in safeguarding children
- Patient Safety – ensuring the incidence of surgical site infection is reduced

Patient Experience

Discharge on agreed date

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

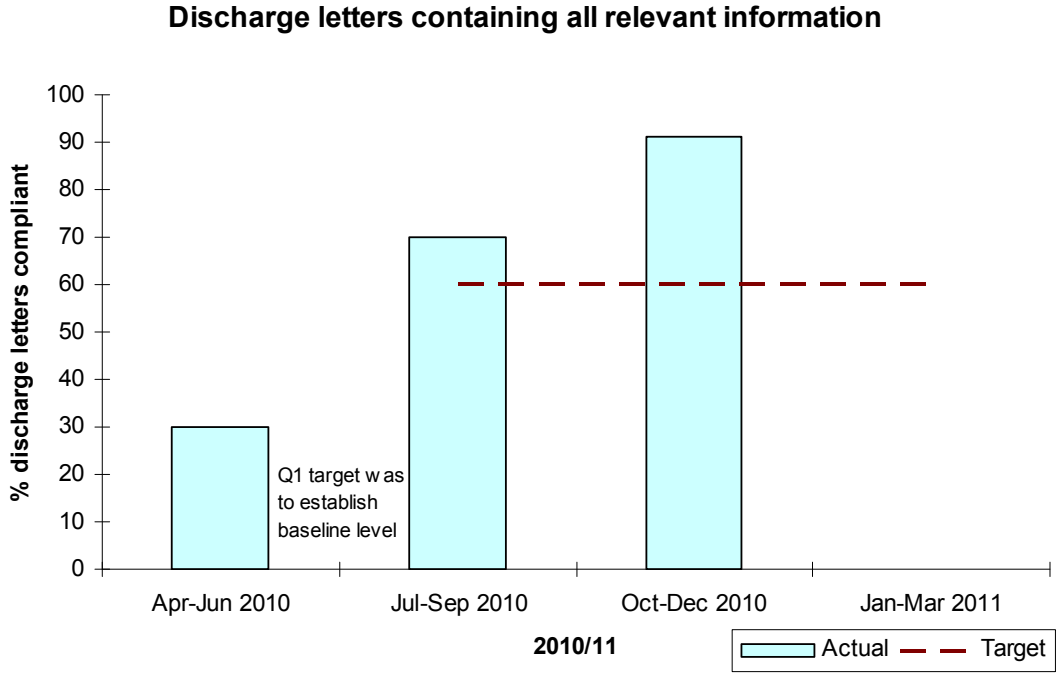
The chart below shows how the Trust has been performing against this target and demonstrates that there has been a steady increase in the number of patients being discharged on or before their agreed date. In the first quarter of the year the baseline was set from which the targets were set for each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



Information in discharge letters

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

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



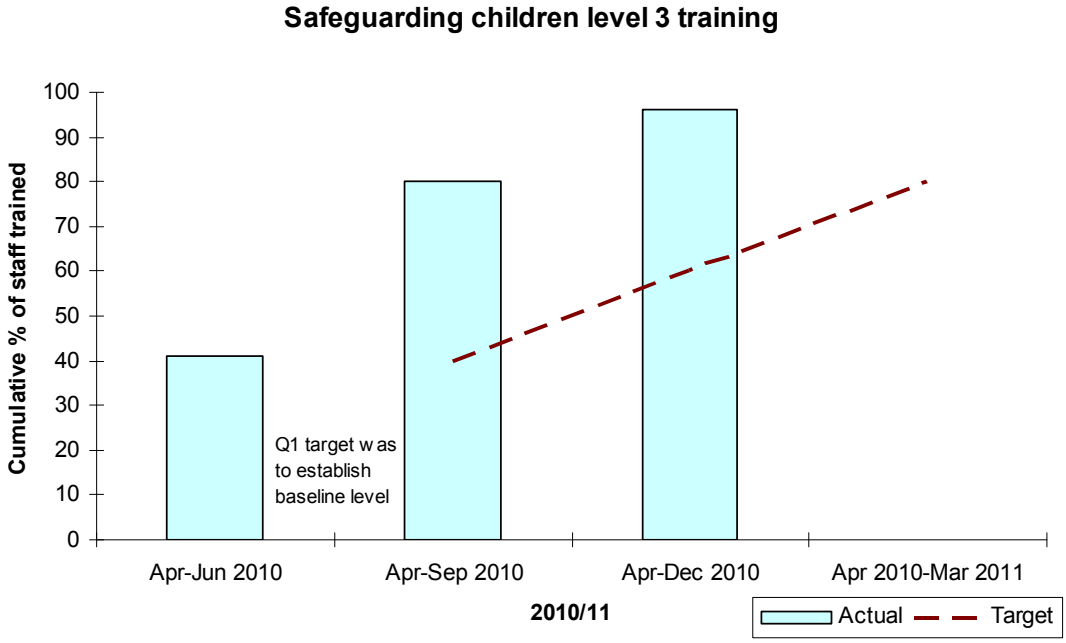
Clinical Effectiveness

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

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

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

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

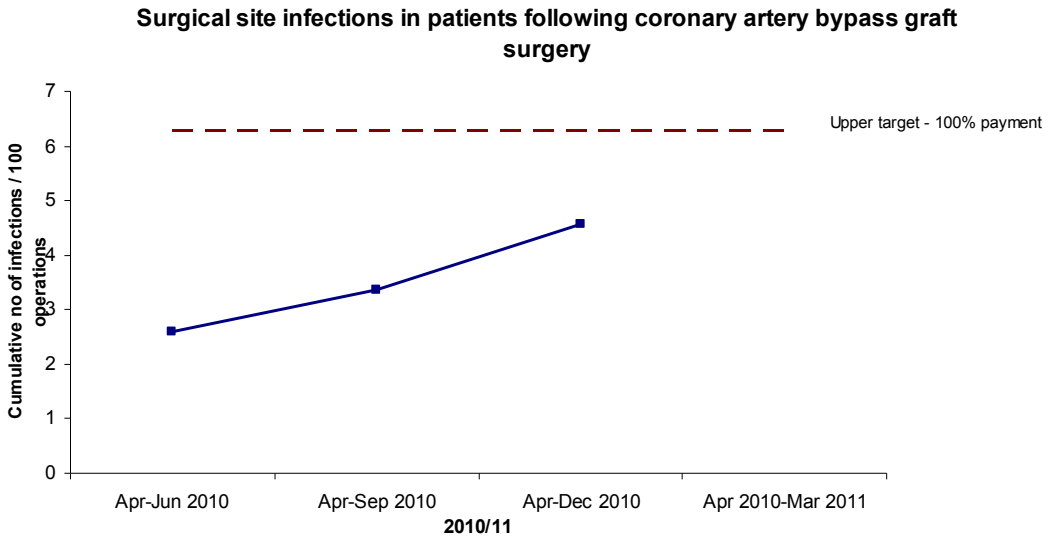

Safeguarding children level 3 training
Cumulative % of staff trained
100
90
80
70
60
50
40
30
20
10
0
Q1 target was to establish baseline level
Apr-Jun 2010
Apr-Sep 2010
Apr-Dec 2010
Apr 2010-Mar 2011
2010/11
Actual
Target

Patient Safety

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

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

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

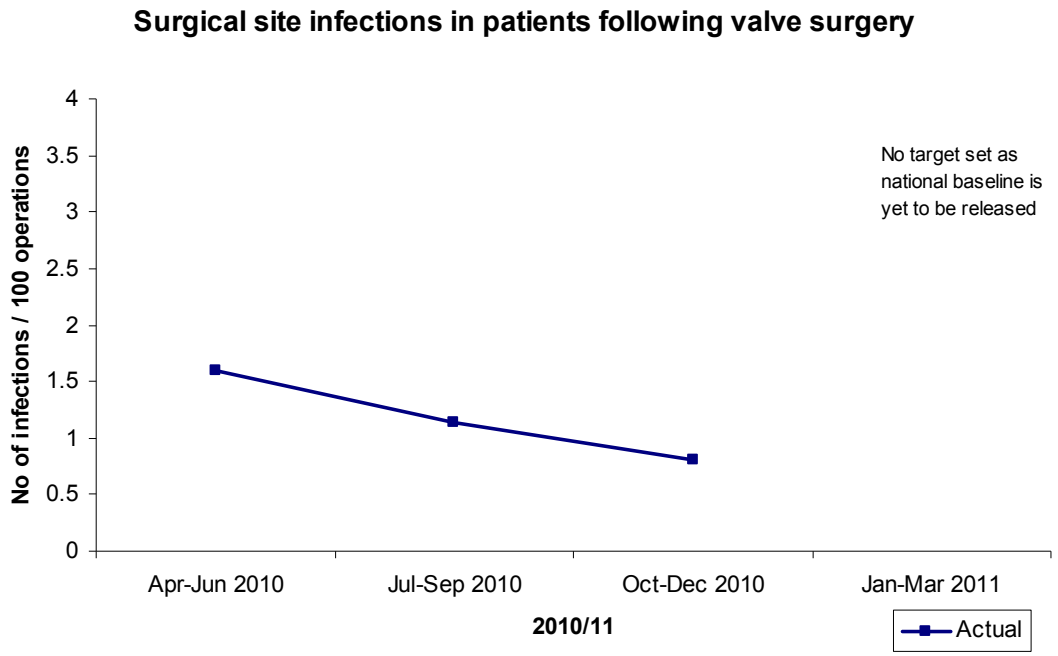


The Trust has been working hard to reduce surgical site infections and has introduced various new practices which have contributed to this. There is a new option for harvesting the vein required for patients undergoing CABG. The vein is harvested endoscopically therefore reducing the infection risk and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

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

Reduce surgical site infections for cardiac valve procedures

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



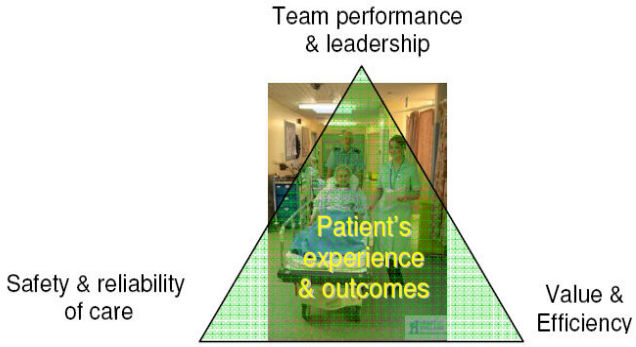
Other Quality Improvement Projects in 2010/11

The Productive Operating Theatre and Catheter Lab Utilisation programme

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

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

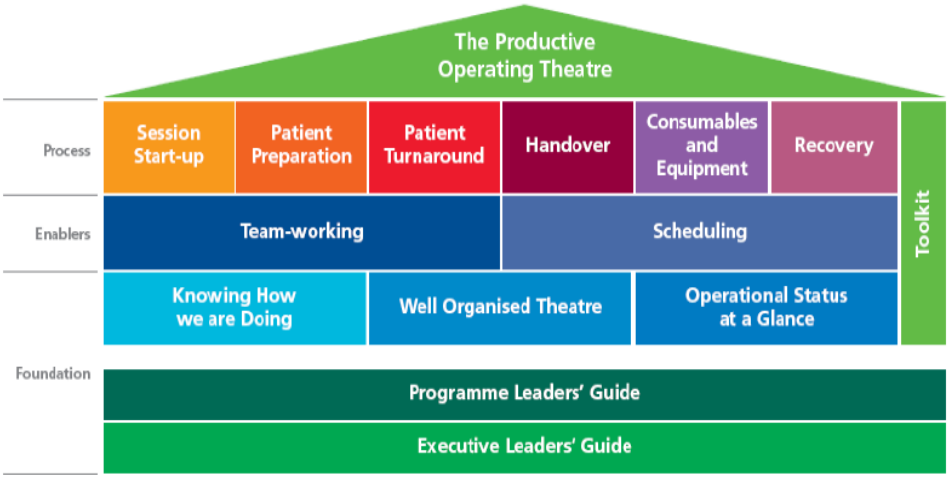
- Increase the **safety and reliability of care** through reducing errors and incidents of harm
- Improve **team-working** and performance, staff morale and leadership
- Add value and improve **efficiency**



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

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

T-POT structure



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

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

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

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

Patient Survey results

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

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

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

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

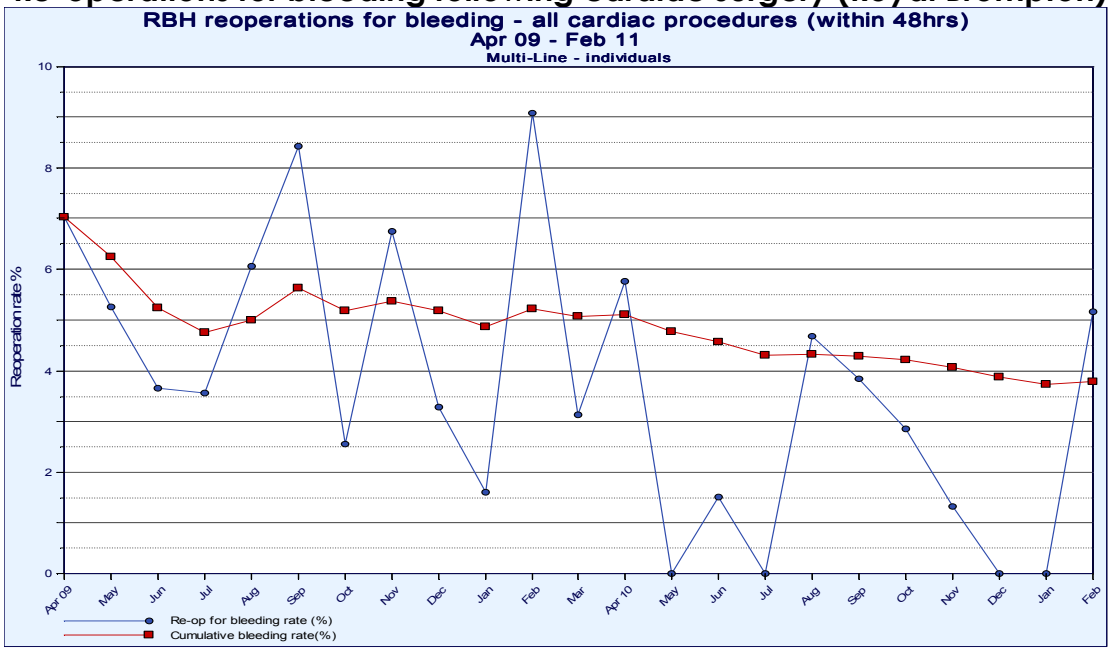
Reducing Re-operations for Bleeding following Cardiac Surgery

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

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

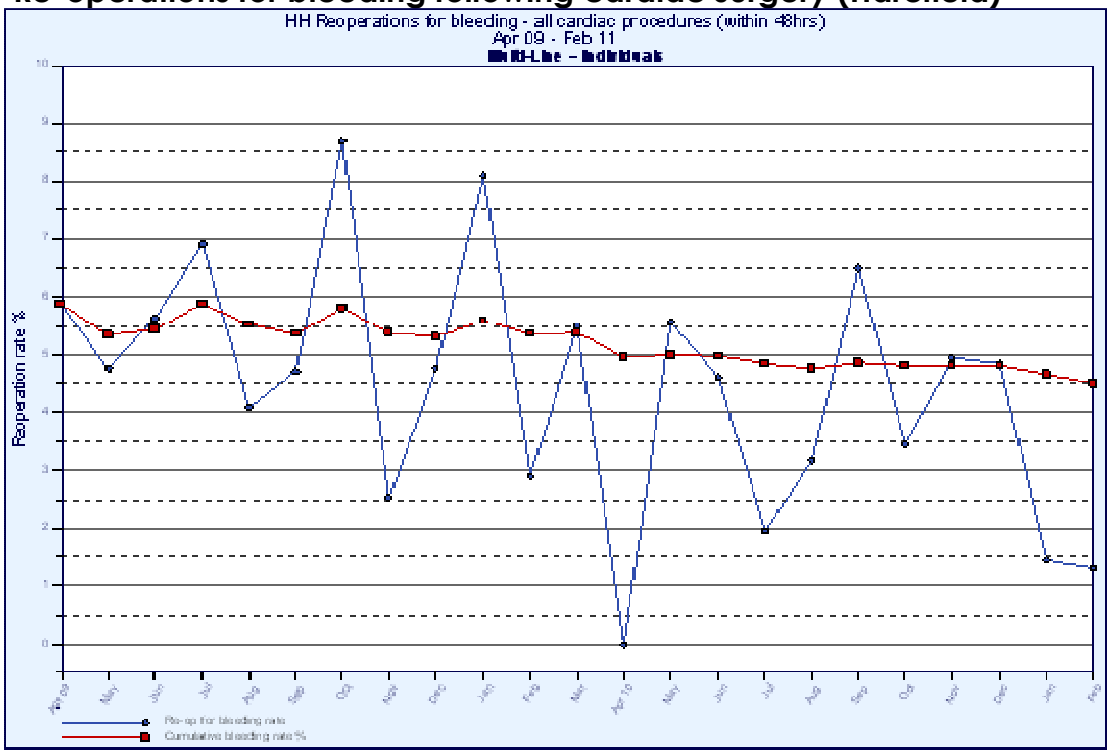
The rate of patients returning to theatre for a re-operation at RBH has reduced by 56.9% in the first three quarters of 2010/11 when compared to 2009/10. The chart below shows the re-operation rate by month and cumulatively since April 2009. For example, in the first three quarters of 2010/11 no patients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

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



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

Re-operations for bleeding following cardiac surgery (Harefield)



Part 4: Involvement in Quality Account 2010-11

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

Choice of Priorities for Quality

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

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

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

Review of Draft Quality Account

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

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

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

Kensington and Chelsea LINks

Hillingdon LINks

Kensington and Chelsea Oversight and Scrutiny Committee

Hillingdon Oversight and Scrutiny Committee

North West London Commissioning Partnership

Glossary

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