The Hillingdon Hospitals NHS
NHS Foundation Trust

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

(take in pictures of ward activity at both hospitals)

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

To be re drafted when the document is complete

CONTENTS

To be re drafted when the document is complete

About this report

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

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

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

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

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

Yours sincerely

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

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

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

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

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

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

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

PRIORITY 1: Enhanced Recovery Programme

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

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

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

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

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

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

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

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

Our aims for 2011/12 are:

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

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

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

PRIORITY 2: Development of Clinical pathways for dementia and diabetes

Why is this one of our priorities?

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

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

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

How are we doing so far?

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

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

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

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

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

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

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

How are we doing so far?

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

Our aims for 2011/12 are

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

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

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

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

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

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

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

Our aims for 2011/12 are:

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

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

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

Why is this one of our priorities?

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

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

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

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

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

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

PRIORITY 5: Communication – Seeing the Person in the Patient

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

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

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

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

What are our aims for 2011/12?

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

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

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

PRIORITY 6: Maternity

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

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

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

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

Priority 7: CQUINs

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

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

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

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

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

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

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

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

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

Priority 2. The Patient Safety First Campaign

We said:

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

We did:

Identifying the patient at risk

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

Reducing harm from insulin

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

Reducing harm from warfarin

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

Reducing harm from surgery

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

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

We said:

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

We did:

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

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

We said:

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

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

- Record Keeping
- Hydration and Fluid Balance
- Medicine Management

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

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

Priority 5. Improving Care - the Emergency Care Pathway

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

We did:

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

We also did:

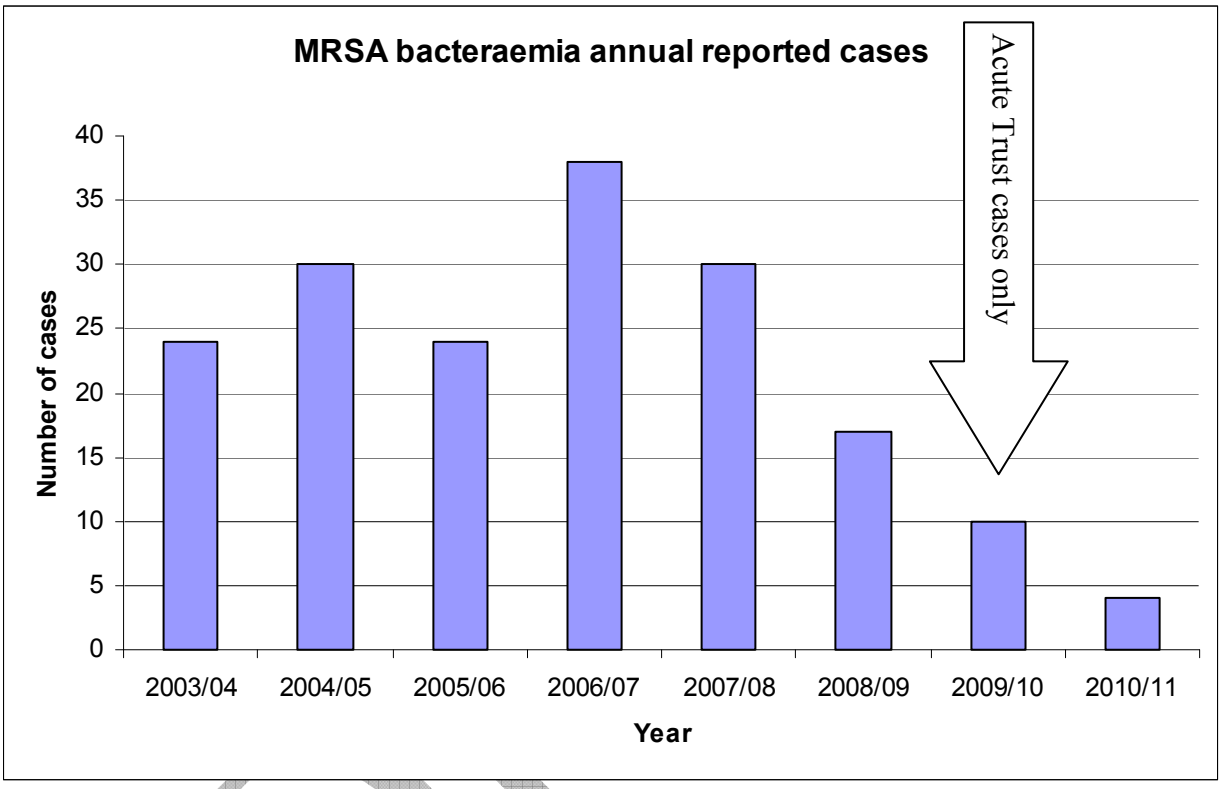
- Introduced a new investigation for patients with chest pain which allows rapid diagnosis and treatment
- Developed the skills of 4 Health Care Assistants to enable them to become Emergency Department Technicians. These staff are now competent to perform tasks such as taking blood, applying plasters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

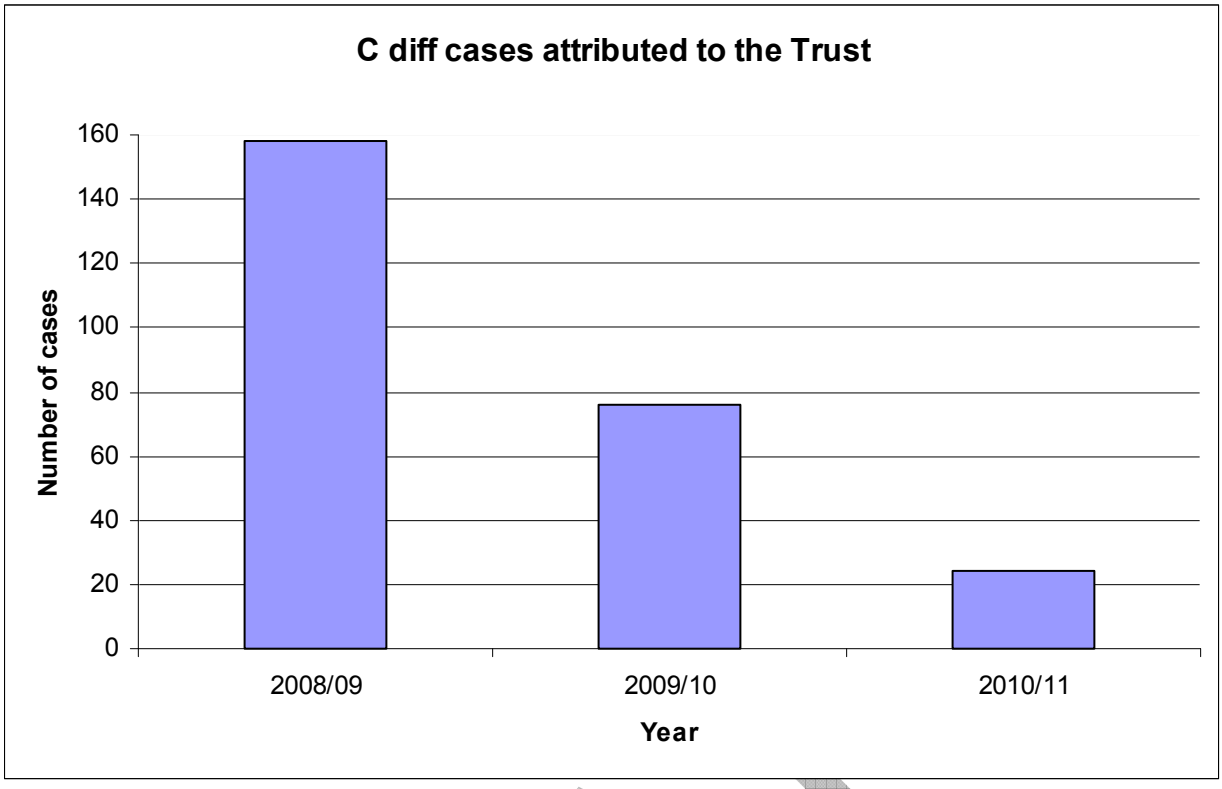
Priority 6. Improving Hospital Acquired Infection

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

We did:

The following graphs show that we have exceeded our targets





This has been achieved through:

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

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

Dashboard of other key quality measures

The Hillingdon Hospitals NHS Foundation Trust Performance

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

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

QA_metrics

Dashboard aim 11

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

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

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

Need text to accompany Dashboard aims 19 and 21

[1] http://www.institute.nhs.uk/quality_and_value/high_volume_care/fractured_neck_of_femur_facts.html, accessed 16 March 2011

[2] http://www.fractures.com/pdf/BOA-BGS-Blue-Book.pdf, accessed 16 March 2011

APPENDIX

Information for our regulators

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

Services

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

Audit

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

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

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

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

Participation Rates

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

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

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

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

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

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

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

**to confirm where reviewed

Local Audits

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

Research

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

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

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

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

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

Goals Agreed with Commissioners (CQUINS)

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

Care Quality Commission

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

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

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

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

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

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

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

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

ANNEXE

Lead Primary Care Trust Statement

500 words maximum – provided through consultation.

LinkS Statement

500 words maximum – provided through consultation.

Overview and Scrutiny Committee Statement

500 words maximum – provided through consultation.

The Hillingdon Hospital NHS Trust response to consultation

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